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FAMILY PACT PROGRAM

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

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$460,031,000	$460,116,000
- STATE FUNDS	$113,948,100	$113,969,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$460,031,000	$460,116,000
STATE FUNDS	$113,948,100	$113,969,400
FEDERAL FUNDS	$346,082,900	$346,146,600

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
The changes are due to updated expenditure data through June 2015. Overall, there is a decrease in utilization in all categories. For the Physicians category, the change is mostly due to a rate drop and decrease in users.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

Methodology:

1. Use linear regressions on actual data from September 2011 to June 2015 for users, units per user, and dollars per unit.

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

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

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

	FY 2015-16		FY 2016-17	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$81,302,000	$20,138,000	$84,292,000	$20,879,000
Other Medical	$276,697,000	$68,537,000	$271,975,000	$67,367,000
Outpatient	$2,888,000	$715,000	$3,013,000	$746,000
Pharmacy	$99,144,000	$24,558,000	$100,836,000	$24,977,000
Total	**$460,031,000**	**$113,948,000**	**$460,116,000**	**$113,969,000**

Funding:

(Dollars in Thousands)

FY 2015-16		**TF**	**GF**	**FF**
50% Title XIX / 50% GF	4260-101-0001/0890	$25,471	$12,736	$12,735
100% GF	4260-101-0001	$64,174	$64,174	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$370,386	$37,039	$333,347
***Total**		**$460,031**	**$113,949**	**$346,082**

FY 2016-17		**TF**	**GF**	**FF**
50% Title XIX / 50% GF	4260-101-0001/0890	$25,476	$12,738	$12,738
100% GF	4260-101-0001	$64,186	$64,186	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$370,454	$37,045	$333,409
***Total**		**$460,116**	**$113,969**	**$346,147**

*Amounts may differ due to rounding.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	4/2012
ANALYST:	Melinda Yegge
FISCAL REFERENCE NUMBER:	1569

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$148,598,000	$189,301,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$148,598,000	$189,301,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$148,598,000	$189,301,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department, counties, and the CDCR to:

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

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to:

- Designate an entity or entities to assist county jail inmates apply for a health insurance affordability program.
- Authorize the entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to:

- Grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a state inmate is granted medical parole, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.

SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or his/her designee, to:

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

For State inmates, with implementation of the Affordable Care Act (ACA), CDCR utilizes the Single Streamlined Application, currently used by counties, and the Department makes an eligibility determination according to current standard eligibility rules. Federal Medicaid regulations and federal guidance provided to states, allow for coverage of inpatient services to eligible inmates when provided off the grounds of a correctional facility. Providers are required to adhere to the utilization review requirements established by the Superior Systems Waiver (SSW). Diagnosis Related Group (DRG) providers will be required to submit a Treatment Authorization Request (TAR) to the Department for authorization in order to be paid for these services. Designated Public Hospitals (DPHs) will be responsible for performing their own utilization review in accordance with the SSW requirements. The Department currently has an interagency agreement with CDCR in order to claim Title XIX FFP.

Reason for Change from Prior Estimate:

The cost per event for State inmates has increased from $9,011 to $11,180 based on recent claims data. The ACA population was previously included in the May 2015 ACA Expansion-Adult Inmates Inpt. Hosp. Costs PC. This population is now included in this policy change which increases the eligible State inmates from 29 to 288, and the eligible county inmates from 64 to 320. Retroactive payments for both state and county inmate claims will begin in FY 2015-16 for FYs 2010-2015.

Methodology:

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

2. Applications for State inmates in Medi-Cal are processed by the Department if the applicant received off-site inpatient related services. Applications for county inmates will be completed by county welfare departments.

3. Based on actual claims data, the average cost for an adult inpatient admission is estimated to be $11,180 for both State and county inmates.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

4. Assume the Department will process 320 applications per month for State inmates with verified citizenship.

5. Assume 90 percent of the monthly applicants will become eligible for Medi-Cal.

6. Of the eligible Medi-Cal applicants, assume 10% are for Non-ACA Medi-Cal and 90% for the ACA Optional Expansion in FY 2015-16 and FY 2016-17.

   - Adults Non-ACA: 320 x 90% x 10% = 29 monthly Non-ACA State inmates
   - Adults ACA Optional Expansion: 320 x 90% x 90% = 259 monthly ACA State inmates

7. State adult Non-ACA inmate inpatient costs are estimated to be $3,891,000 TF ($1,945,500 FF) in FY 2015-16 and FY 2016-17. State adult ACA inmate inpatient costs are estimated to be $34,774,000 TF ($34,774,000 FF) in FY 2015-16 and $34,774,000 TF ($33,905,000 FF) in FY 2016-17. Retroactive claims for State adult inmates (ACA and Non-ACA) in FY 2015-16 are estimated to be $39,144,000 TF ($28,426,500 FF) and $39,144,000 TF ($28,426,500 FF) in FY 2016-17.

8. Assume there are 80,000 monthly county adult inmates. Assume that 2% will utilize inpatient services on a monthly basis and, of these, 20% will be eligible for Medi-Cal.

9. Assume the county application split will be 20% for Non-ACA Medi-Cal and 80% for ACA Optional Expansion in FY 2015-16 and FY 2016-17.

   - County Non-ACA: 80,000 x 2% x 20% x 20% = 64 monthly Non-ACA county inmates
   - County ACA: 80,000 x 2% x 20% x 80% = 256 monthly ACA county inmates

10. County adult Non-ACA inmate inpatient costs are estimated to be $8,586,000 TF ($4,293,000 FF) in FY 2015-16 and FY 2016-17. County adult ACA inmate inpatient costs are estimated to be $34,345,000 TF ($34,345,000 FF) in FY 2015-16 and $34,345,000 TF ($33,486,000 FF) in FY 2016-17. Retroactive claims for county adult inmates (ACA and Non-ACA) in FY 2015-16 are estimated to be $51,878,000 TF ($38,644,500 FF) and $113,598,000 TF ($81,075,500 FF) in FY 2016-17.

11. In FY 2015-16 and FY 2016-17, assume the Department will process 25 applications annually for State Medical Parolees with verified citizenship. Assume these eligibles will receive Long-Term Care (LTC) services for 20 months of continuous coverage. Estimated monthly eligibles are phased-in for an annual total of 500 in FY 2015-16 and FY 2016-17.

12. Based on actual claims data, the average LTC cost for inmates in the State Medical Parole program are estimated to be $9,099 per month.

13. State Medical Parole estimated costs are $4,550,000 TF ($2,275,000 FF) in FY 2015-16 and FY 2016-17.

14. In FY 2015-16 and FY 2016-17, it is assumed that Compassionate Release will be granted to 100 county inmates each year. It is assumed these eligibles will receive LTC services for 9 months of continuous coverage. Estimated monthly eligibles are phased-in for an annual total of 900 in both FY 2015-16 and FY 2016-17.

15. Based on actual claims data, the average LTC cost for inmates in the Compassionate Release program are estimated to be $8,655 per month.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

16. County Compassionate Release program estimated costs are $7,789,000 TF ($3,894,500 FF) in FY 2015-16 and FY 2016-17.

17. Total estimated Medi-Cal Inpatient Hospital Costs for all eligible (Medi-Cal and ACA) adult inmates in FY 2015-16 and FY 2016-17, including retroactive payments are:

(Dollars in Thousands)	**FY 2015-16**		**FY 2016-17**	
State	**TF**	**FF**	**TF**	**FF**
State - Non ACA	$3,891,000	$1,945,500	$3,891,000	$1,945,500
State - ACA	$34,774,000	$34,774,000	$34,774,000	$33,905,000
Medical Parole	$4,550,000	$2,275,000	$4,550,000	$2,275,000
Retroactive Payments	$39,144,000	$28,426,500	$39,144,000	$28,426,500
State Total	$82,359,000	**$67,421,000**	$82,359,000	**$66,552,000**
County	**TF**	**FF**	**TF**	**FF**
County - Non ACA	$8,586,000	$4,293,000	$8,586,000	$4,293,000
County - ACA	$34,345,000	$34,345,000	$34,345,000	$33,486,000
Compassionate Release	$7,789,000	$3,894,500	$7,789,000	$3,894,500
Retroactive Payments	$51,878,000	$38,644,500	$113,598,000	$81,075,500
County Total	$102,598,000	**$81,177,000**	$164,318,000	**$122,749,000**
Grand Total	$184,957,000	**$148,598,000**	$246,677,000	**$189,301,000**

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

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	1/2002
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	3

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$101,577,000	$107,444,000
- STATE FUNDS	$48,657,250	$50,407,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$101,577,000	$107,444,000
STATE FUNDS	$48,657,250	$50,407,150
FEDERAL FUNDS	$52,919,750	$57,036,850

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

A State-Only program covers women 65 years of age or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 24 months for cervical cancer. Estimated State-Only costs include undocumented persons' non-emergency services during cancer treatment. With the implementation of the Affordable Care Act (ACA) in January 2014, some BCCTP beneficiaries now have other coverage options available through Covered California and the Individual Insurance Market.

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

Reason for Change from Prior Estimate:
There is updated eligibles and expenditures data from January 2015 through June 2015. With the implementation of the ACA, there has been a decline in the number of BCCTP beneficiaries due to the other coverage options now available through Covered California and the Individual Insurance Market.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

Overall, there was a 9% decline in the estimated total eligibles for FY 2015-16 when compared to the May 2015 estimate.

Methodology:

1. There were 6,966 FFS and 2,811 managed care eligibles as of May 2015 (total of 9,777). 2,141 of the FFS eligibles were eligible for State-Only services.

2. 213 of the FFS eligibles were in AE as of May 2015.

3. Assume the State will pay Medicare and other health coverage premiums for an average of 460 beneficiaries monthly in FY 2015-16 and FY 2016-17. Assume an average monthly premium cost per beneficiary of $146.61.

   FY 2015-16: 460 x $146.61 x 12 months = $809,000* TF ($809,000 GF) *Rounded
   FY 2016-17: 460 x $146.61 x 12 months = $809,000* TF ($809,000 GF) *Rounded

4. FFS costs are estimated as follows:

(Dollars in Thousands)

FY	FY 2015-16		FY 2016-17	
	TF	GF	TF	GF
Federally Funded Costs	$81,415	$28,495	$87,749	$30,712
State-Only Costs				
Services	$19,353	$19,353	$18,886	$18,886
Premiums	$809	$809	$809	$809
Total	**$101,577**	**$48,657**	**$107,444**	**$50,407**

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

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

Funding:

(Dollars in Thousands)

FY 2015-16:		**TF**	**GF**	**FF**
100% General Fund	4260-101-0001	$20,162	$20,162	$0
65% Title XIX / 35% GF	4260-101-0001/0890	$81,415	$28,495	$52,920
Total		**$101,577**	**$48,657**	**$52,920**
FY 2016-17:		**TF**	**GF**	**FF**
100% General Fund	4260-101-0001	$19,695	$19,695	$0
65% Title XIX / 35% GF	4260-101-0001/0890	$87,749	$30,712	$57,037
Total		**$107,444**	**$50,407**	**$57,037**

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	4/2013
ANALYST:	Melinda Yegge
FISCAL REFERENCE NUMBER:	1755

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$46,958,000	$62,482,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$46,958,000	$62,482,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$46,958,000	$62,482,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 396 (Chapter 394, Statutes of 2011) authorizes the Department, counties, and the CDCR to:

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

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to:

- Designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program.
- Authorize this entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 5

CDCR will utilize the Single Streamlined Application, currently used by counties, and the Department will review these applications to make an eligibility determination according to current standard eligibility rules. Healthcare costs of state inmates are currently paid by the State General Fund. Federal Medicaid regulations and federal guidance provided to states allow for coverage of inpatient services to eligible inmates when provided off the grounds of the correctional facility. Providers are required to adhere to the utilization review requirements established by the Superior Systems Waiver (SSW). Diagnosis Related Group (DRG) providers will be required to submit a Treatment Authorization Request (TAR) to the Department for authorization in order to be paid for these services. Designated Public Hospitals (DPHs) will be responsible for performing their own Utilization review in accordance with the SSW requirements. The Department currently has an interagency agreement with CDCR in order to claim Title XIX FFP.

Reason for Change from Prior Estimate:
No county claims were paid in FY 2014-15 for the County Juvenile Program as a result of the changes in claiming structure. Payments for county claims are expected to begin in FY 2015-16 and completed in FY 2016-17. All retroactive payments for both County and State Juveniles have been updated by the Department and payments will begin in FY 2015-16. Per-member-per-month (PMPM) costs were updated based on updated claims data.

Methodology:

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

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

3. Based on fee-for-service (FFS) cost data, the average cost for a general acute care inpatient admission is estimated at $9,425 for FY 2015-16 and FY 2016-17.

4. The Department estimates that the average inpatient psychiatric cost per client for those less than 21 years old is $6,908 for FY 2015-16 and FY 2016-17.

5. Assume the Department will process 10 applications per month for State juveniles. County welfare departments will process an estimated 495 applications per month for county juveniles with verified citizenship in FY 2015-16 and FY 2016-17.

6. Of the estimated monthly State and county applications, it is assumed 30% are for psychiatric services and 70% for other inpatient services.

7. State juvenile costs are estimated to be $1,041,000 TF ($520,500 FF) in FY 2015-16 and FY 2016-17. Retroactive claims for State juvenile inmates in FY 2015-16 are estimated to be $1,067,500 TF ($533,750 FF) and $1,067,500 TF ($533,500 FF) in FY 2016-17.

8. County juvenile costs are estimated to be $51,483,000 TF ($25,741,500 FF) in FY 2015-16 and FY 2016-17. Retroactive claims for county juvenile inmates in FY 2015-16 are estimated to be $40,324,500 TF ($20,162,250 FF) and $71,373,500 TF ($35,686,500 FF) in FY 2016-17.

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 5

9. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for State and county juvenile inmates in FY 2015-16 and FY 2016-17 are:

	FY 2015-16		FY 2016-17	
State	**TF**	**FF**	**TF**	**FF**
State juveniles	$1,041,000	$520,500	$1,041,000	$520,500
Retroactive Payments	$1,067,500	$533,500	$1,067,500	$533,500
State Total	$2,108,500	**$1,054,000**	$2,108,500	**$1,054,000**
County	**TF**	**FF**	**TF**	**FF**
County juveniles	$51,483,000	$25,742,000	$51,483,000	$25,741,500
Retroactive Payments	$40,324,500	$20,162,000	$71,373,500	$35,686,500
County Total	$91,807,500	**$45,904,000**	$122,856,500	**$61,428,000**
Grand Total	$93,916,000	**$46,958,000**	$124,965,000	**$62,482,000**

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

PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%

REGULAR POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	8/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1873

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$30,024,000	$0
- STATE FUNDS	$15,012,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$30,024,000	$0
STATE FUNDS	$15,012,000	$0
FEDERAL FUNDS	$15,012,000	$0

DESCRIPTION

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

Authority:
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions Code (W&I) 14005.22 and 14005.225
State Plan Amendments (SPA) 13-021 and 14-021
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
Full scope Medi-Cal coverage is currently available to pregnant women with income levels up to and including 60% of the FPL. Pregnant women with incomes above 60% and up to and including 213% of the FPL currently receive pregnancy related services coverage only. Effective July 1, 2014, SB 857 authorized the expansion of full scope Medi-Cal coverage to pregnant women with incomes up to and including 138% of the FPL. SB 857 requires beneficiaries to enroll into a Medi-Cal managed care plan in the counties where one is available. For beneficiaries that reside in counties where Medi-Cal managed care is not available, services are provided via the fee-for-service (FFS) delivery system. The Department is seeking federal approval from the Centers for Medicare and Medicaid Services (CMS) to implement the full scope income level changes for pregnant women. The Department submitted and received approval of:

- SPA 14-021 to expand the income levels from above 60% up to and including 109% of the FPL; and,
- An amendment to the BTR waiver to expand the income levels from above 109% up to and including 138% percent of the FPL.

PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%

REGULAR POLICY CHANGE NUMBER: 6

Reason for Change from Prior Estimate:
Actual implementation date was August 1, 2015 which is a delay from the July 1, 2015 implementation date used for the 2015 May Estimate.

Methodology:

1. Prior to this change, women in the limited scope pregnancy-only program in Medi-Cal were all in the FFS delivery system. After the change they will be in managed care plans.
2. There is no material difference in cost between a limited scope pregnant eligible and a full scope pregnant eligible. However, there will be a difference in cash flow. While managed care payments are made prior to service delivery, FFS payments are made after service delivery. Therefore, there is a temporary increase while managed care payments are being made and FFS payments for prior services continue to be submitted and paid.
3. Implementation date was August 1, 2015.
4. For FY 2015-16, the estimated per-member-per-month (PMPM) for the newly eligible pregnant women is $795.74.
5. For 178,364 eligible months, the estimated managed care capitation payments in FY 2015-16 are $141.9 million TF ($71 million GF).
6. FFS savings, on a cash basis, are estimated to be $111.9 million TF ($55.9 million GF) in FY 2015-16.
7. For 196,443 eligible months, the estimated managed care capitation payments in FY 2016-17 are $156.3 million TF ($78.1 million GF).
8. FFS savings, on a cash basis, are estimated to be $156.3 million TF ($78.1 million GF) in FY 2016-17.
9. The total estimated costs in FY 2015-16 and FY 2016-17 are:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FF**
Managed Care Capitation Payments	$141,932	$70,966	$70,966
FFS Savings (lagged)	($111,908)	($55,954)	($55,954)
Total	**$30,024**	**$15,012**	**$15,012**

FY 2016-17	**TF**	**GF**	**FF**
Managed Care Capitation Payments	$156,318	$78,159	$78,159
FFS Savings (lagged)	($156,318)	($78,159)	($78,159)
Total	**$0**	**$0**	**$0**

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

UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	5/2016
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1913

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$26,193,000	$177,251,000
- STATE FUNDS	$20,420,000	$142,815,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$26,193,000	$177,251,000
STATE FUNDS	$20,420,000	$142,815,000
FEDERAL FUNDS	$5,773,000	$34,436,000

DESCRIPTION

Purpose:
This policy change estimates the benefit costs 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.

Reason for Change from Prior Estimate:
This policy change now only estimates the benefits costs. In May, this policy change included administrative costs which are now budgeted separately in the appropriate policy changes.

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.

UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 7

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 and FY 2016-17 benefit costs are:

(Dollars in Thousands)	**FY 2015-16**		**FY 2016-17**	
	TF	**GF**	**TF**	**GF**
Full Scope Costs	$33,016	$23,831	$244,292	$176,335
Restricted Scope Savings	($6,823)	($3,411)	($67,041)	($33,521)
Net Impact	**$26,193**	**$20,420**	**$177,251**	**$142,815**

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

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	3/2015
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1874

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$6,424,000	$6,735,000
- STATE FUNDS	$1,140,190	$808,320
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	43.42 %	52.93 %
APPLIED TO BASE		
TOTAL FUNDS	$3,634,700	$3,170,200
STATE FUNDS	$645,120	$380,480
FEDERAL FUNDS	$2,989,580	$2,789,690

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Pregnant women, residing in California, with incomes from 213% to 322% of the Federal Poverty Level (FPL) can participate in the Medi-Cal Access Program. The cost for pregnant women in the program is set at 1.5% of their adjusted annual income. Besides the income and residency requirements, pregnant women:

- Must be uninsured, or
- Have health insurance that does not cover maternity services, or
- Have health insurance with a maternity-only deductible or copayment greater than $500.

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER: 9

Medi-Cal Access Program linked infants with incomes from 213% to 266% of the FPL qualify for enrollment into the Optional Targeted Low Income Children's Program (OTLICP) and would be subject to monthly premiums. Infants born to mothers with incomes from 267% to 322% of the FPL would receive health coverage through the Medi-Cal Access Infant Program.

With the transition of the Medi-Cal Access Programs, the Department eliminated the 30 week pregnancy limit to eligibility determinations for pregnant women on March 15, 2015, in accordance with guidance from the Centers for Medicare and Medicaid Services (CMS).

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

Methodology:

1. Implementation date was March 1, 2015.

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

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

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

	Annual Per Member Costs
Medi-Cal Access Program:	
Delivery and Postpartum Costs	$11,582.93
Prenatal Costs	$950.24
Infants	$6,583.47
Medi-Cal:	
OTLICP Infants	$1,284.60

5. Assume approximately 441 applicants per year will be eligible for the Medi-Cal Access Program due to the 30 week change. Medi-Cal OTLICP estimates 74% of infant costs and Medi-Cal Access Infants Program estimates 26% of infant costs.

6. The estimated costs, on a cash basis, in FY 2015-16 and FY 2016-17 are:

(Dollars in Thousands)	**FY 2015-16**			
Medi-Cal Access Program:	**TF**	**GF**	**SF**	**FF**
Delivery and Postpartum Costs	$4,869	$0	$864	$4,005
Prenatal Costs	$399	$0	$71	$329
Infants	$743	$132	$0	$611
Medi-Cal: OTLICP Infants	$413	$73	$0	$339
Total	**$6,424**	**$205**	**$935**	**$5,284**

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER: 9

(Dollars in Thousands)	FY 2016-17			
Medi-Cal Access Program:	**TF**	**GF**	**SF**	**FF**
Delivery and Postpartum Costs	$5,105	$0	$613	$4,492
Prenatal Costs	$419	$0	$50	$369
Infants	$779	$93	$0	$685
Medi-Cal: OTLICP Infants	$432	$52	$0	$381
Total	**$6,735**	**$145**	**$663**	**$5,927**

Funding:
65% Title XXI / 35% GF (4260-113-001/0890)
88% Title XXI / 12% GF (4260-113-001/0890)
65% Title XXI / 35% Perinatal Fund (4260-602-0309/4260-113-0890)
88% Title XXI / 12% Perinatal Fund (4260-602-0309/4260-113-0890)

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1823

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,383,000	$1,496,000
- STATE FUNDS	$423,040	$179,520
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,383,000	$1,496,000
STATE FUNDS	$423,040	$179,520
FEDERAL FUNDS	$1,959,960	$1,316,480

DESCRIPTION

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

Authority:
AB 495 (Chapter 648, Statutes of 2001)
SB 36 (Chapter 416, Statues of 2011)
SB 800 (Chapter 448, Statutes of 2013)
SB 857 (Chapter 31, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

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

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

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER: 10

Reason for Change from Prior Estimate:
The increase is due to outstanding invoices from FY 2013-14 and FY 2014-15 shifting to FY 2015-16.

Methodology:
1. Santa Clara and San Mateo Counties elected not to provide funding for the non-federal share of the IGTs beginning January 1, 2014. San Francisco County elected not to provide funding for the non-federal share of the IGTs beginning January 1, 2015.

FY 2015-16	**TF**	**GF**	**FF**
Benefits			
65% Title XXI FF / 35% GF	$536,000	$188,000	$348,000
88% Title XXI FF / 12% GF	$1,609,000	$193,000	$1,416,000
Admin			
65% Title XXI FF / 35% GF	$59,500	$21,000	$38,500
88% Title XXI FF / 12% GF	$178,500	$21,000	$157,500
Total	**$2,383,000**	**$423,000**	**$1,960,000**

FY 2016-17	**TF**	**GF**	**FF**
Benefits			
88% Title XXI FF / 12% GF	$1,346,000	$162,000	$1,184,000
Admin			
88% Title XXI FF / 12% GF	$150,000	$18,000	$132,000
Total	**$1,496,000**	**$180,000**	**$1,316,000**

Funding:
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	12/1998
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	13

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$201,893,790	-$221,321,880
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$201,893,790	-$221,321,880
FEDERAL FUNDS	$201,893,790	$221,321,880

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding for the 100% and 133% Programs expenditures to be adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI 65% FFP and Title XXI 88% FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)
42 CFR 435.907(e)

Interdependent Policy Changes:
Not Applicable.

Background:
Based on the provisions of SB 903 and Section 1902(l)(3) of the federal Social Security Act (42 U.S.C. Sec 1396a(l)(3)), resources will not be counted in determining the Medi-Cal eligibility for children ages 1 to the month of their 6th birthday in the 133 percent program and ages 6 to the month of their 19th birthday in the 100% program. This change was implemented to help streamline the application process and to align Medi-Cal eligibility more closely with the Healthy Families Program (HFP). Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent to the counties the current subscribers' applications and information. The final group transitioned November 1, 2013. The program has since been renamed as the TLICP.

The Affordable Care Act (ACA) requires that states raise the minimum income level to at least 133 percent of federal poverty level (FPL) and remove the Medicaid asset test for children, effective January 1, 2014. These changes allow certain children who would not have been eligible for Medicaid under the State Plan in effect on March 31, 1997 to now be eligible for Medicaid. As authorized under the Social Security Act, the State will continue to draw enhance Title XXI FMAP for these children.

Pursuant to 42 CFR 435.907(e), California may not collect information concerning asset eligibility. Therefore, the State cannot reasonably determine which children are only eligible for Medicaid because

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 12

of the loosening of the asset test rules. As a result, California was granted a proxy methodology (CS3-Proxy) to claim enhance FMAP for children formerly eligible for Children's' Health Insurance Program (CHIP) who are now eligible for Medicaid.

Reason for Change from Prior Estimate:
This policy change now includes aid codes M5, M6, H0, H6 and H9, the new 8.32% Title XXI Proxy methodology. The new 8.32% Title XXI proxy method includes a retroactive payment amount of $317 Million for funding claims that were on hold waiting for the final CMS approval of the new proxy in August 2015.

Methodology:

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

2. It is assumed the total annual expenditures will be $461,313,330 in both FY 2015-16 and in FY 2016-17.

3. A one-time retroactive payment of $317,005,783 is expected to be made in FY 2015-16.

4. It is assumed the estimated costs of the additional aid codes will be $121,113,274 in both FY 2015-16 and in FY 2016-17.

5. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. From July 1, 2015, through September 30, 2015, estimated costs are eligible for Title XXI 65/35 FMAP. Beginning October 1, 2015, estimated costs are eligible for Title XXI 88/12 FMAP.

6. This Estimate includes the California: CS3 Proxy of 8.32% on the affected children formerly on CHIP, who were moved to Medicaid.

Funding:

(Dollars in Thousands)				
FY 2015-16		**TF**	**GF**	**FF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($899,432)	($449,716)	($449,716)
65 % Title XXI /35 % GF	4260-113-0001/0890	$608,219	$212,877	$395,342
88 % Title XXI /12 % GF	4260-113-0001/0890	$291,213	$34,946	$256,267
Net Impact (rounded)		**$0**	**($201,893)**	**$201,893**
FY 2016-17		**TF**	**GF**	**FF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($582,426)	($291,213)	($291,213)
88 % Title XXI /12 % GF	4260-113-0001/0890	$582,426	$69,891	$512,535
Net Impact (rounded)		**$0**	**($221,322)**	**$221,322**

NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	12/1997
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	15

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$388,613,000	$383,543,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$388,613,000	$383,543,000
FEDERAL FUNDS	-$388,613,000	-$383,543,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

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

Reason for Change from Prior Estimate:
The ACA population which was previously estimated in the ACA Expansion – New Qualified Immigrant policy change has been added to this PC. Additionally, Non-ACA managed care and FFS expenditures have increased by four percent.

Methodology:
1. Based on 2014 FFS expenditure reports of non-emergency services provided to NQIs, the Department estimates in FY 2015-16 and FY 2016-17 the total NQI non-emergency FFS costs will be $107,594,000 TF.

NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 13

2. Based on January through June 2015 managed care reports of non-emergency services provided to NQIs, the Department estimates in FY 2015-16 and FY 2016-17 the total NQI non-emergency managed care capitation costs for the ACA optional expansion population will be $202,813,000 TF. The repayment for this group will be 100% FFP for FY 2015-16 and 100% FFP for FY 2016-17 until January, 2017 when FFP changes to 95%.

3. Based on January through June 2015 managed care reports of non-emergency services provided to NQIs, the Department estimates in FY 2015-16 and FY 2016-17 the total NQI non-emergency managed care capitation costs for the non-ACA (All Others) population will be $264,006,000 TF. The repayment for this group is at 50/50 FMAP.

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

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

6. The estimated FFP Repayment in FY 2015-16 and FY 2016-17:

(Dollars in Thousands)	**FY 2015-16**		**FY 2016-17**	
	TF	**FF Repayment**	**TF**	**FF Repayment**
FFS	$107,594	$53,797	$107,594	$53,797
ACA	$202,813	$202,813	$202,813	$197,743
Managed Care -All Others	$264,006	$132,003	$264,006	$132,003
Total	$574,413	**$388,613**	$574,413	**$383,543**

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

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/2005
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1007

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$110,502,990	-$115,403,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$110,502,990	-$115,403,200
FEDERAL FUNDS	$110,502,990	$115,403,200

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 131 required a State Plan Amendment (SPA) be submitted to claim 65% CHIP federal funding for prenatal care for undocumented women, and legal immigrants who have been in the country for less than five years through the Medi-Cal Program and the Medi-Cal Access Infants Program. Previously, these costs for prenatal care were funded with 100% General Fund for the Medi-Cal Program. California draws down federal CHIP funding through the Title XXI unborn option for both programs.

Reason for Change from Prior Estimate:
The changes are due to updated actuals through April 2015 for legal immigrants, as well as estimated costs being eligible for Title XXI 88/12 FMAP.

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $123,719,000 TF in FY 2015-16 and $120,509,000 TF in FY 2016-17.

2. Assume estimated prenatal costs for undocumented women from July 1, 2015, through September 30, 2015, are eligible for Title XXI 65/35 FMAP. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 14

(Dollars in Thousands)

FY 2015-16:	$30,930 TF x .65 =	$20,105 FFP
	$92,789 TF x .88 =	$81,654 FFP
FY 2015-16 Total		**$101,759 FFP**
FY 2016-17:	$120,509 TF x .88 =	**$106,048 FFP**

3. The cost of prenatal care for legal immigrant women is estimated to be $10,631,000 TF in FY 2015-16 and FY 2016-17.

4. Assume estimated prenatal costs for legal immigrant women from July 1, 2015, through September 30, 2015, are eligible for Title XXI 65/35 FMAP. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP.

(Dollars in Thousands)

FY 2015-16:	$2,658 TF x .65 =	$1,728 FFP
	$7,973 TF x .88 =	$7,016 FFP
FY 2015-16 Total		**$8,744 FFP**
FY 2016-17:	$10,631 x .88=	**$9,355 FFP**

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

(Dollars in Thousands)

		GF Savings
FY 2015-16:	$101,759 + $8,744 =	**$110,503**
FY 2016-17:	$106,048 + $9,355 =	**$115,403**

Funding:
65% Title XXI FF/35% GF (4260-113-0001/0890)
88% Title XXI FF /12% GF (4260-113-0001/0890)
100% GF (4260-101-0001)

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	4/2016
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1371

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$43,872,980	-$10,928,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$43,872,980	-$10,928,120
FEDERAL FUNDS	$43,872,980	$10,928,120

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to NQIs and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US.

Reason for Change from Prior Estimate:
There are several changes: 1) updated actual data through June 2015, 2) updated managed care capitation for FY 2015-16, 3) this policy change now incorporates the Title XXI 88/12 FMAP effective October 1, 2015.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 15

Methodology:

1. Title XXI funding of 65/35 FFP is available for 0 to 18 year olds from July 1, 2015, to September 30, 2015. Title XXI funding of 88/12 FFP is available for this age group effective October 1, 2015, and Title XIX funding of 50/50 FFP is available for 19 and 20 year olds and pregnant women.

2. Children:
   Based upon quarterly claiming reports for 2015, 32.1% of expenditures for NQI services are for non-emergency services.

   FFS:
   Data reports for NQI children for CY 2013 services show (FFS) costs (including managed care carve-outs) of $11,222,000 TF for 0 to 18 year olds and $1,429,000 TF for 19 and 20 year olds.

   Non-emergency FFS expenditures for NQI children are (rounded):

   0-18 year olds: $11,222,000 TF x 32.1% non-emergency = $3,602,000 TF
   19-20 year olds: $1,429,000 TF x 32.1% non-emergency = $459,000 TF

   Managed Care:
   Data reports of NQI children managed care eligibles for calendar 2012 show 169,141 eligible months for 0 to 18 year olds and 18,807 for 19 and 20 year olds. The average capitation for the NQI children and pregnant women is assumed to be $116.77 per-member-per-month (PMPM) in FY 2015-16 and for FY 2016-17.

   Non-emergency managed care expenditures for NQI children are:

   0-18 year olds: 169,141 eligible months x $116.77 x 39.87% = $7,875,000 TF
   19-20 year olds: 18,807 eligible months x $116.77 x 39.87% = $876,000 TF

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

   FFS:
   In FY 2015-16 and FY 2016-17, the total estimated FFS costs, including managed care carve-outs, for pregnant women are $29,909,000 TF. The estimated non-pregnancy related FFS expenditures for pregnant women are:

   $29,909,000 TF x 6.64% = $1,986,000 TF

   Managed Care:
   Reports of NQI pregnant eligibles for CY 2012 show 69,887 eligible months. Assume the average capitation for pregnant women is $116.77 PMPM in FY 2015-16 and FY 2016-17.

   Non-pregnancy services = 69,887 eligible months x $116.77 x 6.64% = $542,000 TF

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 15

(Dollars in Thousands)

	FY 2015-16			FY 2016-17	
	Title XIX	Title XXI		Title XIX	Title XXI
	(50/50)	(65/35)	(88/12)	(50/50)	(88/12)
Children (0-18)					
FFS	$0	$900	$2,700	$0	$3,600
Managed Care	$0	$1,968	$5,905	$0	$7,874
Children (19-20)					
FFS	$458	$0	$0	$458	$0
Managed Care	$876	$0	$0	$876	$0
Pregnant Women					
FFS	$1,986	$0	$0	$1,986	$0
Managed Care	$542	$0	$0	$542	$0
Total	$3,862	$2,868	$8,605	$3,862	$11,474
GF	$1,931	$1,004	$1,033	$1,931	$1,377
FFP	$1,931	$1,864	$7,572	$1,931	$10,097

4. Assume that the retroactive claims from FY 2011-12 through the FY 2014-15 will be paid in FY 2015-16. Total estimated savings by total and by funding type:

(Dollars in Thousands)

	FY 2015-16		FY 2016-17	
	GF	FF	GF	FF
FY 2011-12	($8,851)	$8,851	$0	$0
FY 2012-13	($9,072)	$9,072	$0	$0
FY 2013-14	($8,928)	$8,928	$0	$0
FY 2014-15	($8,029)	$8,029	$0	$0
FY 2015-16	($8,992)	$8,992	($1,907)	$1,907
FY 2016-17	$0	$0	($9,021)	$9,021
Grand Total	**($43,872)**	**$43,872**	**($10,928)**	**$10,928**

Funding:
50% Title XIX FF/ 50% GF (4260-101-0001/0890)
65% Title XXI FF/ 35% GF (4260-113-0001/0890)
88% Title XXI FF/ 12% GF (4260-113-0001/0890)

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1776

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$7,711,000	-$12,047,000
- STATE FUNDS	-$1,267,500	-$2,182,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	36.00 %	26.42 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,935,000	-$8,864,200
STATE FUNDS	-$811,200	-$1,605,990
FEDERAL FUNDS	-$4,123,840	-$7,258,190

DESCRIPTION

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

Authority:
Welfare & Institutions Code, section 14053

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

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

Reason for Change from Prior Estimate:
Managed Care (MC) actual discontinuances continue to increase as a result of enhanced verification sources and processing.

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

2. Based on monthly reports of the IVP and California Department of Corrections and Rehabilitation Division of Juvenile Justice (CDCR-DJJ) matches, it is estimated that a total of 2,933 MC beneficiaries will be discontinued from Medi-Cal in FY 2015-16 and FY 2016-17.

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 16

3. Total MC savings is estimated to be $7,711,000 TF ($2,776,000 GF) in FY 2015-16 and $12,047,000 TF ($3,183,000 GF) in FY 2016-17.

4. In FY 2015-16, it is estimated that 36% of the MC savings is captured in the base trends. In FY 2016-17, it is estimated that 26.42% of the MC savings is captured in the base trends.

(Dollars in Thousands)

FY 2015-16	**TF**	**% in Base**	**Savings in Base**
MC Savings	**($7,711)**	36.00%	($2,776)
FY 2016-17	**TF**	**% in Base**	**Savings in Base**
MC Savings	**($12,047)**	26.42%	($3,183)

5. Total estimated savings not in the base trends:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**
Total Savings	**($4,935)**	**($811)**
FY 2016-17	**TF**	**GF**
Total Savings	**($8,864)**	**($1,606)**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	8/2011
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1632

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$11,637,000	-$17,224,000
- STATE FUNDS	-$5,818,500	-$8,612,000
PAYMENT LAG	0.9363	0.9565
% REFLECTED IN BASE	53.57 %	67.56 %
APPLIED TO BASE		
TOTAL FUNDS	-$5,058,900	-$5,344,400
STATE FUNDS	-$2,529,440	-$2,672,200
FEDERAL FUNDS	-$2,529,440	-$2,672,210

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14124.11

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

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

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

As a result of the implementation of the Affordable Care Act, several million new beneficiaries enrolled in Medi-Cal over the last two years through the California Healthcare Enrollment, Eligibility and Retention System (CalHEERS). Currently, CalHEERS does not screen for military history. As a result, these recently enrolled beneficiaries missed their opportunity to become educated on VA benefits and obtain veteran benefit enhancement activities. The military question is scheduled to be added to CalHEERS in FY 2016-17.

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 17

Reason for Change from Prior Estimate:
The change is due to updated managed care (MC) rates.

Methodology:

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

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

3. It is estimated program expenditures will be reduced for 345 veterans in FY 2015-16 and FY 2016-17, of which 163 will be MC and 182 will be FFS. The Department expects that savings will continue in the budget year through discontinuances, share of cost modifications, and cost avoidance by identifying Other Health Coverage (OHC).

4. Estimated average PMPM savings is $337.39 in FY 2015-16 and FY 2016-17.

5. In FY 2015-16, it is estimated that 53.57% of the MC and FFS savings is captured in the base trends. In FY 2016-17, it is estimated that 67.56% of the MC and FFS savings is captured in the base trends.

(Dollars in Thousands)

FY 2015-16	**Total Savings**	**% in Base**	**Savings in Base**
Managed Care Savings	($2,874)	53.57%	($1,539)
FFS Savings	($8,763)	53.57%	($4,695)
Total	**($11,637)**		**($6,234)**
FY 2016-17	**Total Savings**	**% in Base**	**Savings in Base**
Managed Care Savings	($4,253)	67.56%	($2,874)
FFS Savings	($12,971)	67.56%	($8,763)
Total	**($17,224)**		**($11,637)**

6. Total estimated savings not in the base trends:

(Dollars in Thousands)

FY 2015-16	**TF**	**Payment Lag**	**TF**	**GF**
Managed Care Savings	($1,539)	1.0000	($1,249)	($625)
FFS Savings	($4,695)	0.9363	($3,810)	($1,905)
Total	**($6,234)**		**($5,059)**	**($2,530)**
FY 2016-17	**TF**	**Payment Lag**	**TF**	**GF**
Managed Care Savings	($2,874)	1.0000	($1,320)	($660)
FFS Savings	($8,763)	0.9565	($4,024)	($2,012)
Total	**($11,637)**		**($5,344)**	**($2,672)**

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

TLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1879

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$72,911,000	-$75,084,000
- STATE FUNDS	-$12,941,760	-$9,010,080
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$72,911,000	-$75,084,000
STATE FUNDS	-$12,941,760	-$9,010,080
FEDERAL FUNDS	-$59,969,240	-$66,073,920

DESCRIPTION

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

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

Interdependent Policy Change:
Not Applicable

Background:
Effective January 1, 2013, Healthy Families Program (HFP) subscribers began a transition into Medi-Cal through a phase-in methodology. The Department implemented TLICP, which covers children who would have been previously enrolled in HFP. TLICP covers children with family incomes between 133% of the federal poverty level (FPL) and 266% of the FPL. Those children with family incomes over 160% FPL will be required to pay monthly premiums for coverage.

Reason for Change from Prior Estimate:
Projected average monthly TLICP eligibles increased by 2.42% for FY 2015-16. General Fund (GF) change is due to 88%/12% FMAP effective October 1, 2015.

Methodology:

1. The Department estimates in FY 2015-16 there will be 1,004,723 average monthly TLICP eligibles and 1,034,511 in FY 2016-17. Based on 2011 HFP data, 61.84% of the TLICP population has family incomes over 160% of the FPL.

2. In FY 2015-16, the Department estimates there are 7,455,876 member months subject to monthly premiums and 7,676,933 in FY 2016-17.
   FY 2015-16: 1,004,723 x 12 months x 61.84% = **7,455,876** member months
   FY 2016-17: 1,034,511 x 12 months x 61.84% = **7,676,933** member months

TLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 18

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

	FY 2015-16	FY 2016-17
Total Exempt Member Months	151,123	154,726

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

	FY 2015-16	FY 2016-17
Discount Program	950,624	978,809
Delinquent Premiums	745,588	767,693
Total Loss of Premium Member Months	1,696,212	1,746,502

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

	FY 2015-16	FY 2016-17
Eligible Member Months	7,455,876	7,676,933
Exempt Member Months	(151,123)	(154,726)
Loss Member Months	(1,696,212)	(1,746,502)
Net Member Months	**5,608,542**	**5,775,704**

6. Premium requirement for children with incomes between 160-266% FPL is $13 per month.

7. The total estimated premium revenue for TLICP are:

(Dollars In Thousands)	TF	GF	FF
FY 2015-16	**($72,911)**	**($12,942)**	**($59,969)**
FY 2016-17	**($75,084)**	**($9,010)**	**($66,074)**

Funding:
65% Title XXI / 35% GF (4260-113-0890/0001)
88% Title XXI / 12% GF (4260-113-0890/0001)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	12/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1595

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$1,399,733,000	$1,743,700,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,399,733,000	$1,743,700,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,399,733,000	$1,743,700,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Updated estimates, on a cash basis, as provided by CDSS.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 19

Methodology:

1. It is assumed all eligible participants will enroll retroactively to December 1, 2011.
2. Assume billing for additional FFP will be retroactive to December 2011.
3. Assume costs will be retroactive to December 1, 2011.
4. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%.
5. The estimated costs were provided by CDSS on a cash basis.

Funding:

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

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	1/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1789

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$793,495,000	$1,198,736,000
- STATE FUNDS	$563,000	$29,405,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$793,495,000	$1,198,736,000
STATE FUNDS	$563,000	$29,405,200
FEDERAL FUNDS	$792,932,000	$1,169,330,800

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 23 Payments to Primary Care Physicians
PC 70 SMHS for Adults
PC 64 Intensive Outpatient Treatment Services
PC 63 Narcotic Treatment Program
PC 66 Outpatient Drug Free Treatment Services
PC 67 Residential Treatment Services
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 116 Dental Managed Care (Other M/C)
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans
PC 167 Dental Services

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

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 20

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for county mental health services are included in the PC 70 SMHS for Adults policy change.

Reason for Change from Prior Estimate:
This policy change now shows only the optional expansion over the the base trend. The Department revised the caseload projections based on enrollment data through July 2015. The per member per month rate (PMPM) decreased due to estimated reductions in Medi-Cal managed care plan enrollment from 90.1% to 77.7%.

Methodology:

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

2. Per an August 2015 Gallup poll, it is assumed 11.8% of Californians are currently uninsured. Per a January 2015 report by the UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research, it is assumed 28% of the uninsured population in California will be eligible for Medi-Cal.

3. The Department estimates that 25%, of the eligible but uninsured population will enroll by June 2016. The 2015 California population is 38,714,725, so the estimated growth for the ACA population in Medi-Cal is 319,784.

   38,714,725 Californians x 11.8% x 28% x 25% take-up = 319,784 as of June 2016

4. Based on FY 2014-15 actuals, assume 79.59% of the new enrollment is for the ACA Optional Expansion and 20.41% is for the ACA Mandatory Expansion. The Department estimates 254,519 Optional Expansion beneficiaries will enroll in Medi-Cal by June 2016.

5. Assuming an annual growth rate of 3.5%, the caseload is expected to grow to 263,418 by June 2017. The Department assumes 77.69% of the beneficiaries will be covered by a Medi-Cal managed care plan by June 2016.

6. In FY 2015-16, the estimated weighted average managed care PMPM is $494.17. In FY 2015-16, the estimated FFS PMPM is $268.83 (unlagged). Due to changes in the managed care capitation rate, the estimated weighted average managed care PMPM decreases to $385.60 in FY 2016-17. In FY 2016-17, the estimated FFS PMPM is $283.59 (unlagged).

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 20

7. The estimated costs for the ACA optional expansion in FY 2015-16 and FY 2016-17 are:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Newly Eligible Costs	$763,545	$563	$762,982
Long Term Support Services (LTSS)	$29,950	$0	$29,950
PC 20 Total	**$793,495**	**$563**	**$792,932**

FY 2016-17	TF	GF	FF
Newly Eligible Costs	$1,128,942	$29,405	$1,099,537
Long Term Support Services (LTSS)*	$69,794	$0	$69,794
PC 20 Total	**$1,198,736**	**$29,405**	**$1,169,331**

*The GF component of the LTSS costs is budgeted by CDSS.

Funding:

(Dollars In Thousands)

FY 2015-16	TF	GF	FF
100% Title XIX Federal Share (4260-101-0890)	$792,932	$0	$792,932
100% GF (4260-101-0001)	$563	$563	$0
Total	**$793,495**	**$563**	**$792,932**

FY 2016-17	TF	GF	FF
100% Title XIX Federal Share (4260-101-0890)	$628,720	$0	$628,720
95% Title XIX FF / 5% GF (4260-101-0890/0001)	$569,064	$28,453	$540,611
100% GF (4260-101-0001)	$952	$952	$0
Total	**$1,198,736**	**$29,405**	**$1,169,331**

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	4/2015
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1831

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$258,130,000	$140,580,000
- STATE FUNDS	$83,352,790	$45,769,930
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$258,130,000	$140,580,000
STATE FUNDS	$83,352,790	$45,769,930
FEDERAL FUNDS	$174,777,210	$94,810,070

DESCRIPTION

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

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 130 MCO Tax Managed Care Plans

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

Reason for Change from Prior Estimate:
Fees for Calendar Year (CY) 2013 were included in FY 2014-15 payments. However, due to processing delays, $230,000 of the HIPF payments were made in July 2015. Additionally, FY 2015-16 caseload has been adjusted to account for growth in managed care. Estimated fees for CY 2016 have been determined as a placeholder and are expected to be made in FY 2016-17.

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 21

Methodology:

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

2. This fee will apply to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population, which will be funded at 100% FFP in FY 2015-16 and 95% FFP in FY 2016-17. Therefore, this estimate assumes an overall FMAP of 65% for FY 2015-16 and FY 2016-17.

3. Effective January 1, 2014, fees were assessed to the plans by the federal government and are ongoing. The payments for fees assessed on CY 2013 actual revenues were scheduled to be made in FY 2014-15. However, due to processing delays, $230,000 of the HIPF payments were made in July 2015. Payments for CY 2014 and CY 2015 fees will be made in FY 2015-16. Estimated payments for CY 2016 have been determined as a placeholder and are expected to be made in FY 2016-17.

4. Assume the following amounts:

(Dollars in Thousands)

	FY 2015-16	FY 2016-17
CY 2013 Payments	$230	$0
CY 2014 Payments	$125,240	$0
CY 2015 Payments	$132,660	$0
CY 2016 Payments	$0	$140,580
Total	**$258,130**	**$140,580**

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

Funding:

50% Title XIX FF/ 50% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)
95% Title XIX FF / 5% GF (4260-101-0890/0001)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF/ 12% GF (4260-101-0001/0890)

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	10/2013
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1785

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$85,609,000	$161,458,000
- STATE FUNDS	$36,379,010	$66,418,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$85,609,000	$161,458,000
STATE FUNDS	$36,379,010	$66,418,200
FEDERAL FUNDS	$49,229,990	$95,039,800

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 23 Payments to Primary Care Physicians
PC 64 Intensive Outpatient Services
PC 63 Narcotic Treatment Program
PC 66 Outpatient Drug Free Treatment
PC 67 Residential Substance Abuse Services
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 116 Dental Managed Care (Other M/C)
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans
PC 167 Dental Services

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

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 22

Reason for Change from Prior Estimate:
The Department revised the caseload projections based on actual enrollment data through July 2015 and removed the estimated percent in base as this policy change now is calculated with the caseload over the base trend. The aid categories now tracked in this PC are Medically Needy Seniors, Children under 133% of the FPL, Pregnant Women and Infants, and Optional Targeted Low Income Children's Program (OTLICP) children. The Department calculated per member-per month (PMPM) costs for each group. The Department also revised Managed Care PMPM costs.

Methodology:

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

2. Since January 2014, the Department has experienced significant growth in Medi-Cal as result of the eligibility simplification and ACA outreach efforts.

3. The Department estimates an additional 65,268 eligibles, over base trends, will enroll in Medi-Cal by June 2016 and grow to 67,550 by June 2017. Assume 74.9% of the beneficiaries in FY 2015-16 and FY 2016-17 will be covered by a Medi-Cal managed care plan.

4. In FY 2015-16, The Department estimates the weighted average PMPM cost for currently eligible but not enrolled eligibles are:

	MC PMPM	FFS PMPM
Medically Needy Seniors	$420.10	$319.98
Children Under 133% of FPL	$117.82	$145.21
Pregnant Women and Infants	$117.15	$533.25
OTLICP (0-18 years)	$117.45	$145.21

Managed Care PMPM costs include managed care capitation rates and managed care carve-outs. Fee-for-Service (FFS) PMPM costs are unlagged. The Department assumes an ongoing five percent inflation factor for PMPM costs.

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

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

(Dollars in Thousands)	FY 2015-16		FY 2016-17	
Currently Eligible but Uninsured	**TF**	**GF**	**TF**	**GF**
Medically Needy Seniors	$38,908	$19,454	$72,291	$36,146
Children Under 133% of FPL	$20,522	$10,261	$38,759	$19,379
Pregnant Women and Infants	$6,255	$3,127	$12,749	$6,374
OTLICP (0-18 years)	$19,924	$3,536	$37,660	$4,519
Total	**$85,609**	**$36,379**	**$161,458**	**$66,418**

Funding:

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 22

(Dollars in thousands)

FY 2015-16	TF	GF	FF
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$65,685	$32,842	$32,842
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$4,981	$1,743	$3,238
88% Title XXI FFP / 12% GF (4260-113-0001/0890)	$14,943	$1,793	$13,150
Total	**$85,609**	**$36,379**	**$49,230**

FY 2016-17	TF	GF	FF
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$123,798	$61,899	$61,899
88% Title XXI FFP / 12% GF (4260-113-0001/0890)	$37,660	$4,519	$33,141
Total	**$161,458**	**$66,418**	**$95,040**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	11/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1659

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$5,716,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	27.31 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,155,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,154,960	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

The rate increase applied to eligible primary care services furnished by attested physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine and subspecialists related to the primary care specialists, recognized in accordance with the American Board of Medical Specialties, American Board of Physician Specialties, and American Osteopathic Association. The rate increase would applied to primary care services who were properly billed under the provider number of a physician who was enrolled as one of the specified primary care specialists,

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 23

regardless of whether furnished by the physician directly or under the physician's personal supervision.

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

Methodology:

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

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

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

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

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

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

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

(Dollars in Thousands)

	Annual FFP
FFS	$259,822
Managed Care	$1,424,856
Total	$1,684,678

8. Administrative costs for managed care plans to implement the increase payments are estimated to be $89,939,000 TF annually. Regular managed care administrative costs and ACA Mandatory managed care administrative costs are funded at the regular 50% Federal Medical Assistance Percentage (FMAP). ACA Optional managed care administrative costs are funded at 100% FFP.

9. Some portion of the managed care capitation rates currently in place that were paid at 50% FMAP were eligible for 100% FMAP. The estimated total General Fund (GF) reimbursement due to the adjustment was $47,267,000. $35,450,000 was adjusted in FY 2013-14. The remaining balance, $11,817,000, was adjusted in FY 2014-15.

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 23

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

(Dollars in Thousands)

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

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

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
FFS	$5,716	$0	$5,716
Total	**$5,716**	**$0**	**$5,716**

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

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	1/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1791

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$24,295,000	-$8,904,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$24,295,000	-$8,904,000
FEDERAL FUNDS	$24,295,000	$8,904,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

- Due to delay in abstracting claims data, savings for retroactive period January 1, 2013 to December 31, 2014 shifted from FY 2014-15 to FY 2015-16.
- FY 2015-16 savings period of January 1, 2015 to March 31, 2016 has been revised and will now include savings period January 1, 2013 to September 30, 2015 for Fee-For-Service (FFS) and January 1, 2013 to June 30, 2015 for managed care.
- Managed care estimate was revised using a more accurate methodology and updated capitation data; savings is significantly lower compared to earlier preliminary estimates.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 24

Methodology:

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

2. FFS savings for period January 1, 2013, through September 30, 2015, will occur in FY 2015-16. For FY 2016-17, FFS savings will include period October 1, 2015, through September 30, 2016.

3. Managed care savings for period January 1, 2013, through June 30, 2015, will occur in FY 2015-16. For FY 2016-17, managed care savings will include period July 1, 2015, through June 30, 2016.

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
FY 2012-13 (Jan to Jun)	($4,673)	($4,673)	$0
FY 2013-14	($8,709)	($8,709)	$0
FY 2014-15	($8,904)	($8,904)	$0
FY 2015-16	($8,904)	($2,009)	($6,895)
FY 2016-17	($8,904)	$0	($2,009)
Total		**($24,295)**	**($8,904)**

Funding:

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

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	12/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1802

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$349,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$349,000	$0
FEDERAL FUNDS	-$349,000	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Effective July 1, 2013, the Department changed the existing policy for former foster youth currently receiving Medi-Cal benefits. Prior to July 1, 2013, once a former foster youth turned 21 years old they would lose their Medi-Cal coverage. Instead under the new policy, those who turned 21 years old between July 1, 2013 and December 31, 2013 retained their Medi-Cal benefits until age 26. These costs for the July to December 2013 period for this group are funded with 100% State General Fund. This group became eligible for FFP under the ACA on January 1, 2014.

Reason for Change from Prior Estimate:
The estimated expenditures were updated based on actuals. There was also a delay in the repayment of ineligible FFP from FY 2014-15 to FY 2015-16.

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

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 25

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

3. The total expenditures incurred for these eligible former foster youth are $349,000.

4. The Department will repay CMS the ineligible FFP in FY 2015-16.

FY	FY 2015-16
GF	**$349,000**
FFP	**($349,000)**

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

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	1/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1845

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
Not applicable

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

Beginning in 2014, the ACA establishes an enhanced FMAP for expenditures related to the optional expansion population. Between 2014 and 2016, the federal government will be responsible for 100 percent of the optional expansion expenditures, gradually phasing down to 90 percent in 2020 and beyond. The Department estimates select populations will naturally shift into the optional expansion at the time of enrollment, and this policy change estimates the savings related to the difference of receiving the standard Title XIX 50/50 FMAP and the enhanced ACA FMAP.

Reason for Change from Prior Estimate:
The estimated savings in FY 2015-16 and FY 2016-17 is now assumed to be 100% in the base trends. This policy change is now informational only.

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 26

Methodology:

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

2. The Department estimates six select populations who were eligible prior to the ACA, that will take-up coverage as part of the ACA expansion group. Following are the six select populations and the estimated General Fund savings associated with each population:

Select Populations:	**FY 2015-16**	**FY 2016-17**
Individuals who forego applying for disability	($3,200,000)	($4,779,000)
Disabled not enrolled in Medicare but need LTSS	($2,569,000)	($3,837,000)
Medically Needy 19/20 no SOC not *Sneede v. Kizer*	($757,000)	($1,130,000)
Medically Needy parents with SOC	($13,260,000)	($19,803,000)
Pregnant women income 109-138% FPL	($1,948,000)	($2,089,000)
SB 87 pending disability individuals	($14,395,000)	($21,498,000)
Total	**($36,129,000)**	**($53,136,000)**

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

Funding:

(Dollars in Thousands)

FY 2015-16		**TF**	**GF**
50% Title XIX FF / 50% GF	4260-101-0890/0001	($72,258)	($36,129)
100% Title XIX ACA FF	4260-101-0890	$72,258	$0
Net Impact		**$0**	**($36,129)**
FY 2016-17		**TF**	**GF**
50% Title XIX FF / 50% GF	4260-101-0890/0001	($106,272)	($53,136)
100% Title XIX ACA FF	4260-101-0890	$53,136	$0
95% Title XIX ACA FF / 5% GF	4260-101-0890/0001	$53,136	$2,657
Net Impact		**$0**	**($50,479)**

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	1/2014
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1821

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$134,502,500	-$131,140,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$134,502,500	-$131,140,000
FEDERAL FUNDS	$134,502,500	$131,140,000

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for providing Hospital Presumptive Eligibility (HPE). HPE is a required provision of the ACA.

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)
California State Plan Amendment (SPA) 13-0027-MM7

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine Hospital Presumptive Eligibility (HPE) for Medicaid. The HPE Program offers qualified individuals immediate access to temporary Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage. The HPE Medi-Cal Application is completed on-line with a qualified HPE Provider at a participating, qualified hospital. Eligibility is determined in real-time. To qualify for HPE, individuals must meet the rules below.

- Have income below the monthly limit for household size unless in foster care at age 18 and less than 26 years old;
- Be a California resident;
- Have not received HPE Enrollment Period from any Medi-Cal HPE Program within the past 12 months of applying, unless pregnant and/or 19 years of age or younger;
- If pregnant, have not had an HPE Enrollment Period during the current pregnancy;
- And, be eligible in one of the following HPE groups below:
    - Individuals between the ages of 18-25 who were in foster care at age 18 (no income limit);
    - Children under 19 years of age;

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 27

- Parents and caretaker relatives;
- Pregnant Women;
- Adults between the ages 19-64, not enrolled in Medicare, and not eligible for any other group stated above.

The Centers for Medicare and Medicaid Services (CMS) approved the California State Plan Amendment (SPA) 13-0027-MM7 effective June 22, 2015, making changes to HPE enrollment rules. The SPA changes the date of HPE enrollment to the date an HPE provider submits an approved application on behalf of the beneficiary via the web portal. It expands approved HPE providers' ability to assist with HPE applications by allowing clinics owned by approved HPE providers, listed on the hospital's license, to make HPE determinations at the approved HPE provider's discretion and liability. Approved HPE county providers may also permit their county-owned/operated clinic(s) to assist with gathering information for the HPE Medi-Cal Application (DHCS 7022). Under the SPA, HPE enrollment can no longer be backdated as it could be from program implementation until effective date of the SPA. Finally, the SPA places limitations on the number of HPE Enrollment Periods as indicated in the table below:

Medi-Cal PE Programs	**PE Enrollment Periods Permitted**
HPE – Individuals 18 through 25 years of age who were in foster care at 18 years of age (no income limit)	1 PE enrollment period per year
HPE – Children 19 years of age or younger	2 PE enrollment periods per year
HPE – Parents and caretaker relatives	1 PE enrollment period per year
HPE – Adults 19 through 64 years of age, who are not pregnant, not enrolled in Medicare and not eligible for any other group stated above.	1 PE enrollment period per year
HPE – Pregnant Women	1 PE enrollment period, per pregnancy
Child Health and Disability Prevention (CHDP) Gateway	2 PE enrollment periods per year
Breast and Cervical Cancer Treatment Program (BCCTP)	1 PE enrollment period per year
PE for Pregnant Women	1 PE enrollment period, per pregnancy

Reason for Change from Prior Estimate:
HPE beneficiary costs are captured in the base estimate as of the November 2015 estimate. This policy change now only estimates the technical adjustment in funding from Title XIX 50/50 to the enhanced Title XIX ACA FMAP.

Methodology:

1. Since the start of HPE, many beneficiaries have chosen to continue their coverage beyond the presumptive eligibility period and have enrolled in the new ACA childless adult and parent/caretaker relative categories. For those who enter as part of the optional expansion, the Department assumes retroactive enhanced Title XIX ACA FFP is available for their HPE costs.

2. Based on actual HPE claims from FY 2013-14 Q4 through FY 2014-15, the estimated average quarterly adjustment for enhanced Title XIX ACA FFP is $67,251,000 TF.

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 27

3. In FY 2015-16 and FY 2016-17, the Department estimates to adjust $269,005,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP. The estimated GF savings as result is included below.

Funding:

(Dollars in Thousands)

FY 2015-16		**TF**	**GF**
50% Title XIX FF / 50% GF	(4260-101-0890/0001)	($269,005)	($134,503)
100% Title XIX ACA FFP	(4260-101-0890)	$269,005	$0
Net Impact		**$0**	**($134,503)**

FY 2016-17		**TF**	**GF**
50% Title XIX FF / 50% GF	(4260-101-0890/0001)	($269,005)	($134,503)
100% Title XIX ACA FF	(4260-101-0890)	$201,755	$0
95% Title XIX ACA FF / 5% GF	(4260-101-0890/0001)	$67,250	$3,363
Net Impact		**0**	**($131,140)**

ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	1/2017
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1793

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	-$83,925,000
- STATE FUNDS	$0	-$31,764,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$83,925,000
STATE FUNDS	$0	-$31,764,000
FEDERAL FUNDS	$0	-$52,161,000

DESCRIPTION

Purpose:
This policy change estimates the savings from shifting newly eligible New Qualified Immigrants (NQI) populations to Covered California beginning January 1, 2017.

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

Interdependent Policy Changes:
Not Applicable

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

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

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

Beginning with the 2016-2017 Covered California open enrollment, which is expected to start in

ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 29

October 2016, the Department will begin transitioning optional expansion childless adult NQIs who have been in the country less than five years from Medi-Cal into Covered California. Coverage is expected to begin January 2017. The Department will cover all out-of-pocket expenditures that may occur by transitioning into Covered California.

Reason for Change from Prior Estimate:
There are several changes. First, the ACA optional expansion population (referred to as "newly" in the caseload tab) is now incorporated in the base caseload trends. As a result, this policy change now estimates the savings from shifting the NQI childless adult population to Covered California beginning January 1, 2017. Second, the Department updated the NQI ACA population based on actuals through August 2015. Lastly, the Department updated FFS carve out per member per month (PMPM) costs based on actual data through July 2015, Managed Care PMPM costs, and dental costs.

Methodology:

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

2. Effective January 1, 2017, 43,503 childless adult NQIs will transition into Covered California.

3. The Department estimates the impact from shifting the NQI childless adult population to Covered California beginning January 1, 2017 will be:

(Dollars in thousands)

Exchange related Costs:	**FY 2015-16**		**FY 2016-17**	
Newly Eligible NQI Childless Adults:	**TF**	**GF**	**TF**	**GF**
Premiums for 0-138%	$0	$0	$15,898	$6,017
Wraparounds 0-138%	$0	$0	$3,931	$1,488
Subtotal	**$0**	**$0**	**$19,829**	**$7,505**

Medi-Cal related costs:	**TF**	**GF**	**TF**	**GF**
Benefit costs 0-138%	$0	$0	($103,754)	($39,269)

Net Impact:	**$0**	**$0**	**($83,925)**	**($31,764)**

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

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	1/2016
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1742

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$1,891,000	-$1,547,000
- STATE FUNDS	-$945,500	-$773,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,891,000	-$1,547,000
STATE FUNDS	-$945,500	-$773,500
FEDERAL FUNDS	-$945,500	-$773,500

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

The four provider types identified for RAC audits are Optometrists, Podiatrists, Non-emergency medical transportation and Speech Therapists. As the audit yielded no findings for the first wave of provider types, the Department began its planned provider expansion and is now auditing Physicians, Laboratories, Hospice, and Durable Medical Equipment providers. The combined billing for these providers for the past three years is $2,217,795,914. From this billing, the Department estimates that $1.1 billion is not part of the managed care expansion and eligible for RAC recovery. HMS estimates 1% is recoverable from their automated system; however, the Department is using an estimate of 0.5% recovery for the calculations. The Department assumes a more conservative approach, as there are no actuals available to support the 1% assumption.

Reason for Change from Prior Estimate:
The FY 2014-15 RAC produced no audit findings. Since that time, the contract has expanded to add several new providers resulting in an increase in the estimated savings.

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 30

Methodology:

1. Assume the annual identified overpayment billing is $1,100,000,000 TF.

   $1,100,000,000 TF x 0.5% recovery rate = $5,500,000 TF potential annual savings

2. Assume that HMS will issue finding in October and many providers will appeal these findings. Appeals will cut approximately 60 days from the remaining fiscal year, leaving six months of viable collections.

3. Assume 25% of overpayments will be collected in 60 days.

   $5,500,000 TF x .25 = $1,375,000 TF

4. Assume 75% of findings are appealed.

   $5,500,000 TF x 0.75 = $4,125,000 TF

5. Assume 50% of appealed findings are upheld.

   $4,125,000 TF x 0.5 = $2,062,500 TF

6. Assume the upheld amounts are recovered from March 2016 through June 2017.

   $2,062,500 TF ÷ 16 months = $128,906 TF per month

7. The estimated recoveries for FY 2015-16 and FY 2016-17 are:

   FY 2015-16 savings: $1,375,000 TF + ($128,906 TF x 4 mos) = **$1,891,000 TF ($945,000 GF)**

   FY 2016-17 savings: $128,906 x 12 months = **$1,547,000 TF ($773,500 GF)**

Funding:

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

ACA REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	12/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1904

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$796,842,000	-$796,842,000
- STATE FUNDS	-$333,361,000	-$333,361,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	78.30 %	75.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$172,914,700	-$199,210,500
STATE FUNDS	-$72,339,340	-$83,340,250
FEDERAL FUNDS	-$100,575,380	-$115,870,250

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 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 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:
There is no change.

ACA REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 31

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 2015-16 and FY 2016-17 savings:

(Dollars in Thousands)	**TF**	**GF**	**FF**
FY 2015-16	**($796,842)**	($333,361)	($463,481)
FY 2016-17	**($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)
88% Title XXI FFP / 12% GF (4260-113-0890/0001)
100% Title XIX ACA FF (4260-101-0890)
95% Title XIX ACA FF /5% GF (4260-101-0890/0001)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	4/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1585

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$387,000,000	-$536,400,000
- STATE FUNDS	-$130,036,950	-$186,229,860
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$387,000,000	-$536,400,000
STATE FUNDS	-$130,036,950	-$186,229,860
FEDERAL FUNDS	-$256,963,050	-$350,170,140

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
There was a change in the encounter data reporting system for Managed Care and COHS drug rebates, so no claims were rebated from November 2014 through March 2015. Most plans successfully passed the new reporting requirements and invoices were mailed in the second quarter of 2015 and will be accounted for in FY 2016-17.

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

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 32

2. Assume the annual invoice amount for FY 2015-16 is $430,000,000, which includes $331,100,000 in rebates for the non-ACA expansion population and $98,900,000 for the ACA optional expansion population. Expect a 90% collection rate of invoiced amounts.

(Dollars in Thousands)	
FY 2015-16	
$331,100 x 90% (non-ACA) =	($297,990)
$98,900 x 90% (ACA) =	($89,010)
$430,000 x 90%(Total)	**($387,000)**

3. Assume the annual invoice amount for FY 2016-17 is $596,000,000, which includes $459,000,000 in rebates for the non-ACA expansion population and $137,000,000 for the ACA optional expansion population. Expect a 90% collection rate of invoiced amounts.

(Dollars in Thousands)	
FY 2016-17	
$459,000 x 90% (non-ACA) =	($413,100)
$137,000 x 90% (ACA) =	($123,300)
$596,000 x 90%(Total)	**($536,400)**

4. Beginning July 2012, the ongoing additional FFP claimed by CMS is fully reflected in this policy change, $35,865,000 for FY 2015-16 and $38,652,000 for FY 2016-17. Estimated collections for FY 2015-16 and FY 2016-17:

(Dollars in Thousands)			
FY 2015-16	**TF**	**GF**	**FFP**
50% Title XIX / 50% GF	($258,255)	($129,127)	($129,128)
100% Title XIX FFP	($89,010)	$0	($89,010)
ACA Offset Title XIX	($35,865)	$0	($35,865)
Title XXI 65/35	($1,935)	($677)	($1,258)
Title XXI 88/12	($1,935)	($232)	($1,703)
FY 2015-16	**($387,000)**	**($130,036)**	**($256,964)**

(Dollars in Thousands)			
FY 2016-17	**TF**	**GF**	**FFP**
50% Title XIX / 50% GF	($363,720)	($181,860)	($181,860)
95% Title XIX / 5% GF	($61,650)	($3,082)	($58,568)
100% Title XIX FFP	($61,650)	$0	($61,650)
ACA Offset Title XIX	($38,652)	$0	($38,652)
Title XXI 88/12	($10,728)	($1,287)	($9,441)
FY 2016-17	**($536,400)**	**($186,229)**	**($350,171)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
95% Title XIX ACA FFP / 5% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0890-0001)
88% Title XXI / 12% GF (4260-113-0890-0001)

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	5/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1476

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$273,219,000	$286,516,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$273,219,000	$286,516,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$273,219,000	$286,516,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 33

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

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

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2009 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2015-16 and FY 2016-17.

Reason for Change from Prior Estimate:
The estimated amounts for FYs 2015-16 and 2016-17 have been revised to reflect updated data.

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

(Dollars in Thousands)

	TF	CDDS GF	FF	ARRA
FY 2015-16	$546,438	$273,219	**$273,219**	**$0**
FY 2016-17	$567,660	$281,144	**$283,830**	**$2,686**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	25

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$131,198,000	$138,135,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$131,198,000	$138,135,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$131,198,000	$138,135,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The change is due to:

- A decrease in the FY 2009-10 reconciliation and FY 2015-16 interim payments, and
- Additional FY 2014-15 interim payments to be paid in FY 2015-16.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 34

Methodology:

1. The estimate is based on the analysis of historical claims submitted by LEAs.

2. The FY 2015-16 and FY 2016-17 interim payment estimates are calculated based on the average of the preceding three fiscal years, plus a 10% increase in LEA transportation reimbursements due to the elimination of transportation restrictions per AB 2608.

3. Remaining interim payments from FY 2014-15 and FY 2015-16 are estimated to be paid in FY 2015-16 and FY 2016-17, respectively.

4. The estimated reconciliation of ($9,009,000) for FY 2009-10 will be applied to FY 2015-16.

5. The estimated reconciliation of ($4,286,000) for FY 2010-11 will be applied to FY 2016-17.

(Dollars in Thousands)

FY 2015-16	**TF**	**FF**
FY 2009-10 Reconciliation	($9,009)	($9,009)
FY 2014-15 Interim Payments	$13,849	$13,849
FY 2015-16 Interim Payments	$126,358	$126,358
FY 2015-16 Total	**$131,198**	**$131,198**

(Dollars in Thousands)

FY 2016-17	**TF**	**FF**
FY 2010-11 Reconciliation	($4,286)	($4,286)
FY 2015-16 Interim Payments	$12,759	$12,759
FY 2016-17 Interim Payments	$129,662	$129,662
FY 2016-17 Total	**$138,135**	**$138,135**

Funding:

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

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	3/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1855

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$104,304,000	$206,236,000
- STATE FUNDS	$47,101,100	$90,524,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$104,304,000	$206,236,000
STATE FUNDS	$47,101,100	$90,524,800
FEDERAL FUNDS	$57,202,900	$115,711,200

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
SB 870 (Chapter 40, Statutes of 2014) added W&I Code, Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals less than 21 years of age. The Department is required to implement BHT under the federal interpretation for EPSDT Services for children under age 21. The effective date of this new service was September 15, 2014. Based on the increased call volume and the numbers of individuals who have been referred and/or completed comprehensive diagnostic evaluations and service assessments, utilization is expected to grow to 7,000 in FY 2015-16 and 12,500 in FY 2016-17.

The State Plan Amendment (SPA) for BHT is currently pending CMS' approval. The Department is working closely with the Department of Development Services (DDS), Medi-Cal managed care health plans (MCPs), and stakeholders to transition current Medi-Cal eligible regional center clients who are receiving services to an MCP or Medi-Cal Fee-for-Service, as appropriate. These services are currently covered by MCPs under approval to an amendment to the Section 1115 Medicaid Waiver Special Terms and Conditions. Implementation and coverage in Fee-for-Service are pending federal State Plan Amendment approval. The Department anticipates the transition of responsibility from the DDS regional centers to MCPs will occur no sooner than February 1, 2016.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 35

Reason for Change from Prior Estimate:
The changes are due to updated caseload as a result of utilization increase and updated capitation rate. May 2015 Estimate used a placeholder rate of $3,750 monthly; FY 2014-15 and FY 2015-16 monthly capitation rates ($1,640) is significantly lower than previously estimated.

Methodology:
1. Coverage for BHT began on September 15, 2014.

2. Assume managed care payments will begin March 1, 2016 for BHT services, retroactive to the implementation date.

3. BHT monthly capitation rates for FY 2014-15 and FY 2015-16 are $1,640.24 ($19,683 annually).

4. Assume 1,850 members received BHT services from September 2014 for FY 2014-15; not all members received BHT services each month. Estimated utilizer months for FY 2014-15 are 7,790.

   FY 2014-15: 7,790 x $1,640.24 = $12,777,500 TF

5. Assume 4,650 members received BHT services in FY 2015-16.

   FY 2015-16: 4,650 x $19,683 = $91,526,000 TF

6. Total BHT expenditure for FY 2015-16 is estimated to be $104,304,000 TF.

7. Assume the average member months receiving BHT services will be 9,979 for FY 2016-17 with a monthly capitation rate of $1,722.25 ($20,667 annually).

8. Total expenditure for FY 2016-17 is estimated to be $206,236,000 TF.

   FY 2016-17: 9,979 x $20,667 =$206,236,000

9. Costs for pre-existing Regional Center clients are not included in this policy change.

FY 2015-16	**TF**	**Title XIX**	**Title XXI**	**GF**
FY 2014-15	$ 12,778	$ 5,362	$ 1,335	$ 6,081
FY 2015-16	$ 91,526	$ 38,409	$ 12,097	$ 41,020
Total	**$ 104,304**	**$ 43,771**	**$ 13,432**	**$ 47,101**
FY 2016-17	**$ 206,236**	**$ 86,548**	**$ 29,163**	**$ 90,525**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
65% Title XXI / 35% GF (4260-113-0890/0001)
88% Title XXI / 12% GF (4260-113-0890/0001)

CCS DEMONSTRATION PROJECT PILOTS

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	4/2013
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1775

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$41,388,000	$41,388,000
- STATE FUNDS	$20,694,000	$20,694,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$41,388,000	$41,388,000
STATE FUNDS	$20,694,000	$20,694,000
FEDERAL FUNDS	$20,694,000	$20,694,000

DESCRIPTION

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

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

Interdependent Policy Changes:
OA 2 CCS Case Management
PC 106 County Organized Health Systems (COHS)
PC 150 Extend Hospital QAF – Hospital Payments
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 125 Extend Gross Premium Tax – Funding Adjustment
PC 111 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
The BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, allows the Department to develop and implement organized health care delivery models to provide comprehensive health care services to CCS Medi-Cal eligible children. This includes both primary preventive care and services specific to the child's CCS eligible health condition.

Effective April 1, 2013, the Health Plan of San Mateo (HPSM) an existing managed care organization, began operations as a demonstration project under the Department's 1115 Bridge to Reform Waiver model. Rady Children's Hospital – San Diego (RCHSD) demonstration pilot is currently in development and is expected to be implemented near the end of FY 2015-16. Currently, no dollars are budgeted for this pilot.

CCS DEMONSTRATION PROJECT PILOTS

REGULAR POLICY CHANGE NUMBER: 36

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

Methodology:

1. The CCS Pilot program transitioned CCS Medi-Cal beneficiaries residing in San Mateo County from the COHS, in which CCS services are carved out and reimbursed as fee-for-service, to the HPSM, in which primary preventative care and CCS services are reimbursed through a capitation rate.

2. The estimated capitation rate for HPSM is $1,724.47, including health care and administrative costs.

Average Monthly Enrollment	Capitation Rate	Monthly Payment	Annual Payment
2,000	$1,724.47	$3,449,000	$41,388,000

3. Assume 70% of the CCS Medi-Cal administrative costs of $3,085,000 will be transferred to the HPSM via the OA 2 - CCS Case Management policy change.

   Annual HPSM administrative costs:
   $3,085,000 x 70% = $2,160,000 TF (monthly $180,000 TF)

4. HPSM received capitation payments beginning May 2013.

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

6. Assume the CCS pilot program is budget neutral.

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

   (Dollars in Thousands)

	HPSM TF	**COHS**	**CCS Case Management**
FY 2015-16	**$41,388**	$39,228	$2,160
FY 2016-17	**$41,388**	$39,228	$2,160

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	28

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$40,464,000	$40,464,000
- STATE FUNDS	$20,232,000	$20,232,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,464,000	$40,464,000
STATE FUNDS	$20,232,000	$20,232,000
FEDERAL FUNDS	$20,232,000	$20,232,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 37

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

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

Methodology:

1. The estimates below were provided by CDA on a cash basis.

(Dollars in Thousands)	TF	Reimbursement from CDA	FFP
FY 2015-16	**$40,464**	$20,232	$20,232
FY 2016-17	**$40,464**	$20,232	$20,232

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

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	1/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1832

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$21,252,000	$21,252,000
- STATE FUNDS	$9,255,260	$9,011,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,252,000	$21,252,000
STATE FUNDS	$9,255,260	$9,011,000
FEDERAL FUNDS	$11,996,740	$12,241,000

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The American Dental Association recommends that a child be seen by a dentist as soon as his or her first tooth erupts, but at least no later than the first birthday. Early dental intervention can serve to: detect dental disease, demonstrate proper cleaning techniques for brushing a baby's teeth, discuss diet and fluoride needs, recommend oral care products, build a strong foundation for oral care, and form a rapport for continuous dental visits.

The Department has identified effective strategies which will have positive health outcomes while increasing utilization of services for children. The Department identified beneficiaries ages 0-3 that have not had a dental visit during the past 12 months in order to mail their parents/legal guardians information. These mailings include a letter encouraging them to take their children to see a dental provider as well as educational information about the importance of early dental visits.

Reason for Change from Prior Estimate:
The change in General Fund (GF) is due to the Title XXI funding adjustment from 65% FF / 35% GF to 88% FF / 12% GF effective October 2015.

Methodology:
1. The mailing campaign to beneficiaries aged 0-3 began January2015.

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 38

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

3. A 10% increase in utilization would increase users by 77,985 for both FY 2015-16 and FY 2016-17.

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

   FY 2015-16 and FY 2016-17: 77,985 x $272.51 = **$21,252,000 TF**

5. Of the $21,252,000 TF, it is estimated that 20% is eligible for Title XXI FMAP. The remainder is subject to Title XIX funding.

   FY 2015-16 and FY 2016-17: $21,252,000 x 20% = $4,250,000 TF

6. The annualized impact for the increase in benefits for FY 2015-16 and FY 2016-17 will be $21,252,000 TF ($9,256,000 GF for FY 2015-16 and $9,011,000 GF for FY 2016-17).

Funding:

FY 2015-16		**TF**	**GF**	**FF**
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$17,002,000	$8,501,000	$8,501,000
65% Title XXI FF/ 35% GF	4260-113-0001/0890	$1,062,000	$372,000	$690,000
88% Title XXI FF/ 12% GF	4260-113-0001/0890	$3,188,000	$383,000	$2,805,000
Total		**$21,252,000**	**$9,256,000**	**$11,996,000**

FY 2016-17		**TF**	**GF**	**FF**
50% Title XIX FF/ 50% GF	4260-101-0001/0890	$17,002,000	$8,501,000	$8,501,000
88% Title XXI FF/ 12% GF	4260-113-0001/0890	$4,250,000	$510,000	$3,740,000
Total		**$21,252,000**	**$9,011,000**	**$12,241,000**

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1228

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$20,537,000	$32,282,000
- STATE FUNDS	$2,186,000	$4,303,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,537,000	$32,282,000
STATE FUNDS	$2,186,000	$4,303,000
FEDERAL FUNDS	$18,351,000	$27,979,000

DESCRIPTION

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

Authority:
Federal Deficit Reduction Act (DRA) of 2005, Section 6071
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 51 California Community Transitions Savings
PC 42 CCT Fund Transfer to CDSS and CDDS
PC 48 Quality of Life Surveys for CCT Participants

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and extended by the ACA. It is effective from January 1, 2007, through December 31, 2018. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into qualified residences and with support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 365-days, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2015, through June 30, 2016, are 460 individuals and 472 individuals for July 1, 2016, through June 30, 2017.

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 39

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

Reason for Change from Prior Estimate:
In FY 2015-16, estimated DD enrollment decreased 32 percent from the FY 2015-16 Budget Act. In FY 2016-17, projected DD enrollees are expected to increase along with non-DD post-transition costs.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $69,460 in FY 2015-16 and FY 2016-17. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

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

3. Assume 492 pre-transitions that are unsuccessful for non-DD beneficiaries in both fiscal years cost $1,930 annually in FY 2015-16 and $2,027 annually in FY 2016-17; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $49,269 annually in FY 2015-16 and $51,616 annually in FY 2016-17; reimbursed at 75% MFP and 25% GF.

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

6. Assume DD beneficiaries, upon transitioning into CCT, cost $78,010 in FY 2015-16 and $79,152 in FY 2016-17 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

7. Estimated below is the overall impact of the CCT Demonstration project in FY 2015-16 and FY 2016-17.

FY 2015-16	**TF**	**GF**	**FF**
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	**$20,537,000**	**$2,186,000**	**$18,351,000**
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($12,414,000)	($6,207,000)	($6,207,000)
QoL CCT Costs (PC 48)	$143,000	$0	$143,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	$3,803,000	$0	$3,803,000
CCT Outreach - Admin costs (OA 40)	$330,000	$0	$330,000
Total of CCT PCs including pass through	$12,399,000	($4,021,000)	$16,420,000

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 39

FY 2016-17	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	**$32,282,000**	**$4,303,000**	**$27,979,000**
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($22,518,000)	($11,259,000)	($11,259,000)
QoL CCT Costs (PC 48)	$139,000	$0	$139,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	$4,090,000	$0	$4,090,000
CCT Outreach - Admin costs (OA 40)	$630,000	$0	$630,000
Total of CCT PCs including pass through	$14,623,000	($6,956,000)	$21,579,000

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

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	1/2016
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1854

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$9,118,000	$18,236,000
- STATE FUNDS	$4,323,020	$8,646,040
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,118,000	$18,236,000
STATE FUNDS	$4,323,020	$8,646,040
FEDERAL FUNDS	$4,794,980	$9,589,960

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The Child Health and Disability Prevention (CHDP) program is responsible for the “early and periodic” health assessment screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Fee-for-Service (FFS) Medi-Cal children and youth.

The CHDP legacy periodicity schedule provides for 15 periodic well child health assessments between birth and age 21. The AAP Bright Futures periodicity schedule provides for 29 periodic well child health assessments between birth and age 21. Implementation of the AAP Bright Futures periodicity schedule conforms Medi-Cal FFS EPSDT well child health assessments for children who are full scope Medi-Cal beneficiaries to the periodicity required by the ACA and SPA.

Reason for Change from Prior Estimate:
The implementation date of the Bright Futures periodicity moved from July 1, 2015 to January 1, 2016.

Methodology:
The following assumptions were used to estimate the additional health assessment cost for FY 2015-16 and FY 2016-17:

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER: 40

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

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

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

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

   Full year cost: $16,296,000 + $1,940,000 = $18,236,000 TF

5. Assume Bright Futures periodicity/claiming will not be implemented until January 1, 2016 due to system upgrades to permit claiming in accordance with the Bright Futures periodicity schedule.

   FY 2015-16: $18,236,000 ÷ 12 months x 6 months = **$9,118,000 TF**

   FY 2016-17: **$18,236,000 TF**

6. Assume that 93.19% of screens are for Medi-Cal children and 6.81% of screens are for the Optional Targeted Low Income Children Program (OTLICP).

Funding:

FY 2015-16:		**TF**	**GF**	**FF**
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$8,497,000	$4,248,000	$4,249,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$621,000	$75,000	$546,000
Total for FY 2015-16		**$9,118,000**	**$4,323,000**	**$4,795,000**

FY 2016-17:		**TF**	**GF**	**FF**
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$16,994,000	$8,497,000	$8,497,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$1,242,000	$149,000	$1,093,000
Total for FY 2016-17		**$18,236,000**	**$8,646,000**	**$9,590,000**

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	1/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1772

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$5,126,000	$5,298,000
- STATE FUNDS	$22,000	$21,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,126,000	$5,298,000
STATE FUNDS	$22,000	$21,000
FEDERAL FUNDS	$5,104,000	$5,277,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Projected rate increase to the Indian Health Service daily rate for calendar years 2016 and 2017.

Methodology:
1. The program was implemented January 2014 with an effective date of September 1, 2013.
2. Assume 40 youths will be enrolled in the program in FY 2015-16 and FY 2016-17.
3. Assume the average stay per youth is 180 days.
4. Calendar year 2015 daily rate per youth is $700.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 41

5. Assume the daily rate increases annually by $24.

   FY 2015-16
   (2015 calendar year rate of $700)
   20 youths x 180 days per youth x $700 per day = $2,520,000 TF

   (2016 calendar year rate of $724)
   20 youths x 180 days per youth x $724 per day = $2,606,000 TF

   FY 2016-17
   (2016 calendar year rate of $724)
   20 youths x 180 days per youth x $724 per day = $2,606,000 TF

   (2017 calendar year rate of $748)
   20 youths x 180 days per youth x $748 per day = $2,693,000 TF

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

7. $630,000 FFP from last quarter of FY 2014-15 will be reimbursed in FY 2015-16.

FY 2015-16	TF	GF	FFP
*Apr - June 2014	$0	($630,000)	$630,000
Jul - Sep 2014	$1,260,000	$0	$1,260,000
Oct - Dec 2014	$1,260,000	$0	$1,260,000
Jan - Mar 2015	$1,303,000	$0	$1,303,000
**Apr - Jun 2015	$1,303,000	$652,000	$651,000
Total	**$5,126,000**	**$22,000**	**$5,104,000**

FY 2016-17	TF	GF	FFP
*Apr - June 2015	$0	($652,000)	$652,000
Jul - Sep 2015	$1,303,000	$0	$1,303,000
Oct - Dec 2015	$1,303,000	$0	$1,303,000
Jan - Mar 2016	$1,346,000	$0	$1,346,000
**Apr - Jun 2016	$1,346,000	$673,000	$673,000
Total	**$5,298,000**	**$21,000**	**$5,277,000**

*****Totals may differ due to rounding

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

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

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	10/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1562

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$3,803,000	$4,090,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,803,000	$4,090,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,803,000	$4,090,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through December 31, 2018. The grant requires the Department to develop and implement strategies to assist 4,428 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition into federally-qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS).

Reason for Change from Prior Estimate:
In FY 2015-16, estimated enrollment decreased due to a revision from the FY 2015-16 Budget Act. In FY 2016-17, the projected enrollment is estimated to increase.

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 42

Methodology:

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

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

3. In FY 2010-11, the Department established IA 09-86345 with CDDS and in FY 2011-12 IA 10-87274 was established with CDSS. Both IAs transfer the additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. It is assumed that 55% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs $33,509 in FY 2015-16 and $33,641 in FY 2016-17. The Department will provide 25% of these costs to CDSS.

5. Assume CDDS will receive 75% of the pre-transitional and post transitional services costs for the DD population.

6. Due to system problems with CMIPS II during the period of August 2012 through May 2014, it is anticipated that CDDS will receive an estimated $350,000 FFP, and CDSS will receive $500,000 from reconciled services costs. These costs are expected to be transferred to the appropriate department during FY 2015-16.

	FY 2015-16	FY 2016-17
CDSS	$1,502,000	$1,563,000
CDDS	$1,451,000	$2,527,000
CDSS Reconciliation	$500,000	$0
CDDS Reconciliation	$350,000	$0
Total	**$3,803,000**	**$4,090,000**

FY 2015-16	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$20,537,000	$2,186,000	$18,351,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($12,414,000)	($6,207,000)	($6,207,000)
QoL CCT Costs (PC 48)	$143,000	$0	$143,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	**$3,803,000**	**$0**	**$3,803,000**
CCT Outreach - Admin costs (OA 40)	$330,000	$0	$330,000
Total of CCT PCs including pass through	$12,399,000	($4,021,000)	$16,420,000

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 42

FY 2016-17	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$32,282,000	$4,303,000	$27,979,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($22,518,000)	($11,259,000)	($11,259,000)
QoL CCT Costs (PC 48)	$139,000	$0	$139,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	**$4,090,000**	**$0**	**$4,090,000**
CCT Outreach - Admin costs (OA 40)	$630,000	$0	$630,000
Total of CCT PCs including pass through	$14,623,000	($6,956,000)	$21,579,000

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

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	12/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1877

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$1,153,000	$0
- STATE FUNDS	$576,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,153,000	$0
STATE FUNDS	$576,500	$0
FEDERAL FUNDS	$576,500	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of increased utilization of dental services as a result of enrolling Registered Dental Hygienists (RDHs), Registered Dental Hygienists in Extended Functions (RDHEFs), and Registered Dental Hygienists in Alternative Practice (RDHAPs) in the Medi-Cal Dental Services Program.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 189 Funding Adjust. - ACA Opt. Expansion
PC 190 Funding Adjust. - OTLICP

Background:
The Department proposes the implementation of administrative changes to allow RDHs and RDHEFs employed by a public health program, created by Federal, State, or local law or administered by a Federal, State, county, or local governmental entity to enroll as billing providers in the Medi-Cal Dental Services Program. This includes allowing RDHs and RDEFs to enroll as rendering providers if the public health program that employs them is registered as a billing provider in the Medi-Cal Dental Services Program. Reimbursement for services provided by the aforementioned allied dental professionals is limited to services provided to the extent permitted by the applicable professional licensing statutes and regulations outlined by State law and the requirements delineated in the dental Manual of Criteria. The Centers for Medicare and Medicaid Services (CMS) directed the Department to update the State Plan to include these allied dental professionals as well as RDHAPs to accurately reflect the permissibility of their enrollment in the Medi-Cal Dental Services Program. As such, State Plan Amendment 15-005 was submitted to CMS as the enrollment of these allied dental professionals is permissible under existing state law. The SPA is currently pending CMS approval.

Reason for Change from Prior Estimate:
The estimated cost for FY 2015-16 has decreased due a change in the implementation date.

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 43

Methodology:

1. Assume the enrollment of these allied professionals will be effective December 1, 2015.

2. Assume the first payment will be made in December 2015.

3. Assume the enrollment of these allied professionals will result in an increase in the utilization of dental services that are within the scope of their licensure to provide.

4. Assume that 29% of the total number of RDHs and RDHEF's licensed in the State will enroll in the Denti-Cal program.

5. Assume the annual average amount paid per allied professional is $1,648 and the number of allied professionals enrolled in Denti-Cal is 4,629.

6. RDHAPs perform services at four types of locations. RDHs and RDHEFs can only perform services at one out of the four types of locations (public health facilities). Therefore, assume that an RDH or RDHEF can provide services that are equivalent to a RDHAP in 0.25 locations.

7. The increased utilization cost impact based on enrollment of these professionals is estimated at $1,153,000 TF ($576,500 GF) for FY 2015-16, with an estimated growth factor of 1.018. Costs for FY 2016-17 and subsequent years will be incorporated in the dental rates.

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	7/2013
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1787

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$697,000	$972,000
- STATE FUNDS	$333,400	$460,920
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$697,000	$972,000
STATE FUNDS	$333,400	$460,920
FEDERAL FUNDS	$363,600	$511,080

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 50 Pediatric Palliative Care Expansion and Savings

Background:
AB 1745 required the Department to submit a federal waiver application to the Centers for Medicare and Medicaid Services (CMS) for a Pediatric Palliative Care pilot project. The waiver makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The waiver was approved beginning April 1, 2009 through March 31, 2017 and is expected to be renewed prior to its expiration.

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

A waiver amendment is expected to be approved by CMS by January 1, 2016, which will cease payment of the $300 PMPM administrative fee and increase the provider reimbursement rates by the same amount. A rate study was completed to determine the increase in rate for each service category, totaling $300 PMPM.

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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 44

Reason for Change:
Administrative costs decreased as the caseload expansion is starting three months later than previously anticipated.

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

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

2. Assume caseload expanding to 270 members through FY 2015-16 using a staggered rollout.

3. Assume a $300 PMPM cost for administrative costs paid as a fee for July 1, 2014 – December 31, 2015.

4. Assume a $300 PMPM cost paid via increased provider reimbursement rates effective January 1, 2016.

For FY 2015-16, 150 members x 12 months = 1,800 member months (MM)

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

The FY 2015-16 caseload expansion includes an additional 524 MM.

Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Member Months
0	0	0	12	13	30	37	52	69	86	105	120	**524**

524 MM x $300 PMPM = $157,000 (caseload expansion)

$540,000 + $157,000 = $697,000 TF

For FY 2016-17, 270 members x 12 months = 3,240 MM

3,240 MM x $300 PMPM = $972,000 TF

Funding:

FY 2015-16:		TF	GF	FF
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$650,000	$325,000	$325,000
OTLICP 65% Title XXI / 35% GF	4260-113-0001/0890	$12,000	$4,000	$8,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$35,000	$4,000	$31,000
Total for FY 2015-16		**$697,000**	**$333,000**	**$364,000**

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 44

FY 2016-17:		TF	GF	FF
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$906,000	$453,000	$453,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$66,000	$8,000	$58,000
Total for FY 2016-17		**$972,000**	**$461,000**	**$511,000**

CHDP PROGRAM DENTAL REFERRAL

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	10/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1870

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$606,000	$808,000
- STATE FUNDS	$300,720	$400,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$606,000	$808,000
STATE FUNDS	$300,720	$400,960
FEDERAL FUNDS	$305,280	$407,040

DESCRIPTION

Purpose:
This policy change estimates the cost of referring, Medi-Cal eligible, Child Health and Disability Prevention (CHDP) program children to a dentist at one year of age.

Authority:
Health & Safety Code 124040 (a)(6)(D)

Interdependent Policy Changes:
Not Applicable

Background:
Health & Safety Code 124040 (a)(6)(D), as amended, requires local CHDP programs and CHDP providers to refer all children participating in the program, who are at least one year of age and who are eligible for Medi-Cal, to a dentist participating in the Medi-Cal program, rather than at three years of age. The Health & Safety Code 124040 (a)(6)(D) amendment went into effect July 1, 2015, and provider referrals begin by October 1, 2015.

Reason for Change:
Due to time required to issue related notices and for providers to assimilate the new mandate, providers will begin to comply with the new mandate on October 1, 2015. The previous estimate assumed a July 1, 2015, start date.

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

1. Based on FY 2012-13 actual data, 4,549 (1.43%) of the 318,179 CHDP children one to two years of age that received dental assessments were referred to a dentist.

2. Based on FY 2012-13 actual data, 8,275 (2.76%) of the 300,350 CHDP children age three to five were referred to a dentist.

CHDP PROGRAM DENTAL REFERRAL

REGULAR POLICY CHANGE NUMBER: 45

3. Assume that CHDP children one to two years of age will be referred at the same rate as those three to five years of age; 2.76%.

   318,179 x 2.76% = 8,782 (rounded) referrals for CHDP children one to two years of age.

4. Currently, 4,549 CHDP children one to two years of age are already being referred.

   8,782 – 4,549 = 4,233 additional referrals for CHDP children one to two years of age.

5. The average cost of dental treatment for CHDP children one to two years of age in FY 2012-13 was $190.96. Assume the FY 2015-16 & FY 2016-17 cost of dental treatment is the same:

   FY 2015-16:
   4,233 referrals ÷ 12 months x 9 months = 3,175 x $190.96 = **$606,000 TF**

   FY 2016-17:
   4,233 referrals x $190.96 = **$808,000 TF**

Funding:

FY 2015-16		TF	GF	FF
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$600,000	$300,000	$300,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$6,000	$1,000	$5,000
Total for FY 2015-16		**$606,000**	**$301,000**	**$305,000**

FY 2016-17		TF	GF	FF
Medi-Cal 50% Title XIX / 50% GF	4260-101-0001/0890	$800,000	$400,000	$400,000
OTLICP 88% Title XXI / 12% GF	4260-113-0001/0890	$8,000	$1,000	$7,000
Total for FY 2016-17		**$808,000**	**$401,000**	**$407,000**

BENEFICIARY OUTREACH AND EDUCATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 1/2016
ANALYST: Sandra Bannerman
FISCAL REFERENCE NUMBER: 1934

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$216,000	$860,000
- STATE FUNDS	$66,660	$270,590
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$216,000	$860,000
STATE FUNDS	$66,660	$270,590
FEDERAL FUNDS	$149,340	$589,410

DESCRIPTION

Purpose:
The policy change estimates the cost of implementing strategies to increase utilization for Medi-Cal dental services.

Authority:
Welfare & Institutions Code (WIC) Section 14132.91
Contract 04-35745

Interdependent Policy Changes:
Not Applicable

Background:
In 2014 the California State Auditor (CSA) performed an audit of the Medi-Cal Dental Program. Among the findings/recommendations outlined in CSA's final report was a request that the Department require Delta Dental to develop an annual dental outreach and education program, as required by the provisions of Delta's contract and WIC Section 14132.91. Outreach activities outlined in Delta's Outreach and Education Program plan seek to increase utilization of these services, particularly in counties where utilization levels are lowest. Outreach and education will help increase beneficiary awareness that they have dental benefits and may access assistance in locating a dentist and scheduling an appointment.

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

Methodology:
1. Assume the beneficiary outreach and education program will begin January 1, 2016.

2. Assume the campaign will result in a 1% utilization increase in FY 2015-16 and a 2% utilization increase in FY 2016-17.

3. Assume a 6-month phase-in for FY 2015-16 beginning January 1, 2016.

BENEFICIARY OUTREACH AND EDUCATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 46

4. It is estimated that 20% of costs are eligible for Title XXI FMAP. Assume 23% of costs are eligible for Title XIX ACA FMAP. The remainder is subject to Title XIX funding.

5. The annualized impact for the increase in benefits for FY 2015-16 and FY 2016-17 will be:

FY 2015-16	TF	GF	FF
Title XIX (50/50)	$ 123,000	$ 61,500	$ 61,500
Title XXI (88/12)	$ 43,000	$ 5,000	$ 38,000
Title XIX ACA (100)	$ 50,000	$ -	$ 50,000
Total	**$ 216,000**	**$ 66,500**	**$ 149,500**

FY 2016-17	TF	GF	FF
Title XIX (50/50)	$ 490,000	$ 245,000	$ 245,000
Title XXI (88/12)	$ 172,000	$ 21,000	$ 151,000
Title XIX ACA (100)	$ 99,000	$ -	$ 99,000
Title XIX ACA (95/5)	$ 99,000	$ 5,000	$ 94,000
Total	**$ 860,000**	**$ 271,000**	**$ 589,000**

(Numbers may vary due to rounding)

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
100% Title XIX ACA FF 4260-101-0890
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1436

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$156,000	$115,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$156,000	$115,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$156,000	$115,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

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

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 47

Reason for Change from Prior Estimate:
Target monthly enrollment for FY 2015-16 decreased from 20 individuals to 19 based on actual enrollment data through June 2015. The cost per participant also decreased from current year to budget year due to a lower service level of care.

Methodology:

1. The waiver was amended in 2014 to reduce the maximum capacity to 90 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment began in August 2012. Target monthly enrollment for the period of July 1, 2015 through June 30, 2016 will remain at 19 individuals and revised to 22 individuals for July 1, 2016 through June 30, 2017.

2. The enrollment will be phased in throughout the year. Total participant months will be 201 in FY 2014-15, 206 in FY 2015-16, and 245 in FY 2016-17.

3. The monthly total cost is estimated to be $2,585 per participant in FY 2014-15, $1,110 in FY 2015-16, and $927 in FY 2016-17.

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

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

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

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 7/2010
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1550

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$143,000	$139,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$143,000	$139,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$143,000	$139,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Eligibles have increased by 3% in FY 2015-16 based on updated actual and projected CCT enrollment from FYs 2013-14, 2014-15, and 2015-16.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 48

Methodology:

1. The QoL surveys began in July 2010.

2. In FY 2013-14, 576 beneficiaries were transitioned in the CCT demonstration project and 322 additional beneficiaries transitioned into CCT in FY 2014-15. Projected enrollments are 528 in FY 2015-16 and 540 in FY 2016-17.

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

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

FY 2015-16 Baseline	528 x $100 = $52,800
FY 2014-15 First follow up	322 x $100 = $32,200
FY 2013-14 Second follow up	576 x $100 = $57,600
FY 2015-16 Estimated Costs:	**$143,000 TF** (rounded)
FY 2016-17 Baseline	540 x $100 = $54,000
FY 2015-16 First follow up	528 x $100 = $52,800
FY 2014-15 Second follow up	322 x $100 = $32,200
FY 2016-17 Estimated Costs:	**$139,000 TF**

FY 2015-16	**TF**	**GF**	**FF**
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$20,537,000	$2,186,000	$18,351,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($12,414,000)	($6,207,000)	($6,207,000)
QoL CCT Costs (PC 48)	**$143,000**	**$0**	**$143,000**
CCT Fund Transfer to CDSS & CDDS (PC 42)	$3,803,000	$0	$3,803,000
CCT Outreach - Admin costs (OA 40)	$330,000	$0	$330,000
Total of CCT PCs including pass through	$12,399,000	($4,021,000)	$16,420,000

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 48

FY 2016-17	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$32,282,000	$4,303,000	$27,979,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	($22,518,000)	($11,259,000)	($11,259,000)
QoL CCT Costs (PC 48)	**$139,000**	**$0**	**$139,000**
CCT Fund Transfer to CDSS & CDDS (PC 42)	$4,090,000	$0	$4,090,000
CCT Outreach - Admin costs (OA 40)	$630,000	$0	$630,000
Total of CCT PCs including pass through	$14,623,000	($6,956,000)	$21,579,000

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

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	12/2015
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1770

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$25,000	$339,000
- STATE FUNDS	$5,200	$76,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$25,000	$339,000
STATE FUNDS	$5,200	$76,200
FEDERAL FUNDS	$19,800	$262,800

DESCRIPTION

Purpose:
This policy change estimates the cost and cost-avoidance from reproductive health services benefit changes to the Family Planning, Access, Care and Treatment (Family PACT) and Medi-Cal programs.

Authority:
Welfare & Institutions Code 14132(aa)(8)
Affordable Care Act, Section 2303(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
The Department conducts on-going monitoring and utilization management of reproductive health services to expand access to services, evaluate the cost-effectiveness of services, and identify opportunities to reduce program costs while maintaining the same quality of care.

For the Family PACT program, effective January 1, 2016, the Department plans to adopt a Medi-Cal Preferred List for oral contraceptives.

For Medi-Cal Fee-for-Service, effective December 1, 2015, the Department will add onsite dispensing for the contraceptive patch and ring to ensure continuity of care for women transitioning from the Family PACT program to Medi-Cal.

Reason for Change from Prior Estimate:
The change is due to the addition of onsite dispensing of the contraceptive patch and ring.

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 49

Methodology:

1. The estimate projections is based on FY 2013-14 data:

Benefit	FMAP	FY 2015-16	FY 2016-17
Medi-Cal List of Oral Contraceptives	90%	($2,000,000)	($4,000,000)
Onsite Dispensing for Patch/Ring	90%	$2,025,000	$4,339,000
Total		**$25,000**	**$339,000**

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

FY 2015-16	TF	GF	FF
90% Title XIX / 10% GF	$22,000	$2,000	$20,000
100% GF	$3,000	$3,000	$0
Total	**$25,000**	**$5,000**	**$20,000**

FY 2016-17	TF	GF	FF
90% Title XIX / 10% GF	$292,000	$29,000	$263,000
100% GF Savings	$47,000	$47,000	$0
Total	**$339,000**	**$76,000**	**$263,000**

Funding:

90% Title XIX / 10% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	10/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1885

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$1,642,000	-$4,512,000
- STATE FUNDS	-$784,880	-$2,139,340
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,642,000	-$4,512,000
STATE FUNDS	-$784,880	-$2,139,340
FEDERAL FUNDS	-$857,120	-$2,372,660

DESCRIPTION

Purpose:
This policy change budgets projected savings attributed to the FY 2015-16 expansion of the Pediatric Palliative Care Waiver (PPCW) pilot project.

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 1745, also known as “The Nick Snow Children’s Hospice & Palliative Care Act of 2006,” required the Department to submit a federal waiver application to the Centers for Medicare and Medicaid Services (CMS) for a Pediatric Palliative Care pilot project. The waiver makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The waiver was approved beginning April 1, 2009 through March 31, 2017 and is expected to be renewed prior to its expiration.

AB 1745 also included an evaluation component which was conducted by the University of California, Los Angeles (UCLA), Center for Policy Research. The evaluation reflected a reduction of $3,133 per member per month (PMPM) under the Pediatric Palliative Care Pilot, predominantly resulting from a decrease in inpatient care. Based on the historical success of this pilot program, the Department proposes to expand the program from nine operating counties to an additional seven counties. The projected increase in client participants will be approximately 120 additional clients; the current level of participants is 150 clients.

The administrative costs of the PPCW pilot project are budgeted in other policy changes. Other Administration policy change California Children’s Services (CCS) Case Management (OA 2) budgets for nurse liaisons and support staff. The Pediatric Palliative Care Waiver (PC 44) policy change budgets for indirect services, administrative support, overhead, and training.

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 50

Reason for Change from Prior Estimate:
Net savings decreased as the caseload expansion is starting three months later than previously anticipated.

Methodology:
The following assumptions were used to estimate the caseload expansion cost and program savings:

1. Assume 270 members enroll in PPCW by the end of FY 2015-16 with no further increase in FY 2016-17.

2. Nine counties are operational in FY 2014-15; seven additional counties are expected to become operational in FY 2015-16 with a staggered rollout.

3. Based on the number of members enrolled in FY 2015-16 and $3,133 PMPM savings, assume a gross savings of $1,642,000 for FY 2015-16 and $4,512,000 for FY 2016-17.

4. When accounting for nurse liaison costs (OA 2) and administrative costs (PC 44), the net savings of the PPC expansion are indicated in the table below.

FY 2015-16	**TF**	**GF**	**FF**
OA 2-CCS Case Management	$517,000	$129,000	$388,000
PC 44-PPCW	$157,000	$75,000	$82,000
Savings	**($1,642,000)**	**($785,000)**	**($857,000)**
Net Savings	($968,000)	($581,000)	($387,000)

FY 2016-17	**TF**	**GF**	**FF**
OA 2-CCS Case Management	$1,400,000	$350,000	$1,050,000
PC 44-PPCW	$432,000	$204,000	$228,000
Savings	**($4,512,000)**	**($2,139,000)**	**($2,373,000)**
Net Savings	($2,680,000)	($1,585,000)	($1,095,000)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1222

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$12,414,000	-$22,518,000
- STATE FUNDS	-$6,207,000	-$11,259,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,414,000	-$22,518,000
STATE FUNDS	-$6,207,000	-$11,259,000
FEDERAL FUNDS	-$6,207,000	-$11,259,000

DESCRIPTION

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

Authority:
Federal Deficit Reduction Act (DRA) of 2005, Section 6071
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 39 California Community Transitions Costs
PC 42 CCT Fund Transfer to CDSS and CDDS
PC 48 Quality of Life Surveys for CCT Participants

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and extended by the ACA. It is effective from January 1, 2007, through December 31, 2018. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into qualified residences and with support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 365-days, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2015, through June 30, 2016, are 460 individuals and 472 individuals for July 1, 2016, through June 30, 2017.

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 51

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD beneficiaries expected to transition into CCT is included in this policy change. The cost of transitioning, providing HCBS, and the supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change from Prior Estimate:
In FY 2015-16, projected DD enrollees decreased 32 percent from the FY 2015-16 Budget Act. In FY 2016-17, projected non-DD enrollees are expected to increase.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $69,460 in FY 2015-16 and FY 2016-17. The savings from moving participants from NF-Bs to the waiver are 50% FF and 50% GF.

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

3. Assume 492 pre-transitions that are unsuccessful for non-DD beneficiaries cost $1,930 annually in FY 2015-16 and $2,027 annually in FY 2016-17; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $49,269 annually in FY 2015-16 and $51,616 annually in FY 2016-17; reimbursed at 75% MFP and 25% GF.

5. Assume non-DD beneficiaries have a total of 3,201 enrollment months for FY 2015-16 and 3,990 for FY 2016-17.

6. Assume a monthly rate or $5,788 for FY 2015-16 and FY 2016-17 for NF-B beneficiaries.

   $190.30 NF-B daily rate x 365 days / 12 months = $5,788 per month

7. Assume a savings of $12,414,000 TF for FY 2015-16 and $22,518,000 TF for FY 2016-17.

   FY 2015-16: 3,201 non-DD enrollment months x $5,788 x 0.670 payment lag = **$12,414,000 TF** savings

   FY 201-17: 3,990 non-DD enrollment months x $5,788 x 0.975 payment lag = **$22,518,000 TF** savings

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

9. Assume DD beneficiaries, upon transitioning into CCT, cost $78,010 in FY 2015-16 and $79,152 in FY 2016-17 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

10. Estimated savings in the budget year include phased-in and lagged payments from the current year.

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 51

FY 2015-16	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$20,537,000	$2,186,000	$18,351,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	**($12,414,000)**	**($6,207,000)**	**($6,207,000)**
QoL CCT Costs (PC 48)	$143,000	$0	$143,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	$3,803,000	$0	$3,803,000
CCT Outreach - Admin costs (OA 40)	$330,000	$0	$330,000
Total of CCT PCs including pass through	$12,399,000	($4,021,000)	$16,420,000

FY 2016-17	TF	GF	FF
CCT Costs (PC 39):			
Total Non-DD costs and DD FFP	$32,282,000	$4,303,000	$27,979,000
CCT Savings (PC 51):			
Total Non-DD savings and DD FFP	**($22,518,000)**	**($11,259,000)**	**($11,259,000)**
QoL CCT Costs (PC 48)	$139,000	$0	$139,000
CCT Fund Transfer to CDSS & CDDS (PC 42)	$4,090,000	$0	$4,090,000
CCT Outreach - Admin costs (OA 40)	$630,000	$0	$630,000
Total of CCT PCs including pass through	$14,623,000	($6,956,000)	$21,579,000

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

ORKAMBI BENEFIT

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	7/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1931

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$19,051,000	$56,762,000
- STATE FUNDS	$9,050,500	$26,894,000
PAYMENT LAG	0.9489	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,077,500	$56,762,000
STATE FUNDS	$8,588,020	$26,894,000
FEDERAL FUNDS	$9,489,480	$29,868,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Orkambi for the treatment of certain clients with cystic fibrosis (CF).

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Interdependent Policy Changes:
Not Applicable

Background:
Orkambi is a two-drug therapy combining the drugs ivacaftor with lumacaftor in a single pill designed to address chloride channel abnormalities in CF patients. This condition affects approximately 50% of the total CF population. The FDA approved Orkambi for use in people with CF ages 12 and older who have specific defective or missing proteins resulting from mutations in a specific gene.

The populations included in this policy change are Medi-Cal Fee-for-Service California Children's Services (CCS), Optional Targeted Low Income Children's Program (OTLICP), and Genetically Handicapped Persons Program (GHPP) clients.

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

Methodology:
1. Assume the cost of Orkambi is $259,000 per client per year.

2. For FY 2015-16 and FY 2016-17, assume 202 CCS Medi-Cal, 28 CCS OTLICP, and 209 GHPP Medi-Cal clients, age 12 and over with CF.

ORKAMBI BENEFIT

REGULAR POLICY CHANGE NUMBER: 52

3. For FY 2015-16, assume 16.67% of the CF population is prescribed Orkambi.

CCS Medi-Cal: $259,000 x 34 = $8,806,000 per year

CCS OTLICP: $259,000 x 5 = $1,295,000 per year

GHPP Medi-Cal: $259,000 x 35= $9,065,000 per year

4. For FY 2016-17, assume 50% of the CF population will be prescribed Orkambi.

CCS Medi-Cal: $259,000 x 101 = $26,159,000 per year

CCS OTLICP: $259,000 x 14 = $3,626,000 per year

GHPP Medi-Cal: $259,000 x 105 = $27,195,000 per year

FY 2015-16	**TF**	**GF**	**FF**	CF*
CCS-Medi-Cal	$8,806,000	$4,403,000	$4,403,000	
CCS OTLICP	$267,000	$57,000	$210,000	$57,000
CCS OTLICP (Enhanced)	$913,000	$58,000	$855,000	$58,000
GHPP-Medi-Cal	$9,065,000	$4,532,000	$4,533,000	
Total	**$19,051,000**	**$9,050,000**	**$10,001,000**	$115,000

FY 2016-17	**TF**	**GF**	**FF**	CF*
CCS-Medi-Cal	$26,159,000	$13,079,000	$13,080,000	
CCS OTLICP (Enhanced)	$3,408,000	$217,000	$3,191,000	$218,000
GHPP-Medi-Cal	$27,195,000	$13,598,000	$13,597,000	
Total	**$56,762,000**	**$26,894,000**	**$29,868,000**	$218,000

*County Funds (CF), not included in total funds

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0001/0890)
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)

ADAP RYAN WHITE MEDS DATA MATCH

REGULAR POLICY CHANGE NUMBER: 53
IMPLEMENTATION DATE: 5/2015
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1944

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,400,000	$627,000
- STATE FUNDS	$1,200,000	$313,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,400,000	$627,000
STATE FUNDS	$1,200,000	$313,500
FEDERAL FUNDS	$1,200,000	$313,500

DESCRIPTION

Purpose:
This policy change estimates the cost of client shift from AIDS Drug Assistance Program (ADAP) to Medi-Cal as a result of Ryan White client data match.

Authority:
Interagency Agreement (IA) 13-21043

Interdependent Policy Changes:
Not Applicable

Background:
ADAP is a State-based program funded by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. In California, ADAP is administered through the California Department of Public Health (CDPH). The program provides medications to treat HIV disease or prevent related serious deterioration in health.

Federal requirements stipulate that Ryan White grant funds are to be used solely as a payer of last resort. To minimize the possibility of paying for medications that should be billed to Medi-Cal, CDPH executed an interagency agreement with the Department requiring a monthly cross match of Ryan White and Medi-Cal Eligibility Data System (MEDS) client data. Clients that are identified as enrolled in Medi-Cal with no Share of Cost (SOC) will be unenrolled from ADAP.

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

Methodology:
1. The Ryan White MEDS cross match began in May 2015 on a monthly basis.

2. Assume the cross match will identify 295 ADAP clients enrolled in Medi-Cal during FY 2014-15 and FY 2015-16 and 36 ADAP clients in FY 2016-17.

ADAP RYAN WHITE MEDS DATA MATCH

REGULAR POLICY CHANGE NUMBER: 53

3. The estimate is provided by CDPH on a cash basis.

	TF	GF	FF
FY 2015-16	**$2,400,000**	**$1,200,000**	**$1,200,000**
FY 2016-17	**$627,000**	**$313,500**	**$313,500**

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

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2015
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1909

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,400,000	$2,400,000
- STATE FUNDS	$1,200,000	$1,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	9.75 %	8.79 %
APPLIED TO BASE		
TOTAL FUNDS	$2,166,000	$2,189,000
STATE FUNDS	$1,083,000	$1,094,520
FEDERAL FUNDS	$1,083,000	$1,094,520

DESCRIPTION

Purpose:
This policy change estimates the increased costs of Hepatitis C (Hep C) drugs to account for the expansion of clinical guidelines.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 130 MCO Enrollee Tax
PC 129 MCO Enrollee Tax – Funding Adjustment
PC 111 MCO Enrollee Tax – Increase Capitation Rates

Background:
Chronic Hep C is a common blood-borne infection that can lead to liver damage or liver failure. The Medi-Cal program currently treats patients with a Stage 3 or Stage 4 diagnosis and patients with liver manifestations or post-liver transplants.

Based on recent scientific evidence and research, the Department is updating the Hep C policy to include newly FDA-approved drugs and include people with less advanced stages of the disease (including Stage 2). The new policy will include Hep C patients, regardless of stage, who also have:

- Diabetes,
- HIV,
- Hepatitis B,
- Debilitating fatigue,
- A desire to become pregnant, and
- Other comorbid conditions.

Hep C costs are also included in the managed care base policy changes (PCs 105, 106, 107, and 110).

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER: 54

Reason for Change from Prior Estimate:
Managed care costs have been removed from this policy change and are now included in the Hep C kick payment estimate.

Methodology:
1. Assume additional fee-for-service (FFS) costs of 17% due to the expansion of clinical guidelines.

2. The proposed increase in FFS costs for FY 2015-16 and FY 2016-17 is:

	FY 2015-16		**FY 2016-17**	
	TF	GF	TF	GF
FFS	$ 4,300,000	$ 2,100,000	$ 4,300,000	$ 2,100,000
FFS Rebates	$ (1,900,000)	$ (900,000)	$ (1,900,000)	$ (900,000)
Totals	**$ 2,400,000**	**$ 1,200,000**	**$ 2,400,000**	**$ 1,200,000**

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

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	3/2007
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	108

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$221,500	$19,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$221,500	$19,500
FEDERAL FUNDS	-$221,500	-$19,500

DESCRIPTION

Purpose:
This policy change budgets 100% General Fund (GF) costs to reimburse the federal share to the Centers for Medicare and Medicaid Services (CMS) for drugs ineligible for federal funds(FF) (Non-FFP drugs).

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Interdependent Policy Changes
Not Applicable

Background:
Federal Medicaid rules specify that there is no FF for drugs provided by state Medicaid programs if the manufacturer of the drug has not signed a rebate contract with the CMS.

Effective March 2007, an automated quarterly report was made available to determine the costs of drugs for which there is no FF. The Department reimburses the federal government for FF claimed for these drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from September 2014 to June 2015.

Methodology:
1. The Department reimburses CMS quarterly for ongoing non-FF drugs purchased. Based on data from July 2004 to June 2015, the FF actual total costs were compared to the base estimate amounts which created a percentage used to calculate the estimate.

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 55

	Non-FF Drug Expenditures	Est. FF Repayment
FY 2015-16	$443,000	**$221,000**
FY 2016-17	$39,000	**$19,000**

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	1/2010
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1433

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$16,000,000	-$16,000,000
- STATE FUNDS	-$5,600,000	-$5,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$16,000,000	-$16,000,000
STATE FUNDS	-$5,600,000	-$5,600,000
FEDERAL FUNDS	-$10,400,000	-$10,400,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Welfare & Institutions Code 14105.33(b)(4)

Interdependent Policy Changes:
Not Applicable

Background:
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP program in January 2010. This policy change reflects ongoing rebates invoiced. Revenues resulting from the resolution of disputed rebates are budgeted in the Aged and Disputed Drug Rebate policy change.

Reason for Change from Prior Estimate:
The rebates are expected to decline based on FY 2014-15 collection data.

Methodology:
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. It is estimated that $16,000,000 in rebates will be collected in both FY 2015-16 and FY 2016-17.

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	10/2006
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1181

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$29,518,000	-$30,923,000
- STATE FUNDS	-$12,692,500	-$6,756,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$29,518,000	-$30,923,000
STATE FUNDS	-$12,692,500	-$6,756,700
FEDERAL FUNDS	-$16,825,500	-$24,166,300

DESCRIPTION

Purpose:
This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:
Welfare & Institutions Code 14100.95(a) and 14105.47(c)(1)

Interdependent Policy Changes:
Not Applicable

Background:
The Department negotiates Maximum Acquisition Cost (MAC) for diabetic testing supplies with manufacturers to make available the best price to all providers. The Department establishes the product reimbursement rates for diabetic testing products which are based on the contracted MAC. The Department also negotiates rebates with some diabetic testing supply manufacturers to provide savings to the Department. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers for the contracted rebate percentage of the MAC.

Reason for Change from Prior Estimate:
The FY 2015-16 rebates are expected to decline based on FY 2014-15 collection data.

Methodology:
1. The current medical supply diabetic testing products rebate contract terms were effective January 1, 2013 through December 31, 2015. The Department is negotiating new MAC and rebate contract terms effective January 1, 2016 through December 31, 2018.

2. Based on actual rebate data for the last four quarters, the average quarterly collection is $7,028,000.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 57

3. Based on the current contract terms through December 31, 2015, assume there is no significant change in rebates for the third and fourth quarter of CY 2015 and no significant change in rebate collection.

4. Beginning in the first quarter of 2016, the quarterly rebate collection is estimated to increase by 10%, assuming no significant change in reimbursed service units.

5. Assume the medical supply rebates collected are $29,518,000 in FY 2015-16 and $30,923,000 in FY 2016-17.

6. Assume 14% of medical supply rebates are associated with ACA optional expansion caseload and will be 100% FFP.

(Dollars in Thousands)			
	TF	**GF**	**FFP**
FY 2015-16			
50% Title XIX / 50% GF	($25,385)	($12,693)	($12,693)
100% Title XIX FFP	($4,133)		($4,132)
Total	**($29,518)**	**($12,693)**	**($16,825)**
FY 2016-17			
50% Title XIX / 50% GF	($26,594)	($13,297)	($13,297)
100% Title XIX FFP	($2,164)		($2,164)
95% Title XIX / 5% GF	($2,165)	($108)	($2,057)
Total	**($30,923)**	**($13,405)**	**($17,518)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% ACA FF Title XIX (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	8/2009
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1449

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$36,262,000	$0
- STATE FUNDS	-$36,262,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$36,262,000	$0
STATE FUNDS	-$36,262,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department works collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging of Medicaid.

Reason for Change from Prior Estimate:
Settlements expected to be received in FY 2014-15 have shifted to FY 2015-16. Also, additional settlement agreements were added (AstraZeneca - $1,230,000, Cephalon - $219,000, NuVasive - $75,000, PharMerica - $120,000, Warner Chilcott - $1,544,000).

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 58

Methodology:
The following settlements are expected to be received in FY 2015-16:

	FY 2015-16
AstraZeneca	($1,230,000)
Bioscrip	($65,000)
Bioscrip	($185,000)
Bio Med	($2,000,000)
Cephalon	($219,000)
EBI (Biomet)	($1,000)
Johnson and Johnson	($2,977,000)
Johnson & Johnson (Omnicare)	($1,684,000)
KV Pharmaceuticals, Inc.	($11,000)
NuVasive	($75,000)
Pacific Health Corporation	($635,000)
PharMerica	($120,000)
Seacliff Diagnostics	($124,000)
Senior Care Action Network	($24,673,000)
Saint Helen's	($160,000)
Shire	($559,000)
Warner Chilcott	($1,544,000)
Total GF Savings, Initial Settlement Amts	**($36,262,000)**

Funding:
100% GF (4260-101-0001)

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	12/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	51

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$54,527,000	-$54,989,000
- STATE FUNDS	-$6,839,900	-$6,897,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$54,527,000	-$54,989,000
STATE FUNDS	-$6,839,900	-$6,897,700
FEDERAL FUNDS	-$47,687,100	-$48,091,300

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Welfare & Institutions Code 14105.33 (b)(4)

Interdependent Policy Changes:
Not Applicable

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2015 to June 2015. FPACT rebates declined as beneficiaries continue to transition to Medicaid.

Methodology:
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 6.36% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 93.64% of the FPACT rebates.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59

2. Actual data from July 2013 to June 2015 is used to project rebates.

(Dollars in Thousands)

	FPACT Drug Expenditures	FPACT Rebate
FY 2015-16	$99,990	($54,257)
FY 2016-17	$100,836	($54,989)

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	($3,468)	($1,734)	($1,734)
Title XIX 90/10	($51,059)	($5,106)	($45,953)
Total	**($54,527)**	**($6,840)**	**($47,687)**

FY 2016-17	TF	GF	FF
Title XIX 50/50	($3,497)	($1,749)	($1,749)
Title XIX 90/10	($51,492)	($5,149)	($46,343)
Total	**($54,989)**	**($6,898)**	**($48,091)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	1/1991
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	54

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$185,506,000	-$233,749,000
- STATE FUNDS	-$74,556,900	-$97,656,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$185,506,000	-$233,749,000
STATE FUNDS	-$74,556,900	-$97,656,000
FEDERAL FUNDS	-$110,949,100	-$136,093,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33

Interdependent Policy Changes:
Not Applicable

Background:
State supplemental drug rebates for drugs provided through fee-for-service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2015 to August 2015.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. In the past three years, the average percentage of collections in State supplemental rebates was 6.02% of actual drug expenditures.

3. Of the total Federal and State supplemental rebates collected, assume 11.55% will be collected as State supplemental rebates in FY 2015-16 and FY 2016-17.

4. Family planning drugs account for 0.010% of rebates and are funded with 90% federal funds and 10% General Fund.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 60

5. The optional expansion ACA population collections are estimated to be $36,377,000 for FY 2015-16, funded at 100% FF, and $40,443,000 for FY 2016-17, funded at 95% FF and 5% GF.

FY 2015-16			
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($149,110,000)	($74,555,000)	($74,555,000)
90% Title XIX / 10% GF	($19,000)	($2,000)	($17,000)
100% Title XIX FFP	($36,377,000)	$0	($36,377,000)
Total	**($185,506,000)**	**($74,557,000)**	**($110,949,000)**

FY 2016-17			
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($193,286,000)	($96,643,000)	($96,643,000)
90% Title XIX / 10% GF	($19,000)	($2,000)	($17,000)
95% Title XIX / 5% GF	($20,222,000)	($1,011,000)	($19,211,000)
100% Title XIX	($20,222,000)	$0	($20,222,000)
Total	**($233,749,000)**	**($97,656,000)**	**($136,093,000)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	4/2004
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1182

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$300,000,000	-$300,000,000
- STATE FUNDS	-$149,988,000	-$149,988,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$300,000,000	-$300,000,000
STATE FUNDS	-$149,988,000	-$149,988,000
FEDERAL FUNDS	-$150,012,000	-$150,012,000

DESCRIPTION

Purpose:
This policy change estimates the recovery of monies due to the resolution of aged and disputed drug rebate payments for the State Supplemental, Federal, Breast and Cervical Cancer Treatment Program (BCCTP), Family Planning, Access, Care and Treatment (FPACT), and Managed Care Organizations (MCO) rebate programs.

Authority:
Welfare & Institutions Code, Section 14105.33

Interdependent Policy Changes:
PC 60 State Supplemental Drug Rebates
PC 62 Federal Drug Rebate Program
PC 56 BCCTP Drug Rebates
PC 59 Family PACT Drug Rebates

Background:
Aged Rebates
Between 1991 and 2002, the Medi-Cal program accumulated large rebate disputes with participating drug companies for which the Department was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

Disputed Rebates
Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are being defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and receive payments.

Reason for Change from Prior Estimate:
The estimated aged and disputed rebates for FY 2015-16 increased based on the actual rebates collected in the first two quarters of FY 2015-16.

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 61

Methodology:

1. For FY 2015-16 and FY 2016-17, it is estimated that the Department will collect $300,000,000 in aged and disputed rebates.

2. The family planning drug portion accounts for 0.01% of the rebates. This is funded at 90% FFP and 10% GF.

FY 2015-16	TF	GF	FF
50% Title XIX / 50% GF	($299,970,000)	($149,985,000)	($149,985,000)
90% Title XIX / 10% GF	($30,000)	($3,000)	($27,000)
Total	**($300,000,000)**	**($149,988,000)**	**($150,012,000)**

FY 2016-17	TF	GF	FF
50% Title XIX / 50% GF	($299,970,000)	($149,985,000)	($149,985,000)
90% Title XIX / 10% GF	($30,000)	($3,000)	($27,000)
Total	**($300,000,000)**	**($149,988,000)**	**($150,012,000)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/1990
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	55

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$2,056,458,000	-$2,047,526,000
- STATE FUNDS	-$776,288,700	-$780,548,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,056,458,000	-$2,047,526,000
STATE FUNDS	-$776,288,700	-$780,548,800
FEDERAL FUNDS	-$1,280,169,300	-$1,266,977,200

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.

Interdependent Policy Changes:
Not Applicable

Background:
The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from December 2014 to July 2015. The impact of the ACA offset has been included.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. In FY 2015-16 and FY 2016-17, it is assumed that 50.97% of projected FFS base drug expenditures will be collected as rebates.

3. Family planning drugs account for 0.010% of rebates and are funded with 90% federal funds and 10% General Fund.

4. The optional expansion ACA population collections are estimated to be $386,083,000 for FY 2015-16 at 100% FFP and $382,016,000 for FY 2016-17 at 95% FFP and 5% GF.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 62

5. Beginning July 2012, the ongoing additional FFP claimed by CMS is fully reflected in this policy change. The additional FFP is $117,680,000 for FY 2015-16 and $123,390,000 for FY 2016-17.

FY 2015-16	TF	GF	FFP
50% Title XIX / 50% GF	($1,552,548,000)	($776,274,000)	($776,274,000)
90% Title XIX / 10% GF	($147,000)	($15,000)	($132,000)
100% Title XIX FFP	($386,083,000)	$0	($386,083,000)
ACA Offset Title XIX	($117,680,000)	$0	($117,680,000)
Total	**($2,056,458,000)**	**($776,289,000)**	**($1,280,169,000)**

FY 2016-17	TF	GF	FFP
50% Title XIX / 50% GF	($1,541,966,000)	($770,983,000)	($770,983,000)
90% Title XIX / 10% GF	($154,000)	($15,000)	($139,000)
95% Title XIX / 5% GF	($191,008,000)	($9,550,000)	($181,458,000)
100% Title XIX FFP	($191,008,000)	$0	($191,008,000)
ACA Offset Title XIX	($123,390,000)	$0	($123,390,000)
Total	**($2,047,526,000)**	**($780,548,000)**	**($1,266,978,000)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% Title XIX FFP (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)

RESIDENTIAL TREATMENT SERVICES EXPANSION

REGULAR POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	12/2015
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1930

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$14,561,000	$90,892,000
- STATE FUNDS	$5,096,500	$32,493,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,561,000	$90,892,000
STATE FUNDS	$5,096,500	$32,493,700
FEDERAL FUNDS	$9,464,500	$58,398,300

DESCRIPTION

Purpose:
This policy change estimates the cost for Drug Medi-Cal (DMC) Residential Treatment Services (RTS) expansion to non-perinatal beneficiaries in facilities with no bed capacity limit.

Authority:
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, Section 1115 BTR Waiver
Title 22, California Code of Regulations 51341.1 (b)(20); 51341.1 (d)(4); 51516.1 (a)

Interdependent Policy Changes:
Not Applicable

Background:
RTS provides rehabilitation services to perinatal 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.

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.

On August 14, 2015, the DMC-ODS waiver was amended to allow the Department to expand DMC RTS coverage to non-perinatal beneficiaries in facilities with no bed capacity limit. Counties are expected to participate in the waiver in four phases. Phases one and two will be implemented in FY 2015-16 and will include 22 counties. Phases three and four will be implemented in FY 2016-17 and will include 31 counties.

Reason for Change from Prior Estimate:
- In the May 2015 Estimate, FY 2015-16 costs for RTS non-perinatal expansion was budgeted in the base policy change titled Residential Treatment Services.
- Total number of available bed days have been updated for phases one and two.

RESIDENTIAL TREATMENT SERVICES EXPANSION

REGULAR POLICY CHANGE NUMBER: 65

- Implementation date for phase one counties has shifted from September 2015 to December 2015.

Methodology:

1. In FY 2015-16, DMC will expand RTS to the non-perinatal population in 22 counties in phases beginning December 1, 2015. In FY 2016-17, an additional 31 counties will add RTS.

2. Due to the phase in implementation for the counties, assume there will be a 3 month lag in payment processing.

3. The Department estimates the cost of RTS expansion will be:

Fiscal Year		Accrual	Cash Basis
FY 2015-16	22 Counties	$35,290,000	$ 14,561,000
FY 2016-17	53 Counties	$94,493,000	$ 90,892,000

4. Funding for RTS expansion is 50% FF and 50% GF. For beneficiaries under ACA optional expansion category, funding is at 100% FF until December 2016. Beginning January 2017, funding will change to 95% FF and 5% GF.

Funding:

FY 2015-16	TF	GF	FFP
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$10,193,000	$5,096,500	$5,096,500
ACA 100% FFP (4260-101-0890)	$4,368,000	$0	$4,368,000
Total	**$14,561,000**	**$5,096,500**	**$9,464,500**

FY 2016-17	TF	GF	FFP
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$63,624,000	$31,812,000	$31,812,000
ACA 100% FFP (4260-101-0890)	$13,634,000	$0	$13,634,000
ACA 95% FFP/ 5% GF (4260-101-0890)	$13,634,000	$682,000	$12,952,000
Total	**$90,892,000**	**$32,494,000**	**$58,398,000**

*Totals may differ due to rounding

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	1/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1723

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$3,036,000	$3,036,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,036,000	$3,036,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,036,000	$3,036,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-Narcotic Treatment Program services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE).

Reimbursement for non-Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

Reimbursement for Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 68

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

Methodology:
1. The interim cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. Estimated reimbursement for FY 2012-13 and FY 2013-14 settlements will be:

FY 2012-13 Settlements	TF	CF	FF
Regular	$3,206,000	$398,000	$2,808,000
Perinatal	$223,000	($5,000)	$228,000
Total for FY 2015-16	$3,429,000	$393,000	**$3,036,000**

FY 2013-14 Settlements	TF	CF	FF
Regular	$3,206,000	$398,000	$2,808,000
Perinatal	$223,000	($5,000)	$228,000
Total for FY 2016-17	$3,429,000	$393,000	**$3,036,000**

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

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1724

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$1,135,000
- STATE FUNDS	$0	$369,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,135,000
STATE FUNDS	$0	$369,000
FEDERAL FUNDS	$0	$766,000

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6 (b)(1); 14021.9 (c); and 14105 (a)
Title 22, California Code of Regulations, Section 51516.1 (a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates for use in FY 2016-17 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Intensive Outpatient Treatment Service
- Naltrexone Treatment Service
- Residential Treatment Service
- Outpatient Drug Free (ODF) Treatment Service - Individual Counseling
- ODF- Group Counseling

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 69

Reason for Change from Prior Estimate:
The annual rate adjustment from FY 2014-15 to FY 2015-16 is included in the May 2015 Estimate. The FY 2015-16 to FY 2016-17 rate adjustments are due to updated escalation factors which increased the CIP deflator from 12.4% to 14.6%.

Methodology:
1. The CIP deflator used in the proposed FY 2016-17 DMC rate is based on FY 2009-10 rates adjusted by the CIP deflator. For FY 2016-17, the adjusted rate is 14.6%. This is comprised of:
   - 12.4% for the change from FY 2009-10 to FY 2015-16, and
   - 2.2% assumed for the change from FY 2015-16 to FY 2016-17.

Regular Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2016-17 Rates *	FY 2016-17 Developed Rates	FY 2016-17 Required Rates
NTP-Dosing	$11.34	14.60%	$13.00	$11.44	$11.44
NTP-Individual	$13.30	14.60%	$15.24	$13.39	$13.39
NTP- Group	$3.14	14.60%	$3.60	$3.02	$3.02
Intensive Outpatient	$61.05	14.60%	$69.96	$58.30	$58.30
Naltrexone	$19.07	14.60%	$21.85	$19.06	$19.06
ODF-Individual	$66.53	14.60%	$76.24	$66.93	$66.93
ODF-Group	$28.27	14.60%	$32.40	$27.14	$27.14

Perinatal Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2016-17 Rates *	FY 2016-17 Developed Rates	FY 2016-17 Required Rates
NTP-Dosing	$12.21	14.60%	$13.99	$13.88	$13.88
NTP-Individual	$19.04	14.60%	$21.82	$28.84	$21.82
NTP- Group	$6.36	14.60%	$7.29	$5.79	$5.79
Intensive Outpatient	$73.04	14.60%	$83.70	$88.43	$83.70
Residential Treatment	$89.90	14.60%	$103.03	$115.02	$103.03
ODF-Individual	$95.23	14.60%	$109.13	$144.19	$109.13
ODF-Group	$57.26	14.60%	$65.62	$52.11	$52.11

2. The incremental difference between FY 2015-16 required rates and FY 2016-17 required rates are:

Regular Services	FY 2015-16 Required Rates	FY 2016-17 Required Rates	Incremental Difference
NTP-Dosing	$11.44	$11.44	$0.00
NTP- Individual	$13.39	$13.39	$0.00
NTP-Group	$3.02	$3.02	$0.00
Intensive Outpatient	$58.30	$58.30	$0.00
Naltrexone	$19.06	$19.06	$0.00
ODF-Individual	$66.93	$66.93	$0.00
ODF-Group	$27.14	$27.14	$0.00

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 69

Perinatal Services	FY 2015-16 Required Rates	FY 2016-17 Required Rates	Incremental Difference
NTP-Dosing	$13.72	$13.88	$0.16
NTP-Individual	$21.40	$21.82	$0.42
NTP-Group	$5.79	$5.79	$0.00
Intensive Outpatient	$82.10	$83.70	$1.60
Residential Treatment	$101.05	$103.03	$1.98
ODF-Individual	$107.04	$109.13	$2.09
ODF-Group	$52.11	$52.11	$0.00

3. The cost estimate is developed by the following:

   Caseload x Units of Service (UOS) x Rates

4. The incremental rate change on an accrual basis is shown below:

(Dollars In Thousands)	
Regular	
Residential Treatment	$962,000
Total for Regular	$962,000
Perinatal	
Narcotic Treatment	$8,000
Intensive Outpatient	$24,000
Outpatient Drug Free	$2,000
Residential Treatment	$643,000
Total for Perinatal	$677,000

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

	Accrual	FY 2016-17	FY 2017-18
Regular	$962,000	$722,000	$241,000
Perinatal	$677,000	$507,000	$169,000
Total	$1,639,000	$1,229,000	$410,000

6. The annual rate adjustment for FY 2016-17 is:

	Total	GF	FF	CF
FY 2016-17	$1,229,000	**$369,000**	**$766,000**	$94,000

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

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$232,291,000	$175,544,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$232,291,000	$175,544,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$232,291,000	$175,544,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723

Interdependent Policy Changes:
Not Applicable

Background:
State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

The supplemental payment State Plan Amendment (SPA) and Certified Public Expenditure Protocol are pending approval from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change from Prior Estimate:
The projected supplemental payments decreased based on settled cost reports for FYs 2010-11 and 2011-12 shifting from FY 2015-16 to FY 2016-17.

Methodology:
1. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).

2. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 72

3. The FY 2008-09 estimates were developed using the final filed cost reports received from each county mental health plan.

4. The FY 2009-10 estimates were developed using the final filed cost reports received from each county and are still under Department review.

5. Assume the FY 2010-11 supplemental payments will increase by 3.2% from the payment for FY 2009-10 and the FY 2011-12 supplemental payments will increase by 3.4% from the payment for FY 2010-11.

(Dollars In Thousands)

FY 2015-16	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2008-09 FFP	$52,108	$12,079	$64,187
FY 2009-10 FFP	$90,402	$20,484	$110,886
FY 2010-11 FFP	$46,648	$10,570	$57,218
Total for FY 2015-16	$189,158	$43,133	**$232,291**

(Dollars in Thousands)

FY 2016-17	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2010-11 FFP	$46,648	$10,570	$57,218
FY 2011-12 FFP	$118,326	$0	$118,326
Total for FY 2016-17	$164,974	$10,570	**$175,544**

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

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1759

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$78,309,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$78,309,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$78,309,000	$0

DESCRIPTION

Purpose:
This policy change estimates the elimination of the state maximum rates for Medi-Cal specialty mental health services (SMHS).

Authority
AB 1297 (Chapter 651, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Welfare and Institution (W&I) Code, sections 5720 and 5724, limited reimbursement of SMHS to the state maximum rates. The state maximum rate is a schedule of maximum allowances (SMA) for SMHS. AB 1297 amended W&I Code, sections 5720 and 5724 to change the manner in which SMHS are reimbursed. AB 1297 requires the Department to reimburse mental health plans based upon the lower of their certified public expenditures or the federal upper payment limit. The federal upper payment limit will be equal to the aggregate allowable cost or customary charge for all SMHS provided by the mental health plan and its network of providers. These changes to the reimbursement methodology will result in an increase of federal reimbursement to mental health plans for SMHS. The elimination of the state maximum rate was implemented in the Short-Doyle/Medi-Cal (SD/MC) claiming system in fiscal year 2012-13.

In FY 2016-17, assume the elimination of the state maximum rate will be captured in the base trends.

Reason for Change from Prior Estimate:
There is no change for FY 2015-16. There are no claims estimated for FY 2016-17.

Methodology:
1. The costs are developed using approved claims from each county for services provided in FYs 2012-13 and 2013-14.

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 73

2. The approved units, by county and type of service, were multiplied by the SMA rate that would have been in place in FY 2013-14 to calculate the SMA limit.

3. The SMA limit was subtracted from the approved amount by county and service type to calculate the approved amount in excess of the SMA for approved claims paid in FYs 2012-13 and 2013-14.

(Dollars in Thousands)

	Approved Claims in Excess of SMA	FF in Excess of SMA
FY 2012-13	$132,826	$66,413
FY 2013-14	$149,285	$74,643

4. The FY 2013-14 actual approved claims were increased by the percentage change in the home health agency market basket to estimate the impact of the elimination of SMA rates in FY 2014-15 and FY 2015-16.

(Dollars In Thousands)

	FF	COLA	Increase
FY 2013-14	$74,643	2.61%	$1,948
FY 2014-15	$76,591	2.91%	$2,229
FY 2015-16	$78,820		

5. On a cash basis for FY 2015-16, the Department will pay 1% of FY 2013-14 claims, 21.01% of FY 2014-15 claims, and 77.99% of FY 2015-16 claims.

(Dollars In Thousands)

	FF	FY 2015-16
FY 2013-14	$74,643	$746
FY 2014-15	$76,591	$16,092
FY 2015-16	$78,820	$61,471
Total		**$78,309**

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

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1719

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$53,804,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$53,804,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$53,804,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for specialty mental health benefits associated with transitioning the Healthy Families Program (HFP) subscribers into the Medi-Cal program.

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

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to AB 1494, HFP subscribers were transitioned into the Medi-Cal program using a phased-in approach that began January 2013 and concluded November 2013. Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) enrollees were carved out of the HFP and provided by county mental health plans. The Medi-Cal program does not have an “SED carve-out,” but Medi-Cal specialty mental health services (SMHS) are carved out from the Medi-Cal managed care plans’ covered services. Children that transitioned from the HFP to Medi-Cal have access to the carved-out Medi-Cal SMHS provided by county mental health plans if they meet medical necessity criteria for those services. County mental health plans are eligible to claim federal funds (FF) through the Certified Public Expenditure (CPE) process.

HFP subscribers that transitioned into the Medi-Cal program are considered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible and can receive the full array of Medi-Cal SMHS based on medical necessity and their mental health needs.

While all HFP beneficiaries have transitioned to Medi-Cal, the Department will continue to carry this policy change through FY 2015-16. The change will be fully captured in the base estimate.

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 74

Reason for Change from Prior Estimate:
There is no change, but CHIP enhancement adjusted totals.

Methodology:

1. Beginning January 1, 2013, HFP subscribers transitioned to Medi-Cal.

2. The majority of mental health services provided to current SED enrollees will continue under the Medi-Cal SMHS. As such, the current SED expenditures shifted from the HFP Families – SED policy change to the Children's SMHS policy change.

3. Additional EPSDT clients may be served by the mental health plans as a result of changing from SED criteria to Medi-Cal medical necessity criteria, which will increase utilization of Medi-Cal SMHS.

4. Additional psychiatric inpatient services will be provided by the mental health plans that were previously covered by the HFP managed care plans.

5. The Department assumes these claims and beneficiaries are now captured in the Medi-Cal SMHS base estimate for FY 2016-17.

(Dollars In Thousands)

	TF	FF	CF
SED Services	$37,932	$31,199	$6,733
Outpatient	$49,292	**$40,543**	$8,749
Inpatient	$16,123	**$13,261**	$2,862
FY 2015-16	$103,347	$85,003	$18,344

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

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$35,954,000	$35,364,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$35,954,000	$35,364,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$35,954,000	$35,364,000

DESCRIPTION

Purpose:
This policy change estimates the increase in costs due to the *Katie A. v. Diana Bontá* lawsuit.

Authority:
Katie A. v. Diana Bontá

Interdependent Policy Changes:
Not Applicable

Background:
On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services (SMHS) waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. Since October 13, 2011, the parties have met with the Special Master to develop a plan for settlement implementation. As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner. In this context, these existing services are referred to as Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and TFC. The ICC and IHBS were available effective January 1, 2013.

Reason for Change from Prior Estimate:
TFC expenditures for FY 2014-15 and 2015-16 have been updated and claims data reflects slightly lower expenditures for FY 2015-16.

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER: 75

Methodology:

1. The *Katie A*. cost estimate is based on two factors:

   - An increase in the penetration rate of children receiving SMHS within the *Katie A*. subclass of clients; and
   - An increase in the cost of services per client for existing clients due to the availability of IHBS, ICC, and TFC.

2. This estimate assumes the increase in the cost of services per client for ICC, IHBS, and TFC.

3. The estimated annual cost for new clients using ICC and IHBS is $38,830,000 and the estimated annual increase in cost for existing clients is $14,672,000, giving a total annual cost of $53,502,000. These amounts are on an accrual basis.

4. Assume the TFC services have an annual cost of $15,723,000.

5. Based on historical claims received, assume 78% of the each fiscal year claims will be paid in the year the services occur, 21% is paid in the second year, and 1% is paid in the third year.

(Dollars in Thousands)

Cash Estimate	TF	FF	County
FY 2013-14	$535	$268	$267
FY 2014-15	$11,235	$5,617	$5,618
FY 2015-16	$60,138	$30,069	$30,069
FY 2015-16	$71,908	**$35,954**	$35,954

(Dollars in Thousands)

Cash Estimate	TF	FF	County
FY 2014-15	$535	$268	$267
FY 2015-16	$16,191	$8,095	$8,096
FY 2016-17	$54,002	$27,001	$27,001
FY 2016-17	$70,728	**$35,364**	$35,364

Funding:

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

INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	1/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1805

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$24,000,000	$25,500,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,000,000	$25,500,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$24,000,000	$25,500,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for mobile crisis support teams and triage personnel to enhance mental health services for community wellness.

Authority:
SB 82 (Chapter 34, Statutes of 2013) Investment in Mental Health Wellness Act of 2013

Interdependent Policy Changes:
Not Applicable

Background:
The Investment in Mental Health Wellness Act of 2013 specifies to add 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders. The California Health Facilities Financing Authority (CHFFA) within the State Treasurer's Office implemented a grant program for one-time funding to build supporting infrastructure. The CHFFA approved thirty-one grant applications for mobile crisis support teams, crisis stabilization beds, and crisis residential treatment beds as of June 2015. The anticipated federal fund reimbursements are $2.8 million for the mobile crisis support services.

This Act also specifies to add at least 600 triage personnel to assist individuals in gaining access to medical, specialty mental health care, alcohol and drug treatment, social, educational, and other services. The Mental Health Services Oversight and Accountability Commission (MHSOAC) will implement an allocation process based on funding applications for Mental Health Services Act funds totaling $32 million. The majority of the triage personnel costs are assumed to be Medi-Cal reimbursable. The total estimated federal reimbursement is $22 million annually. The initial triage personnel grants were awarded to 22 counties in January 2014.

INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER: 76

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

Methodology:
1. On a cash basis, the Department will pay 78% of each fiscal year claims in the year services occur, 21% will be paid in the second year, and 1% in the third year.

(Dollars In Thousands)

	Accrual	FY 2015-16	FY 2016-17
FY 2014-15	$44,000	$9,000	$1,000
FY 2015-16	$50,000	$39,000	$11,000
FY 2016-17	$50,000	$0	$39,000
Total	$144,000	$48,000	$51,000

2. On a cash basis, the estimate is shown below:

(Dollars In Thousands)

	TF	FFP
FY 2015-16	$48,000	**$24,000**
FY 2016-17	$51,000	**$25,500**

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

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1712

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$5,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$5,000	$0

DESCRIPTION

Purpose:
This policy change estimates the costs of providing services to Healthy Families enrollees who are Seriously Emotionally Disturbed (SED).

Authority:
California Insurance Code 12693.61 and 12694.1

Interdependent Policy Changes:
Not Applicable

Background:
The former Healthy Families Program (HFP) provided low cost insurance for eligible children under the age of 19 whose families:

- Had no health insurance;
- Did not qualify for zero share of cost Medi-Cal; and
- Had income at or below 250 percent of the federal poverty level.

Mental health services for the HFP subscribers who have an SED were “carved-out” of the HFP managed care health plans’ array of covered services and were provided by county mental health departments. County mental health departments were responsible for the provision and payment of all treatment of SED conditions, with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remained the responsibility of the HFP health plan. This covered benefit was referred to as the “HFP SED benefit.”

When a county mental health department assumed responsibility for the treatment of the HFP subscriber’s SED condition, it submitted claims to obtain federal reimbursement for the services. County mental health departments received 65% federal financial participation (FFP) reimbursement for services provided to HFP subscribers and paid for the 35% match with realignment dollars or other local funds. The costs associated with the HFP SED benefit are fully captured in the Specialty Mental Health Services for Children policy change.

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 77

On December 31, 2012, HFP stopped enrolling new subscribers and HFP subscribers began transitioning into the Medi-Cal program in phases. The last group of HFP children transitioned to Medi-Cal on November 1, 2013.

Assembly Bills 1494 and 1468 provided for the transition of children from HFP to the Medi-Cal program. Beginning January 2013, Medi-Cal covers these children under an optional coverage group known as the Optional Targeted Low-Income Children's Program (OTLICP). OTLICP covers children with family incomes between 100% of the federal poverty level (FPL) and 250% of the FPL. Those children with family incomes over 150% FPL are required to pay monthly premiums for coverage.

Reason for Change from Prior Estimate:
There is no change for FY 2015-16. No additional claims are expected in FY 16-17.

Methodology:

1. The costs are developed using actual Short-Doyle/Medi-Cal (SD/MC) approved claims, excluding disallowed claims. The SD/MC data is current as of December 31, 2014, with dates of service from July 1, 2007 through January 2014.

2. Medi-Cal Specialty Mental Health programs costs are shared between FFP and a county match. State Children's Health Insurance Program (S-CHIP) claims are eligible for federal reimbursement of 65%.

3. The service year of costs on an accrual basis is below:

Accrual Estimate			
	TF	**FFP**	**County**
FY 2012-13	$25,154,000	$16,350,000	$8,804,000
FY 2013-14	$817,000	$531,000	$286,000

4. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 SD/MC claims.

Cash Estimate			
	TF	**FFP**	**County**
FY 2013-14	$8,000	$5,000	$3,000
TOTAL FY 2015-16	$8,000	**$5,000**	$3,000

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

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	1/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1660

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$4,412,000	$270,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$4,412,000	$270,000
FEDERAL FUNDS	-$4,412,000	-$270,000

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement process, the Department identified overpayments to the Siskiyou County Mental Health Plan as a result of improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FFP to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department in the amount of $200,000 per year until it fulfills its obligation for repayment. The County has submitted two payments totaling $400,000.

Reason for Change from Prior Estimate:
Additional cost settlements have been added and repayments to CMS scheduled for payment in FY 2014-15 were made in FY 2015-16.

Methodology:
1. The Department began making repayments to CMS in January 2012 and has repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2008-09 and audit settlements for FY 2005-06 through FY 2008-09.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 78

2. In FY 2015-16, a repayment amount of $1,131,000 was added as a result of a chart review audit disallowing service claims for Heal Therapy and an additional $1,369,000 was added for a cost settlement for FY 2009-10.

3. In FY 2015-16, a repayment amount of $1,912,000 was added as a result of various cost settlements for FY 2006-07 through 2009-10.

4. Siskiyou County will reimburse the GF $200,000 annually. The total FFP repayment due from the County totals $10,870,000. The Department will continue to repay CMS for overpayments within one year of discovery. The Department will pay from the GF $4,412,000 in FY 2015-16 and $270,000 in FY 2016-17. Reimbursements are shown in the Management Summary.

		FY 2015-16	FY 2016-17	
Date of Overpayment Discovery	**Due to DHCS**	**GF Due to CMS**	**GF Due to CMS**	
1/11/2011	$1,754,000			
3/2/2011	$116,000			
8/4/2011	$2,189,000			
11/15/2011	$586,000			
12/21/2011	$95,000			
3/26/2012	$443,000			
4/15/2013	$2,917,000	$1,912,000		
4/9/2014	$1,369,000	$1,369,000		
5/30/2013	$1,131,000	$1,131,000		
9/9/2015	$270,000		$270,000	
Total:	$10,870,000	**$4,412,000**	**$270,000**	
		($200,000)	**($200,000)**	Reimbursement

Funding:
100% GF (4260-101-0001)
100% Title XIX FF (4260-101-0890)
Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	7/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	-$4,000,000	-$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the cost of federal fund (FF) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs).

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 14053.3

Interdependent Policy Changes:
Not Applicable

Background:
Ancillary services provided to Medi-Cal beneficiaries who are ages 21 through 64 residing in IMDs are not eligible for federal reimbursement. Identifiers are currently not available in the Medi-Cal Eligibility Data System (MEDS) to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement. The Department uses data from the mental health Client and Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FF, as required by CMS. This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Due to the County of Colusa Court of Appeals decision on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs. The State is now financially responsible for ancillary outpatient services provided to eligible individuals who are residing in an IMD.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 79

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

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. The estimated FF repayment to CMS for FY 2015-16 and FY 2016-17 is:

(Dollars in Thousands)

	TF	FF	GF
FY 2015-16	$0	**($4,000)**	**$4,000**
FY 2016-17	$0	**($4,000)**	**$4,000**

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

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$1,138,000	-$913,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,138,000	-$913,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,138,000	-$913,000

DESCRIPTION

Purpose:
This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers.

Authority:
Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:
Not Applicable

Background:
Since January 2005, the Department has been conducting on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries.

Reason for Change from Prior Estimate:
The FY 2015-16 estimate includes more actual data from the completion of FY 2014-15 reviews and recoupments.

Methodology:
1. The FY 2015-16 estimate includes recoupments from chart reviews conducted in FY 2014-15 and an estimate of recoupments from chart reviews to be conducted in FY 2015-16.

2. The FY 2016-17 estimate includes recoupments from charts to be reviewed in FY 2015-16 and FY 2016-17.

	TF	FFP
FY 2015-16	**($1,138,000)**	**($1,138,000)**
FY 2016-17	**($913,000)**	**($913,000)**

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$74,280,000	$0
- STATE FUNDS	$29,877,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$74,280,000	$0
STATE FUNDS	$29,877,000	$0
FEDERAL FUNDS	-$104,157,000	$0

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 81

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

(Dollars in Thousands)

Interim Settlement (FY 2009-10)	Underpaid	Overpaid	Net
Children and Adults	$17,108	($1,962)	$15,146
ARRA	$2,456	($453)	$2,002
M-CHIP*	$283	($230)	$54
BCCTP	$0	($19)	($19)
Refugees	$1	($0)	$1
Healthy Families*	$0	($790)	($790)
FY 2009-10 Total	$19,848	($3,453)	$16,395

(Dollars in Thousands)

Interim Settlement (FY 2010-11)	Underpaid	Overpaid	Net
Children and Adults	$4,461	($137,614)	($133,153)
ARRA	$16,147	$0	$16,147
M-CHIP*	$2,308	($6)	$2,302
BCCTP	$3	($55)	($52)
Refugees	$8	($5)	$3
Healthy Families*	$82	($1,497)	($1,415)
FY 2010-11 Total	$23,009	($139,177)	($116,168)

(Dollars in Thousands)

Final Settlement (Multi-Years)	Underpaid	Overpaid	Net
Children and Adults	$2,774	($7,086)	($4,312)
Healthy Families*	$21	($93)	($72)
Multi-Years Total	$2,795	($7,179)	($4,384)
Total FY 2015-16	$45,651	($149,809)	($104,157)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 81

4. Cost settlements prior to 2011 Realignment may consist of General Fund (GF).

(Dollars in Thousands)

Interim Settlement	GF Underpaid	GF Overpaid	Net GF
2009-10	$26,734	($20)	$26,714
2010-11	$4,059	($896)	$3,163
Total	$30,793	($916)	$29,877

5. The net FF and GF to be paid in FY 2015-16 is:

(Dollars in Thousands)

	TF	GF	FF
Children and Adults	($92,442)	$29,877	($122,319)
ARRA	$18,150	$0	$18,150
M-CHIP*	$2,356	$0	$2,356
BCCTP	($71)	$0	($71)
Refugees	$4	$0	$4
Healthy Families*	($2,277)	$0	($2,277)
Total FY 2015-16	**($74,280)**	**$29,877**	**($104,157)**

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

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1073

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$184,358,000	$34,000,000
- STATE FUNDS	$62,090,000	$17,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$184,358,000	$34,000,000
STATE FUNDS	$62,090,000	$17,000,000
FEDERAL FUNDS	$122,268,000	$17,000,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1066 (Chapter 86, Statutes of 2011)
HR 2 (2015)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Non-emergency services for undocumented individuals are eligible for DSH program funding. The 2015-16 and 2016-17 DSH allotments are estimated to be $1,211,580,614, and $1,235,812,226, respectively.

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. The federal

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 82

reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-22, are allocated a total of $160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

AB 1066 provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) reduction in the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction until October 1, 2017.

The California Bridge to Reform Section 1115(a) Medicaid Demonstration will end on October 31, 2015. CMS and the Department have agreed in principle on the terms for a five year extension of the subsequent waiver where DPH DSH payments to the remaining uninsured population will be paid under a new global payment approach. See the Global Payment Program policy change (PC 206) for more information.

Reason for Change from Prior Estimate:
The change is due to:

- The inclusion of FY 2006-07 final reconciliation payments,
- Updated FY 2011-12 payments to delay NDPH recoupments and shift DPH payments from FY 2014-15 to FY 2015-16,
- Updated data for FY 2012-13 and FY 2014-15 payments,
- An updated FY 2015-16 DSH allotment, and
- FY 2015-16 DPH payments are no longer included in this policy change, and are now budgeted under the new Global Payment Program policy change (PC 206).

Methodology:

1. The FY 2015-16 DSH allotment assumes a 2% increase from the FY 2014-15 DSH allotment. The FY 2016-17 DSH allotment assumes a 2% increase over the FY 2015-16 estimate.

2. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2015-16	TF	GF**	FF	IGT*
DSH 2006-07	$1,492,000	$633,000	$859,000	$0
DSH 2011-12	$485,000	$0	$348,000	$137,000
DSH 2012-13	$4,299,000	$1,017,000	$2,575,000	$707,000
DSH 2013-14	$2,702,000	$1,351,000	$1,351,000	$0
DSH 2014-15	$144,214,000	$1,676,000	$101,552,000	$40,986,000
DSH 2015-16	$31,166,000	$15,583,000	$15,583,000	$0
Total FY 2015-16	**$184,358,000**	**$20,260,000**	**$122,268,000**	**$41,830,000**

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FY 2016-17	TF	GF**	FF
DSH 2015-16	$2,834,000	$1,417,000	$1,417,000
DSH 2016-17	$31,166,000	$15,583,000	$15,583,000
Total FY 2016-17	**$34,000,000**	**$17,000,000**	**$17,000,000**

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% Title XIX / 50% MIPA (4260-606-0834/4260-101-0890)*
50% Title XIX / 50% GF (4260-101-0001/0890)**

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	3/2011
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1570

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$786,080,000	$0
- STATE FUNDS	$393,040,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$786,080,000	$0
STATE FUNDS	$393,040,000	$0
FEDERAL FUNDS	$393,040,000	$0

DESCRIPTION

Purpose:
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Designated Public Hospitals' (DPH) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.77
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010. The BTR establishes the DSRIP. AB 1066 provides the authority for the Department to implement payment methodologies under the BTR to determine DSRIP payments to DPHs.

There are five categories for which funding is available under the DSRIP in the Medi-Cal program:

(1) Infrastructure Development
(2) Innovation and Redesign
(3) Population-focused Improvement
(4) Urgent Improvement in Care
(5) HIV Transition Projects

Category 5 payments are budgeted in the BTR—LIHP—DSRIP HIV Transition Projects policy change. DPHs submitted their DSRIP proposal for approval and are paid based on meeting milestones. DPHs provide the non-federal share of their DSRIP through IGTs.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 83

The total federal funding for DSRIP for categories 1-4 shall not exceed total computable expenditures of $6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$1,006,880	$591,601
2011-12	$1,300,000	$650,000
2012-13	$1,400,000	$700,000
2013-14	$1,400,000	$700,000
2014-15	$1,400,000	$700,000

Reason for Change from Prior Estimate:

Projections for FY 2015-16 were updated according to updated expenditure data as follows:

- Remaining DY 2012-13 is no longer expected to be 100% achieved by hospitals.
- DY 2013-14 and DY 2014-15 has been updated to assume 100% of funding will be achieved and claimed.
- DY 2014-15 now includes additional funding reallocated from DY 2011-12 and DY 2012-13.
- DY 2015-16 is no longer budgeted under the BTR DSRIP program and is now budgeted under the new PC 205 Public Hospital Redesign & Incentives in Medi-Cal policy change.

Methodology:

1. In DY 2011-12 and subsequent demonstration years, payments are expected to be made in April of the same fiscal year and October of the subsequent fiscal year.

2. For categories 1 and 2, hospitals that did not achieve full funding for DY 2010-11 through 2012-13 can claim the remaining funding until the end of the waiver, subject to the following carry forward limitations:
   - Carry forward funding from DY 2010-11 and DY 2011-12 is subject to a 10% penalty beginning January 1, 2014.
   - Carry forward funding from DY 2012-13 is subject to a 10% penalty beginning July 1, 2014.
   - The Special Terms and Conditions (STCs) of the BTR waiver do not allow funding to be carried forward in categories 1 and 2 for DY 2013-14 and DY 2014-15.
   - In DY 2010-11, DPHs claimed 100% of DSRIP funding in categories 1 and 2 so there are no carry forward funds associated with these years.

3. For categories 1 and 2, DPHs have 90 days from January 1, 2014 to claim the available carry forward funds for DY 2010-11 and DY 2011-12, and 90 days from July 1, 2014 to claim carry forward funds for DY 2012-13.

4. The STCs do not allow carry forward funding associated with category 3.

5. The STCs allow DPHs to carry forward funding associated with category 4 through the end of the BTR waiver.

6. CMS has approved the reallocation of funding remaining from Categories 1 and 2 from DY 2011-12 and DY 2012-13 to be available for additional projects and milestones in DY 2014-15.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 83

7. DPH payments on a cash basis for FY 2015-16 include DSRIP claiming for DY 2014-15 as well as carry forward claiming.

8. The STCs require the Department to identify any unused DSRIP amounts eligible to be rolled over into the Safety Net Care Pool (SNCP) to CMS by January 1, 2015. The Department submitted a request to CMS on February 23, 2015 to request that these amounts be rolled to the SNCP to cover the other safety net services.

9. For DY 2014-15, it is anticipated that hospitals will achieve 100% of funding for all categories.

10. DY 2014-15 spans FY 2014-15 and four months of FY 2015-16, covering a total of 16 months.

11. On a cash basis, DSRIP payments are estimated to be:

(Dollars in Thousands)

FY 2015-16	TF	IGT	FF
DY 2013-14	$26,990	$13,495	$13,495
DY 2014-15	$759,090	$379,545	$379,545
Total	**$786,080**	**$393,040**	**$393,040**

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 7/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1071

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$656,305,000	$571,258,000
- STATE FUNDS	$328,152,500	$285,629,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$656,305,000	$571,258,000
STATE FUNDS	$328,152,500	$285,629,000
FEDERAL FUNDS	$328,152,500	$285,629,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
HR 2 (2015)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 84

The Affordable Care Act (ACA) reduction to the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction until October 1, 2017. The private DSH replacement payments are affected because, as required by SB 1100, the methodology to determine the DSH replacement payments is based on the DSH allotment.

Reason for Change from Prior Estimate:
The change is due to updated payment data. In addition, estimated payments were revised to reflect the updated DSH allotment for FY 2015-16 and FY 2016-17.

Methodology:

1. The remaining balance of 2012-13 and 2013-14 final payments are assumed to be paid in FY 2015-16.

2. SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by $21 million TF ($10.5 million GF) in 2012-13 and $10.5 million TF ($5.25 million GF) in 2013-14.

3. The California Bridge to Reform Section 1115(a) Medicaid Demonstration will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

4. The FY 2015-16 DSH allotment assumes a 2% increase to the FY 2014-15 DSH allotment. The FY 2016-17 DSH allotment assumes a 2% increase to the FY 2015-16 DSH allotment estimate.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2015-16	TF	GF	FF
FY 2012-13	$51,936,000	$25,968,000	$25,968,000
FY 2012-13 SB 335 Adjustment	($1,898,000)	($949,000)	($949,000)
FY 2013-14	$47,136,000	$23,568,000	$23,568,000
FY 2013-14 SB 335 Adjustment	($746,000)	($373,000)	($373,000)
FY 2014-15	$45,652,000	$22,826,000	$22,826,000
FY 2015-16	$514,225,000	$257,112,500	$257,112,500
Total FY 2015-16	**$656,305,000**	**$328,152,500**	**$328,152,500**

FY 2016-17	TF	GF	FF
FY 2015-16	$46,748,000	$23,374,000	$23,374,000
FY 2016-17	$524,510,000	$262,255,000	$262,255,000
Total FY 2016-17	**$571,258,000**	**$285,629,000**	**$285,629,000**

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

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 10/2007
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1152

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$326,815,000	-$218,972,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$326,815,000	-$218,972,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$326,815,000	-$218,972,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.4
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 or 2552-10 cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 85

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

Methodology:
1. DPH's final reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the audited costs and the respective payments.

2. The final reconciliation for DY 2007-08 is expected to be completed and paid by June 2016 and is estimated to be $326,815,000.

3. The final reconciliation for DY 2013-14 is expected to be completed and paid by December 2016 and the Department is estimated to pay back $218,972,000.

(Dollars in Thousands)

FY 2015-16	**TF**	**FF**	**ACA FF**
2007-08 Final Reconciliation	**$326,815**	**$326,815**	**$0**
FY 2016-17			
2013-14 Final Reconciliation	**($218,972)**	**($191,586)**	**($27,386)**

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

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 7/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1085

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$280,704,000	$258,202,000
- STATE FUNDS	$140,352,000	$129,101,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$280,704,000	$258,202,000
STATE FUNDS	$140,352,000	$129,101,000
FEDERAL FUNDS	$140,352,000	$129,101,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14
State Plan Amendment 14-008

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR implementation, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of $118,400,000 annually from the General Fund (GF) (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 86

the requirements specified in SB 1100. Due to the inactivation of the Selective Provider Contracting Program (SPCP) for private hospitals on July 1, 2013; State Plan Amendments (SPAs) were required to continue the Private Hospital Supplemental Program and secure distributions from the Private Hospital Supplemental Fund. The Department received SPA approvals from the Centers of Medicare and Medicaid Services (CMS) to continue the Private Hospital Supplemental Program for FY 2013-14 and FY 2014-15. The Department will submit SPA 15-003 requesting continuation of the program for FY 2015-16 and forward.

Reason for Change from Prior Estimate:

FY 2015-16 amounts were revised to include updated interest and rollover from FY 2014-15 based on actuals. Expenditures in FY 2015-16 have been revised. The remaining payments for FY 2014-15 will be made in FY 2015-16.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs.

2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.

3. IGTs are estimated to total $21,000,000 in FY 2015-16 and $21,000,000 in FY 2016-17.

4. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

It is assumed private hospital supplemental payments will be made on a cash basis as follows:

FY 2015-16	**TF**	**GF**	**FF**
FY 2014-15 Ending Balance	$19,786,000	$9,893,000	$9,893,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2014-15 interest	$344,000	$172,000	$172,000
2014-15 remaining IGT	$3,000,000	$1,500,000	$1,500,000
2015-16 IGT	$21,000,000	$10,500,000	$10,500,000
Total	$280,930,000	$140,465,000	$140,465,000
Expenditures to Hospitals 2014-15	$22,502,000	$11,251,000	$11,251,000
Expenditures to Hospitals 2015-16	$258,202,000	$129,101,000	$129,101,000
Total Cash Expenditures to Hospitals	**$280,704,000**	**$140,352,000**	**$140,352,000**
FY 2015-16 Ending Balance	$226,000	$113,000	$113,000

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 86

FY 2016-17	TF	GF	FF
FY 2015-16 Ending Balance	$226,000	$113,000	$113,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2015-16 interest	$388,000	$194,000	$194,000
IGT	$21,000,000	$10,500,000	$10,500,000
Total	$258,414,000	$129,207,000	$129,207,000
Cash Expenditures to Hospitals	**$258,202,000**	**$129,101,000**	**$129,101,000**
FY 2016-17 Ending Balance	$212,000	$106,000	$106,000

Funding:
100% GF (4260-105-0001)
Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
50% Title XIX / 50% Private Hospital Supplemental Fund (4260-601-3097/4260-101-0890)

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 11/2010
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1573

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$19,667,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,667,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$19,667,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) for uncompensated care provided to individuals with no source of third party coverage for the services they receive.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.71
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after November 1, 2010 until October 31, 2015, based on the Special Terms and Conditions of the BTR, SNCP was established to support the provision of services to the uninsured. The SNCP is to be claimed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in Demonstration Year (DY) 6 of the BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

Reason for Change from Prior Estimate:
This policy change has been updated for FY 2015-16 to remove DY 2015-16 estimated payments based upon the terms for a five year extension of the 1115 Waiver.

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 87

Methodology:

1. Interim payments are made to the DPHs on a quarterly basis. The fourth quarter payment is split into two payments. Payments are made in October, January, April, June, and July. The June payment includes the months of April and May, while the July payment is for the month of June.

2. The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands)

Demonstration Year	State - Only Funded Programs	Due to DPHs
2010-11	$400,000	$565,422
2011-12	$400,000	$436,000
2012-13	$400,000	$386,000
2013-14	$400,000	$311,000
2014-15	$400,000	$236,000

3. The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

Demonstration Year	FY 2015-16
2014-15	**$19,667**

Funding:

100% Health Care Support Fund (4260-601-7503)

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	7/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1622

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$187,327,000	$70,492,000
- STATE FUNDS	$93,663,500	$35,246,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$187,327,000	$70,492,000
STATE FUNDS	$93,663,500	$35,246,000
FEDERAL FUNDS	$93,663,500	$35,246,000

DESCRIPTION

Purpose:
This policy change estimates the funding for the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) Out-of-Network (OON) Emergency Care Services Fund that was created to reimburse out-of-network hospitals for providing certain services to LIHP MCE enrollees.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
SB 920 (Hernandez, Statutes of 2012)
California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required post stabilization care provided by private hospitals that are outside the LIHP coverage network. SB 920 changes the amount transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and subsequent payments. SB 920 further removes the non-designated public hospitals eligibility for this program.

Reason for Change from Prior Estimate:
- The available transfer amount from the HQARF to the LIHP MCE OON Emergency Care Services Fund decreased after the SB 335 program Hospital Quality Assurance Fee was reconciled:
  - No HQARF funds were available for FY 2011-12, and FY 2012-13 funds have decreased,
- A portion of the FY 2012-13 payment is delayed to FY 2016-17.

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 88

Methodology:

1. IGT funds are to be used in their entirety before HQARF funds are used.

2. SB 920 authorizes HQARF funds to be transferred to LIHP MCE Out-of-Network Emergency Care Services Fund.

3. Current HQARF collections and disbursements project that $86.7 million is available for transfer from the HQARF funds for FY 2012-13 and FY 2013-14.

4. LIHPs will provide utilization data for FY 2011-12, FY 2012-13, and FY 2013-14 to the Department after the fiscal year. The LIHP ended on December 31, 2013. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations.

5. The LIHP funds will be used to reimburse private out-of-network hospitals.

6. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund. IGT amounts are estimated to total $32,578,000 in FY 2015-16 and $9,585,000 in FY 2016-17.

(Dollars in Thousands)

FY 2015-16	LIHP	IGT	HQARF
2011-12	$12,162	$12,162	$0
2012-13	$38,302	$10,416	$27,886
2013-14	$43,200	$10,000	$33,200
Total FY 2015-16	$93,664	$32,578	$61,086

FY 2016-17	LIHP	IGT	HQARF
2012-13	$35,246	$9,585	$25,661

(Dollars in Thousands)

FY 2015-16	**TF**	**FF**	**LIHP**
2011-12	$24,324	$12,162	$12,162
2012-13	$76,603	$38,301	$38,302
2013-14	$86,400	$43,200	$43,200
Total FY 2015-16	**$187,327**	**$93,663**	**$93,664**
FY 2016-17	**TF**	**FF**	**LIHP**
2012-13	$70,492	$35,246	$35,246
Total FY 2016-17	**$70,492**	**$35,246**	**$35,246**

Funding:

50% LIHP MCE OON Emergency Care Services Fund (4260-610-3201)/
50% Title XIX FFP (4260-101-0890)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	7/2011
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1578

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$162,795,000	$141,648,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$162,795,000	$141,648,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$162,795,000	$141,648,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The HCCI covered those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs),
- Intergovernmental Transfers for capitation rates payments (IGT-CAP), and
- IGTs for county-owned Federally Qualified Health Centers (IGT-FQHCs)

The Department has used the CI cost claiming protocol for the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 89

Conditions of the Section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

On August 13, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGT-FQHC on February 5, 2013 retroactive to November 1, 2010.

On January 7, 2015, CMS denied the LIHP cost claiming protocol for claims based on capitation rates for health care services provided to only MCE enrollees. The Department has submitted an appeal to CMS to reconsider this denial for the five local LIHPs interested in the capitated rates. These five local LIHPs are: Alameda, Riverside, San Francisco, Santa Clara, and San Mateo. CMS denied the Department's appeal. Therefore, the capitation rate payments are no longer included in the budget.

The local LIHPs with CMS's approval to use the capitation payment mechanism for federal reimbursement of the MCE component of their program will continue to use CPEs to claim for reimbursement of their allowable health care services that are excluded from their capitation rates. The remaining local LIHPs will only use CPEs to claim for federal reimbursement. The MCE program is not subject to the federal funding cap.

Reason for Change from Prior Estimate:
The change is due to:

- The addition of DY 2011-12 CPE recoupment payments,
- Decreased MCE cost estimates for DY 2012-13, and DY 2013-14, and
- Elimination of IGT capitation rate payments.

Methodology:

1. Assume the interim reconciliations for DY 2011-12, DY 2012-13, and DY 2013-14 will occur in FY 2015-16.

2. Assume the interim reconciliation for DY 2010-11 will occur in FY 2016-17.

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2015-16	TF	FF
2011-12 (CPEs)	($3,247)	($3,247)
2012-13 (CPEs)	$28,423	$28,423
2013-14 (CPEs)	$137,619	$137,619
Total FY 2015-16	**$162,795**	**$162,795**

(Dollars in Thousands)

FY 2016-17	TF	FF
2010-11 (CPEs)	$141,648	$141,648
Total FY 2016-17	**$141,648**	**$141,648**

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

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	11/2010
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1572

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$126,379,000	-$12,363,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$126,379,000	-$12,363,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$126,379,000	-$12,363,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP, effective November 1, 2010 through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the HCCI. The MCE covered eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those eligible individuals with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and Conditions of the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 90

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. CMS approved this change retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013, retroactive to November 1, 2010.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and $180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

However, local spending under the HCCI has not reached $360 million. The Department obtained CMS approval through two amendments to the BTR Medicaid Demonstration waiver to reallocate the unused HCCI funds from DY 2010-11 through DY 2013-14 to the Safety Net Care Pool (SNCP) uncompensated care component. The total reallocation amount for DY 2010-11 through DY 2013-14 is $222 million in federal funds.

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

- The inclusion of the DY 2011-12 interim reconciliation payment, and
- Increased HCCI cost estimates for DY 2012-13 and DY 2013-14.

Methodology:

1. Assume the interim reconciliations for DY 2011-12, DY 2012-13, and DY 2013-14 will occur in FY 2015-16.

2. Assume the interim reconciliation for DY 2010-11 will occur in FY 2016-17.

3. The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2015-16	TF	FF
DY 2011-12	$56,753	$56,753
DY 2012-13	$41,028	$41,028
DY 2013-14	$28,598	$28,598
Total FY 2015-16	**$126,379**	**$126,379**

(Dollars in Thousands)

FY 2016-17	TF	FF
DY 2010-11	($12,363)	($12,363)
Total FY 2016-17	**($12,363)**	**($12,363)**

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	5/2008
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1078

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$87,171,000	$80,844,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$87,171,000	$80,844,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$87,171,000	$80,844,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.35 State Plan Amendment (SPA) 05-023

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and Bridge to Reform (BTR) implementation, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, pursuant to SPA 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (CMS) in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 91

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

Reason for Change from Prior Estimate:
The changes to FY 2015-16 were due to:

- Increased FY 2015-16 payments which were updated based on recent FY 2013-14 cost reports.
- Delayed FY 2006-07 final reconciliation to FY 2016-17.
- Inclusion of a late FY 2014-15 payment.
- Inclusion of the FY 2005-06 final reconciliation and FY 2012-13 interim reconciliation.

Methodology:

1. In FY 2015-16 and FY 2016-17, one annual payment will be made to DPHs for those respective years.

2. Interim reconciliations of program years are anticipated to be completed upon receipt of the Physician/Non-Physician Practitioner time studies and the filed cost report information which are required components of the reconciliation process.

3. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements.

(Dollars in Thousands)

FY 2015-16	**TF**	**FF**
FY 2005-06 Final Reconciliation	($150)	($150)
FY 2012-13 Interim Reconciliation	($2,572)	($2,572)
FY 2014-15 Interim Payment	$1,686	$1,686
FY 2015-16 Interim Payment	$88,207	$88,207
Total	**$87,171**	**$87,171**
FY 2016-17		
FY 2006-07 Final Reconciliation	($5,018)	($5,018)
FY 2012-13 Interim Reconciliation	($9,699)	($9,699)
FY 2013-14 Interim Reconciliation	$9,863	$9,863
FY 2013-14 Interim Reconciliation ACA	$4,791	$4,791
FY 2016-17 Interim Payment	$80,907	$80,907
Total	**$80,844**	**$80,844**

Funding:
100% Title XIX FF (4260-101-0890)
100% ACA 2014-2016 FF (4260-101-0890)

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 7/2015
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1162

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$41,218,000	$100,365,000
- STATE FUNDS	$20,609,000	$50,182,500
PAYMENT LAG	0.6324	0.7835
% REFLECTED IN BASE	0.45 %	0.21 %
APPLIED TO BASE		
TOTAL FUNDS	$25,949,000	$78,470,800
STATE FUNDS	$12,974,480	$39,235,420
FEDERAL FUNDS	$12,974,480	$39,235,420

DESCRIPTION

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 102 MH/UCD & BTR — DPH Interim Rate
PC 189 Funding Adjust. — ACA Opt. Expansion

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the Selective Provider Contracting Program (SPCP) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Reason for Change from Prior Estimate:
- DPH data was updated through July 2015. The Affordable Care Act (ACA) optional population and Hospital Presumptive Eligibility (PE) expenditures are now included in this base data.
- The FY 2015-16 average interim rate increase was 3% instead of 4.8%.

Methodology:
1. The DPHs received new FY 2015-16 interim rates as of July 1, 2015. These rates were based on FY 2013-14 costs trended to FY 2015-16.

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 92

2. For FY 2015-16:
   - Assume an average interim rate increase of 3%.
   - An additional cost of $41,218,000 TF is estimated for the FY 2015-16 interim rates. The lagged cost on a cash basis is estimated to be approximately $26 million TF.

3. For FY 2016-17:
   - Assume an average interim rate increase of 4.28%.
   - An additional cost of $100,365,000 TF is estimated for the FY 2016-17 interim rates. The lagged cost on a cash basis is estimated to be approximately $78 million TF.

4. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust. — ACA Opt. Expansion

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 9/2007
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1154

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$23,509,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$23,509,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$23,509,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD).

Authority:
SB 1448 (Chapter 76, Statutes of 2006)
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10.

The federal funds available will reimburse the HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their certified public expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP). The Special Terms and Conditions (STC) of the MH/UCD waiver allowed the Department to reallocate unspent Coverage Initiative (CI) funding to counties who have additional expenditures.

The Demonstration, which would have ended on August 31, 2010, was extended until October 31, 2010. The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 93

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

Methodology:
1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	$ 8,204
Contra Costa County/Contra Costa Health Services	$ 15,250
County of Orange	$ 16,872
County of San Diego, Health and Human Services Agency	$ 13,040
County of Kern, Kern Medical Center	$ 10,000
Los Angeles County Department of Health Services	$ 54,000
San Francisco Department of Public Health	$ 24,370
San Mateo County	$ 7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	$ 20,700
Ventura County Health Care Agency	$ 10,000
Total	$180,000

2. Payments due to reallocation and related reconciliation for DY 2007-08, DY 2008-09, and DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2015-16.

The estimated HCCI reconciliation payments on a cash basis are:

FY 2015-16	TF	FF
DY 2007-08	$19,272,000	$19,272,000
DY 2008-09	$698,000	$698,000
DY 2009-10	$3,539,000	$3,539,000
Total FY 2015-16	**$23,509,000**	**$23,509,000**

Funding:
Health Care Support Fund (4260-601-7503)

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	11/2010
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1571

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$3,458,000	$0
- STATE FUNDS	-$146,481,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,458,000	$0
STATE FUNDS	-$146,481,000	$0
FEDERAL FUNDS	$149,939,000	$0

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
Interagency Agreement 10-87249 A 03
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 104 MH/UCD & BTR —CCS and GHPP
PC 101 MH/UCD & BTR —BCCTP
PC 103 MH/UCD & BTR —MIA-LTC

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 94

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) · Song-Brown HealthCare Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program · Mental Health Loan Assumption Program University of California* California State University* California Community Colleges*
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

* CMS approval to include the University of California (UC), California State University (CSU) and California Community Colleges (CCCs) programs as DSHPs is still pending.

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five year total of $2 billion. This claiming has first priority on the Safety Net Care Pool (SNCP) funds. In addition to the above programs, AB 1467 allows the Designated Public Hospitals (DPHs) to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

Reason for Change from Prior Estimate:

The changes are due to:

- Updated program expenditures and final reconciliations
- Reserved SNCP Funds for DSHP claims have been updated based on revised program expenditures
- Remaining FY 2014-15 ADAP claiming and ADAP reimbursement to the California Department of Public Health (CDPH) was delayed to FY 2015-16.
- The FY 2015-16 offset to the CDPH budget decreased based on updated data.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 94

Methodology:

1. The FFP for other departments is offset against State General Fund expenses in Item 4260-101-0001. Portions of the ADAP FFP, however, are offset against the CDPH budget. In FY 2015-16, of the $18,191,000 ADAP FFP available on an accrual basis, $873,000 is offset against the CDPH budget. $2,585,000 budgeted to offset the FY 2014-15 CDPH budget will be reimbursed to CDPH in FY 2015-16.

(Dollars in Thousands)

Cash Basis	
FY 2015-16	**ADAP Reimbursement**
2014-15	$2,585
2015-16	$873
Total	**$3,458**

2. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR —MIA-LTC and MH/UCD & BTR —BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF impact is reflected in that estimate.

3. In prior years, the CPEs available from DSHP programs have not been sufficient to claim the $400 million FFP for each DY. AB 1467 permits the State to use DPH CPEs, as a condition for DPHs receiving Health Care Coverage Initiative rollover payments, to claim up to the $400 million limit. See “Reserved SNCP Funds for DSHP” in the table below.

4. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP will not continue in the subsequent waiver.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 94

The estimated BTR DSHP federal reimbursements are as follows:

(Dollars in Thousands)

	Total DSHP (Accrual Basis)	**(Cash Basis)**
	FF	**FF**
	DY 2014-15	**FY 2015-16**
CCS (PC 104)	$64,329	$12,611
GHPP (PC 104)	$49,727	$5,289
MIA-LTC (PC 103)	$18,932	$393
BCCTP (PC 101)	$1,308	$327
DHCS Total	$134,296	$18,620
ADAP	$72,765	$21,795
Co. Mental Health	$62,061	$15,515
DDS	$84,952	$21,238
EWC	$0	$0
PCTP	$1,209	$302
OSHPD	$8,296	$2,074
Univ. of Calif.	$0	$0
CSU/Comm. Colleges	$0	$0
CMSP	$0	$0
Reserved SNCP fund for DSHP	$36,421	$89,015
Other Programs Total (PC 94)	**$265,704**	**$149,939**
Grand Total	$400,000	$168,559

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/2012
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1672

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$10,204,000	$0
- STATE FUNDS	$5,102,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,204,000	$0
STATE FUNDS	$5,102,000	$0
FEDERAL FUNDS	$5,102,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Delivery System Reform Incentive Pool (DSRIP) Category 5 Human Immunodeficiency Virus (HIV) Transition Projects. Non-federal share of the payments are made through intergovernmental transfers (IGTs).

Authority:
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)
Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White)

Interdependent Policy Changes:
Not Applicable

Background:
As part of BTR, California counties implemented the Low Income Health Program (LIHP). The LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covers eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covers those with family incomes above 133% through 200% of the FPL.

The Department received program direction from the federal Health Resources and Services Administration (HRSA) and the Centers for Medicare & Medicaid Services (CMS) that according to the Ryan White HIV/AIDS Treatment Extension Act of 2009 “payer of last resort” requirements, Ryan White funded services can no longer be available to individuals living with HIV once they are determined eligible for and enrolled in a local LIHP. Therefore, these individuals who were previously covered under the Ryan White program will, upon enrollment in a local LIHP, be required to receive their medical care, pharmaceuticals, and mental health services under the LIHP.

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 95

The Department proposed an amendment to the BTR Demonstration to CMS which authorizes the implementation of quality improvement projects within Designated Public Hospitals (DPHs). The DPHs support continuity of quality care, care coordination and other coverage transition issues concerning LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under the Ryan White program. CMS approved the amendment to the BTR Demonstration on June 28, 2012.

The Department developed a DSRIP Category 5 HIV Transition Projects proposal (Proposal) which established the framework, performance measures, deliverables, and incentive payment structure for DSRIP Category 5 HIV Transition Projects. This Proposal was submitted to CMS on July 20, 2012, and it was approved on October 31, 2012. The Proposal served as the foundation for the development of two new supplements to the Special Terms and Conditions (STC Attachment P – Supplement 1 and Attachment Q – Supplement 1) authorized by the June 28, 2012 amendment. On November 7, 2012, the Department submitted the proposed new supplements to CMS and they were approved on November 19, 2012.

The DSRIP Category 5 HIV Transition Projects were effective from July 1, 2012 through December 31, 2013. DPHs that implemented these approved projects receive incentive payments under the Safety Net Care Pool (SNCP) upon achievement of project milestones. According to the carry forward provisions of the STC, Attachment P – Supplement 1, the DPHs have until the end of the demonstration, October 31, 2015, to achieve the project milestones.

Reason for Change from Prior Estimate:
The change is due to a delay in a portion of the FY 2013-14 payment to FY 2015-16.

Methodology:

1. During the term of the LIHP component commencing with FY 2012-13, a total of $110 million in DSRIP Category 5 HIV Transition Project payments (total computable) was available annually.

2. $55 million (total computable) was available for July 1 - December 31, 2013. The total available payments were consistent with the Demonstration budget neutrality limit.

3. Of the $55 million, $10,204,000 remains available to be claimed. This balance relates to the FY 2013-14 service year.

4. Total payment amounts will be allocated to each participating DPHs on the basis of its approved proposal. Payment amounts will be disbursed in semi-annual payments, if project milestones are achieved.

(Dollars in Thousands)

FY 2015-16	TF	IGT	FF
2013-14	**$10,204**	**$5,102**	**$5,102**

Funding:
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)
50% Title XIX FFP (4260-101-0890)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1072

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$8,186,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,186,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$8,186,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
MH/UCD

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a SNCP was established to support the provision of services to the uninsured. The SNCP makes available $586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional $180 million per DY for implementing a healthcare coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual $100,000,000 of the SNCP federal financial participation (FFP) for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 96

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed $586 million.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each DY may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR demonstration. A modified SNCP continues in the BTR demonstration; see policy change Bridge to Reform – Safety Net Care Pool.

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

Methodology:
1. The final reconciliation for DY 2007-08 will occur in FY 2015-16.

The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

Demonstration Year	FY 2015-16
	FF
2007-08	$8,186
Total	**$8,186**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 7/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1076

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$4,712,000	$3,800,000
- STATE FUNDS	$2,356,000	$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,712,000	$3,800,000
STATE FUNDS	$2,356,000	$1,900,000
FEDERAL FUNDS	$2,356,000	$1,900,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.17
Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR implementation, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on January 1, 2014, State Plan Amendments (SPAs) were required to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund. The Department received SPA approval from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for FY 2014-15. The Department will submit SPA 15-004 requesting continuation of the program for FY 2015-16 and forward.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 97

Reason for Change from Prior Estimate:
In FY 2015-16, the changes are due to updated FY 2014-15 ending balance and updated interest.

Methodology:
1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.

2. SB 1100 requires that $1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

It is assumed NDPH supplemental payments will be made on a cash basis as follows:

FY 2015-16	**TF**	**GF**	**FF**
FY 2014-15 Ending Balance	$904,000	$452,000	$452,000
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2014-15 Interest Earned	$8,000	$4,000	$4,000
Total Funds Available	$4,712,000	$2,356,000	$2,356,000
Cash Expenditures in FY 2015-16	**$4,712,000**	**$2,356,000**	**$2,356,000**
FY 2015-16 Ending Balance	$0	$0	$0

FY 2016-17	**TF**	**GF**	**FF**
FY 2015-16 Ending Balance	$0	$0	$0
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2015-16 Interest Earned	$5,000	$2,500	$2,500
Total Funds Available	$3,805,000	$1,902,500	$1,902,500
Cash Expenditures in FY 2016-17	**$3,800,000**	**$1,900,000**	**$1,900,000**
FY 2016-17 Ending Balance	$5,000	$2,500	$2,500

Funding:
100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 7/2006
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1153

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,650,000	$0
- STATE FUNDS	$2,650,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,650,000	$0
STATE FUNDS	$2,650,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:
Not Applicable

Background:
Stabilization funding is calculated as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
  a. The NDPHs' aggregate payment increase, and
  b. The sum of $0.544 million and 0.64% of total stabilization funding.

- Private Hospitals will receive total funds payment equal to the difference between:
  a. The Private Hospitals' aggregate payment increase, and
  b. The sum of $42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.

- Distressed Hospitals will receive total funds payments equal to the lesser of $23.5 million or 10% of total stabilization funding, with a minimum of $15.3 million.

- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 98

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

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

Methodology:

1. Stabilization funding is calculated after the final reconciliation of the DPH interim payments is completed.

2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.

3. Stabilization funding to NDPHs, Private Hospitals, and Distressed Hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

4. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the BTR.

5. The MH/UCD final reconciliation calculation takes into account claiming for Designated State Health Programs as well as payments to DPHs and Distressed Hospitals. Additional stabilization payments may be made in FY 2015-16 in order to stay within the federal SNCP allotment of $586 million for DY 2005-06; this estimate is currently being finalized.

6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

7. Final reconciliations will result in updated stabilization amounts for NDPH and Private Hospitals. These updated stabilization amounts will not be paid out.

8. Distressed Hospital payments are calculated as part of the MH/UCD waiver final reconciliation. These payments were previously distributed based on negotiations with the Office of the Selective Provider Contracting Program, formerly CMAC. The Department will now distribute these payments. Distressed Hospital payments for 2005-06 and 2006-07 were paid prior to FY 2013-14. Until the distribution methodology for Distressed Hospital payments is finalized, Distressed Hospital payments for DY 2007-08 through DY 2009-10 will not be paid out.

9. The DY 2006-07 interim reconciliation for DPHs was calculated in FY 2014-15 and paid in FY 2014-15 and FY 2015-16. There were no stabilization payments due to DPHs as a result of the FY 2006-07 interim reconciliation.

10. The DY 2007-08 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2015-16.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 98

The estimated stabilization payments are:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
2007-08 DPHs	**$2,650**	**$2,650**	**$0**

Funding:
100% GF (4260-101-0001)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/2013
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1769

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,164,000	$1,471,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,164,000	$1,471,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,164,000	$1,471,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Pursuant to the Special Terms and Conditions (STCs) of the BTR waiver, for the period covering April through December of 2013, IHS facilities may claim for services provided to uninsured individuals and optional benefits eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009).

On December 24, 2013, CMS approved the extension of IHS payments for the period covering January through December 2014. On December 30, 2014, CMS approved the extension of IHS payments for the period covering January through October 2015. Under the extensions, IHS facilities may claim for eliminated optional Medi-Cal benefits, but not for services provided to uninsured individuals.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 99

Covered Services for Uninsured Individuals (April 5, 2013 to December 31, 2013)
Until December 31, 2013, IHS facilities were eligible to receive payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who were not enrolled in a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

Covered Services for Medi-Cal Enrollees (April 5, 2013 to October 31, 2015)
For Medi-Cal enrolled individuals, IHS facilities may receive payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology
Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For the period covering April through December of 2013, services provided to non-IHS eligible individuals are also eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan include:

- Acupuncture
- Audiology
- Chiropractic
- Dental*
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology**
- Speech therapy

*AB 82 (Chapter 23, Statutes of 2013) restores certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration does not affect calendar year 2013. For calendar year 2014, eliminated dental services will be claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and will no longer be claimable under this program.

**SBX1 1 (Chapter 4, Statutes of 2013) restores psychology services, effective January 1, 2014.

Reason for Change from Prior Estimate:
The change is due to payments for additional calendar year (CY) 2014 claims, the updated encounter rate for CY 2015, and the tribal facilities not submitting CY 2015 claims in FY 2014-15.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 99

Methodology:

1. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

2. Additional claims for calendar year 2014 in the amount of $158,004 were paid in July 2015.

3. CY 2015 is included in 10 months of the BTR. Two months are assumed in the new waiver. CY 2015 is estimated to be paid all in FY 2015-16.

4. CY 2016 is assumed in the new waiver. Assume the first quarter is paid in FY 2015-16 and remaining 3 quarters in FY 2016-17.

5. CY 2017 is assumed in the new waiver. Assume the first quarter is paid in FY 2016-17.

6. The IHS global encounter rate is updated on the Federal Register for each calendar year (CY). For CY 2015, the rate is $350. Assume the same rate for CY 2016 and CY 2017.

7. IHS claims are paid for each encounter. Assume the encounters for CY 2015 is 4,680, CY 2016 is 4,200, and CY 2017 is 4,200.

CY 2015			
BTR (10 Mo.)	3,348 encounters X	$350 =	$1,171,800 FF
New Waiver (2 Mo.)	1,332 encounters X	$350 =	$466,200 FF
CY 2016	4,200 encounters X	$350 =	$1,470,000 FF
CY 2017	4,200 encounters X	$350 =	$1,470,000 FF

FY 2015-16	**TF**	**FF**
Calendar Year 2014	$158,000	$158,000
Calendar Year 2015	$1,638,000	$1,638,000
Calendar Year 2016	$368,000	$368,000
Total	**$2,164,000**	**$2,164,000**

FY 2016-17	**TF**	**FF**
Calendar Year 2016	$1,103,000	$1,103,000
Calendar Year 2017	$368,000	$368,000
Total	**$1,471,000**	**$1,471,000**

Funding:

100% Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 7/2016
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1459

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$12,022,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$12,022,000
FEDERAL FUNDS	$0	-$12,022,000

DESCRIPTION

Purpose:
This policy change estimates the impact of the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:
Welfare & Institutions Code 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, $360 million of the funding was unused. On February 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change from Prior Estimate:
There is no change to FY 2015-16. This estimate now assumes the completion of the DY 5 County Mental Health Services (CMHS) program final reconciliation in FY 2016-17.

Methodology:
1. The Department may claim these funds using the certified public expenditures from State-Only funded programs: Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 100

2. AB 1653 (Chapter 218, Statutes of 2010) allowed the State to retain up to $420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. $135.083 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011.

4. The MH/UCD demonstration required settled and audited cost reports in order to complete the final reconciliation for CMHS. The claimable time period for DY 2009-10 (DY 5) for CMHS is February 2010 through August 2010. This spans five months in FY 2009-10 and two months in FY 2010-11. Final reconciliation of DY 2009-10 will be completed when FY 2009-10 and FY 2010-11 mental health cost reports are settled and audited.

5. The Department is assuming completion of the CMHS reconciliation in FY 2016-17.

The General Fund costs resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)

FY 2016-17	**TF**	**GF**	**FF**	**ARRA**
DY 5 CMHS Final Reconciliation	$0	$12,022	($9,372)	($2,650)
Total	**$0**	**$12,022**	**($9,372)**	**($2,650)**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	9/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1084

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$327,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$327,000	$0
FEDERAL FUNDS	$327,000	$0

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 94 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by the MH/UCD.

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the BCCTP, effective January 1, 2002, for women under 200% of the federal poverty level (FPL). BCCTP is a State-Only program that covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family Planning, Access, Care, and Treatment (Family PACT) providers.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a five-year demonstration, the BTR. The Special Terms and Conditions of the BTR demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The BCCTP is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 101

Reason for Change from Prior Estimate:
The change is due to the completion of the DY 2012-13 final reconciliation in FY 2014-15.

Methodology:
1. The FFP received for the BCCTP will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The BCCTP federal reimbursements are:

Fiscal Year	BCCTP
FY 2005-06	$1,182,000
FY 2006-07	$582,000
FY 2007-08	$0
FY 2008-09	$3,634,000
FY 2009-10	$2,137,000
FY 2010-11	$2,026,000
FY 2011-12	$1,509,000
FY 2012-13	$1,158,000
FY 2013-14	$1,786,000
FY 2014-15	$1,663,000

FY 2015-16	FF
DSHP-BTR (DY 2014-15)	$327,000
Total	**$327,000**

Funding:
100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1161

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$414,987,500	-$437,269,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$414,987,500	-$437,269,450
FEDERAL FUNDS	$414,987,500	$437,269,450

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 92 MH/UCD & BTR — DPH Interim Rate Growth

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF/95% FFP to 100% FFP beginning January 2017.

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 102

Reason for Change from Prior Estimate:

- DPH data was updated through July 2015. The ACA optional population and Hospital Presumptive Eligibility (PE) expenditures are now included in this base data.
- The FY 2015-16 average interim rate increase was 3% instead of 4.8%.
- In addition to the 50% GF/50% FFP to 100% FFP shift, this policy change will shift funding for the ACA optional population.

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF shift
FY 2015-16	**$1,399,876**	**$414,988**
FY 2016-17	**$1,419,381**	**$437,269**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)
95% Title XIX / 5% GF (4260-101-0001/0890)

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 103
IMPLEMENTATION DATE: 9/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1079

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$393,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$393,000	$0
FEDERAL FUNDS	$393,000	$0

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the Medically Indigent Adult Long-Term Care (MIA-LTC) program claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 94 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the MIA-LTC from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA-LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a five-year demonstration, the BTR. The Special Terms and Conditions of the BTR demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

Reason for Change from Prior Estimate:
The change is due to the completion of the DY 2012-13 final reconciliation in FY 2014-15.

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 103

Methodology:

1. The FFP received for the MIA-LTC program will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The MIA-LTC federal reimbursements are:

Fiscal Year	MIA LTC
FY 2005-06	$12,834,000
FY 2006-07	$18,375,000
FY 2007-08	$3,696,000
FY 2008-09	$18,980,000
FY 2009-10	$23,858,000
FY 2010-11	$26,939,000
FY 2011-12	$19,457,000
FY 2012-13	$19,661,000
FY 2013-14	$18,932,000
FY 2014-15	$18,343,000

FY 2015-16	**FF**
DSHP-BTR (DY 2014-15)	$393,000
Total	**$393,000**

Funding:

100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 9/2005
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1108

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$17,900,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,900,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$17,900,000	$0

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 94 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the CCS and GHPP from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a five-year demonstration, the BTR. The Special Terms and Conditions of the BTR allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 104

Reason for Change from Prior Estimate:
DY 2010-11 final reconciliations were updated and delayed from FY 2014-15 to FY 2015-16. In addition, DY 2012-13 final reconciliations are delayed and no longer in this estimate.

Methodology:

1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF impact is reflected in the Family Health Estimate.

2. The final reconciliation for DY 2010-11 has been updated and the Department estimates it will claim an additional $6.061 million in federal funds in FY 2015-16.

3. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)

Fiscal Year	CCS	GHPP	Total
FY 2005-06	$15,523	$8,485	$24,008
FY 2006-07	$46,856	$15,300	$62,156
FY 2007-08	$18,000	$8,000	$26,000
FY 2008-09	$20,958	$19,096	$40,054
FY 2009-10	$114,023	$43,313	$157,336
FY 2010-11	$96,910	$53,578	$150,488
FY 2011-12	$65,095	$30,351	$95,446
FY 2012-13	$67,718	$34,811	$102,529
FY 2013-14	$83,621	$47,438	$131,059
FY 2014-15	$39,558	$47,363	$86,920

(Dollars in Thousands)

FY 2015-16	CCS FF	GHPP FF	Total
DSHP-BTR (DY 2014-15)	$6,550	$5,289	$11,839
DY 2010-11 Final Reconciliation	$6,061	$0	$6,061
Total	**$12,611**	**$5,289**	**$17,900**

Funding:
100% Health Care Support Fund (4260-601-7503)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	108
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1766

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$9,889,062,000	$10,319,468,000
- STATE FUNDS	$4,944,531,000	$5,159,734,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	56.85 %	55.66 %
APPLIED TO BASE		
TOTAL FUNDS	$4,267,130,300	$4,575,652,100
STATE FUNDS	$2,133,565,130	$2,287,826,060
FEDERAL FUNDS	$2,133,565,130	$2,287,826,060

DESCRIPTION

Purpose:
This policy changes estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 109 CCI-Transfer of IHSS Costs to CDSS
PC 132 CCI-Savings and Deferral
PC 193 CCI-Transfer of IHSS Costs to DHCS
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings are generated from a reduction in inpatient and LTC institutional services.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 108

The CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Reason for Change from Prior Estimate:
Opt-In enrollment percentages were updated based on data as of July 2015. Caseload data was updated based on actuals through April 2015. In addition, the FY 2015-16 and 2016-17 capitation rates for the CMC, non-CMC, and non-dual populations were updated.

Methodology:

1. Dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional FFS model were passively enrolled into the CCI no later than January 1, 2015, except for Orange. Orange began August 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Dual eligibles in Medicare Advantage (MA) plans that are also CMC plans passively enrolled into the CCI on January 1, 2015, except for Orange. Orange began August 1, 2015. There is no phase-in assumed for this population.

3. Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) had their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange. Orange began August 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. In FY 2015-16, the Department estimates 1,291,651 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,291,651 average monthly beneficiaries, it is estimated 1,014,785 will be enrolled in a managed care plan.

5. In FY 2016-17, the Department estimates 1,318,044 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,318,044 average monthly beneficiaries, it is estimated 1,093,886 will be enrolled in a managed care plan.

6. Assume for participating dual eligibles, there will an overall average 2.31% savings in FY 2015-16 and 4.35% in FY 2016-17.

7. The Department performs reconciliation of IHSS category of service to actual IHSS expenditures paid out to providers by CDSS for the same quarter. The Department will determine the appropriate amount of reimbursement during reconciliation which will identify IHSS over/underpayments to CDSS or the managed care plans. Reconciliation will be operationalized in the capitated payment system in January 2016.

8. The Department re-casted capitation rates for plans participating in the CCI for full-benefit dual eligible beneficiaries. Preliminary data suggests the department will recoup the difference between the paid capitation rate and the re-casted rate from plans participating in CCI. The recoupment of payments in excess of plans re-casted capitation payments is for the period of April 2014 through December 2014. The recasts will continue to occur through the CCI demonstration period, which ends December 31, 2017. The Department anticipates recoupments beginning in April 2016.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 108

9. Estimated below is the overall impact of the CCI demonstration in FY 2015-16 and FY 2016-17.

(Dollars in Thousands)

FY 2015-16	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	**$9,889,062**	**$4,944,531**	**$4,944,531**	**$0**
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($6,783,616)	($3,391,808)	($3,391,808)	$0
Defer Managed Care Payment	($175,840)	($87,920)	($87,920)	$0
Total	($6,959,456)	($3,479,728)	($3,479,728)	$0
IHSS FFS Savings (In the Base)	($1,114,753)	$0	($1,114,753)	$0
Delay 1 Checkwrite (In the Base)	$24,401	$12,201	$12,201	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,114,753)	$0	$1,114,753
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,307,539	$0	$0	$2,307,539
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$29,062	$14,406	$14,657	$0
CCI IHSS Reconciliation (PC 173)	$60,000	$0	$60,000	$0
Retro MC Rate Adjustments (PC 133)	$198,881	($18,060)	($18,060)	$235,000
Total of CCI PCs including pass through	$4,434,737	$358,596	$418,847	$3,657,293

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	**$10,319,468**	**$5,159,734**	**$5,159,734**	**$0**
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($7,716,973)	($3,858,487)	($3,858,487)	$0
Defer Managed Care Payment	$1,708	$854	$854	$0
Total	($7,715,265)	($3,857,633)	($3,857,633)	$0
IHSS FFS Savings (In the Base)	($1,196,798)	$0	($1,196,798)	$0
Delay 1 Checkwrite (In the Base)	$6,872	$3,436	$3,436	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,196,798)	$0	$1,196,798
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,477,372	$0	$0	$2,477,372
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$19,823	$9,912	$9,912	$0
Retro MC Rate Adjustments (PC 133)	($428,219)	($214,110)	($214,110)	$0
Total of CCI PCs including pass through	$3,483,252	($95,459)	($95,459)	$3,674,170

Funding:

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

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1653

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,307,539,000	$2,477,372,000
- STATE FUNDS	$2,307,539,000	$2,477,372,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,307,539,000	$2,477,372,000
STATE FUNDS	$2,307,539,000	$2,477,372,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the California Department of Social Services (CDSS) for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles who receive LTC institutional services, IHSS, and other Home and Community-Based Services (HCBS) to managed care health plans beginning April 1, 2014.

The IHSS program provides an alternative to out-of-home care, such as nursing homes or board and care facilities. The transition and coordination of care for this group helps beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS. It is assumed that the transition to managed care will increase the use of IHSS and other HCBS by 3.5%.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the CDSS pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population.

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 109

This policy change addresses the transfer of IHSS costs from the managed care rates to the Department who will in turn transfer the funds to CDSS to pay the IHSS providers. The policy change, CCI-Transfer of IHSS Costs to DHCS, reflects the transfer of General Fund and county funds to the Department which is used to increase managed care capitation rates.

Reason for Change from Prior Estimate:
Opt-In enrollment percentages were updated based on data as of July 2015. Caseload data was updated based on actuals through April 2015. In addition, the FY 2015-16 and 2016-17 capitation rates for the CMC, non-CMC, and non-dual populations were updated.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2015-16 and FY 2016-17.

(Dollars in Thousands)

FY 2015-16	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$9,889,062	$4,944,531	$4,944,531	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($6,783,616)	($3,391,808)	($3,391,808)	$0
Defer Managed Care Payment	($175,840)	($87,920)	($87,920)	$0
Total	($6,959,456)	($3,479,728)	($3,479,728)	$0
IHSS FFS Savings (In the Base)	($1,114,753)	$0	($1,114,753)	$0
Delay 1 Checkwrite (In the Base)	$24,401	$12,201	$12,201	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,114,753)	$0	$1,114,753
CCI-Transfer of IHSS Costs to CDSS (PC 109)	**$2,307,539**	**$0**	**$0**	**$2,307,539**
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$29,062	$14,406	$14,657	$0
CCI IHSS Reconciliation (PC 173)	$60,000	$0	$60,000	$0
Retro MC Rate Adjustments (PC 133)	$198,881	($18,060)	($18,060)	$235,000
Total of CCI PCs including pass through	$4,434,737	$358,596	$418,847	$3,657,293

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 109

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$10,319,468	$5,159,734	$5,159,734	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($7,716,973)	($3,858,487)	($3,858,487)	$0
Defer Managed Care Payment	$1,708	$854	$854	$0
Total	($7,715,265)	($3,857,633)	($3,857,633)	$0
IHSS FFS Savings (In the Base)	($1,196,798)	$0	($1,196,798)	$0
Delay 1 Checkwrite (In the Base)	$6,872	$3,436	$3,436	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,196,798)	$0	$1,196,798
CCI-Transfer of IHSS Costs to CDSS (PC 109)	**$2,477,372**	**$0**	**$0**	**$2,477,372**
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$19,823	$9,912	$9,912	$0
Retro MC Rate Adjustments (PC 133)	($428,219)	($214,110)	($214,110)	$0
Total of CCI PCs including pass through	$3,483,252	($95,459)	($95,459)	$3,674,170

Funding:

100% Reimbursement (4260-610-0995)

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

REGULAR POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	7/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1781

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$1,744,753,000	$0
- STATE FUNDS	$564,183,520	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,744,753,000	$0
STATE FUNDS	$564,183,520	$0
FEDERAL FUNDS	$1,180,569,480	$0

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 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 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:
FY 2015-16 estimates have changed due to updated tax revenues based on managed care premiums.

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

REGULAR POLICY CHANGE NUMBER: 111

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 FY 2015-16 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 2015-16	**$1,744,753**	**$564,184**	**$1,180,569**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% Title XIX FFP (4260-101-0890)

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1054

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$637,364,000	$871,975,000
- STATE FUNDS	$294,454,000	$401,101,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$637,364,000	$871,975,000
STATE FUNDS	$294,454,000	$401,101,000
FEDERAL FUNDS	$342,910,000	$470,874,000

DESCRIPTION

Purpose:
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for the purpose of providing capitation rate increases to the managed care plans.

Authority:
Welfare & Institutions Code 14164 and 14301.4

Interdependent Policy Changes:
PC 126 Managed Care IGT Admin. And Processing Fee
PC 124 Extend Gross Premium Tax
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 125 Extend Gross Premium Tax – Funding Adjustment
PC 111 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 130 MCO Tax Mgd. Care Plans

Background:
An IGT is a transfer of funds from a public entity to the State. The non-federal share from the fund is matched with federal funds and used to make payments for capitation rate increases.

The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

The Department's rate range IGT program has grown significantly as more plans and providers have decided to participate. As Medi-Cal managed care significantly expands, the Department seeks to maintain the safety net and access to care by continuing and expanding plan and public providers' ability to leverage additional federal funding through the rate range IGT program.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 112

Reason for Change from Prior Estimate:
The policy change was revised to incorporate updated IGTs.

Methodology:
COHS:
The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; and Orange, Napa, and Yolo counties were effective retroactive to July 1, 2010. The IGTs for Marin, Mendocino, and Ventura Counties were effective retroactive to July 1, 2011. The IGTs will continue on an ongoing basis.

The COHS expansion counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) are eligible to participate in the rate range IGT program retroactive to September 1, 2013. Funds for these counties will be expended beginning in FY 2015-16.

Two Plan Model:
An IGT for Los Angeles County was effective October 2006 and will continue on an ongoing basis.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and Fresno, Stanislaus, and Tulare Counties were effective retroactive to October 1, 2011. The IGTs will continue on an ongoing basis.

Geographic Managed Care:
The IGTs for Sacramento and San Diego Counties were retroactive to January 2012. The IGTs will continue on an ongoing basis.

Regional:
The Regional counties (Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Imperial, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba) are eligible to participate in the rate range IGT program retroactive to November 1, 2013. Funds for these counties will be expended beginning in FY 2015-16.

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax (MCO Tax) of 2.35% on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. SB 78 (Chapter 33, Statutes of 2013) extended the gross premium tax through June 30, 2013. SB 78 also provides for a 3.9375% statewide tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in PC 129 Extend Gross Premium Tax – Funding Adjustment.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 112

(Dollars in Thousands)

FY 2015-16	IGT*	T19 FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	$294,454	$286,832	$24,587	$31,491	$342,910	**$637,364**

FY 2016-17	IGT*	T19 FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	$401,101	$390,720	$37,257	$42,897	$470,874	**$871,975**

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

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	113
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1588

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$518,150,000	$531,316,000
- STATE FUNDS	$259,075,000	$265,658,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$518,150,000	$531,316,000
STATE FUNDS	$259,075,000	$265,658,000
FEDERAL FUNDS	$259,075,000	$265,658,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases, as well as the related federal match portion of the capitation rate increases.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
PC 124 Extend Gross Premium Tax
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 125 Extend Gross Premium Tax – Funding Adjustment
PC 127 General Fund Reimbursement from DPHs
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Previously, DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided to the fee-for-service (FFS) members receiving services at a DPH facility. The transition of FFS SPDs to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while ensuring that there are not new state General Fund (GF) expenditures.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 113

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs. This portion is budgeted in the General Fund Reimbursements from DPHs Policy Change. In addition, the Public Providers will provide the non-federal share of the adjusted capitation related to the full recognition of the allowable costs (previously addressed by the FFS state plan reimbursement methodologies) for outpatient and other non-inpatient services through an IGT which is budgeted in this policy change.

Reason for Change from Prior Estimate:
FY 2015-16 costs have increased as Year 3 excess out-of-network placeholder costs were adjusted to reflect updated information provided by the hospitals. Year 4 excess out-of-network placeholder and Year 5 payments have been added to FY 2016-17.

Methodology:

1. Calculate the historical DPH allowable cost per day and related utilization.
2. Calculate the DPH utilization and costs that are built into the baseline managed care capitation rates for transitioned members.
3. Calculate capitation rate adjustments.
4. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient rate adjustments for inpatient services and the amount related to the non-inpatient rate adjustments for non-inpatient services.
5. Add IGTs for Inpatient hospital services and non-inpatient services to determine total IGTs from DPHs.
6. The Department collects an estimated amount of the IGT in advance. Once the capitation payments have been made, the Department can determine the actual amount owed by the Health Plans. If there is an overage, the amount is applied toward the following year.
7. The Year 3 IGTs include the period January 1, 2014, through June 30, 2014, for the GMC model counties, and October 1, 2013, through June 30, 2014, for the Two-Plan model counties. The IGTs in the amount of $170,222,000 were collected from the DPHs in FY 2014-15. The Year 2 DPH overpayments of $3,421,000 were applied against the year 3 IGTs prior to collection. Year 3 excess out-of-network costs in the amount of $19,750,000 for the non-federal share will be paid in FY 2015-16.
8. The Year 4 IGTs include the period July 1, 2014, through June 30, 2015, for both the GMC model and Two-Plan model counties. Payments are expected to occur in FY 2015-16. The actual IGTs have not yet been determined; therefore a placeholder in the amount of $239,325,000 for the non-federal share is estimated for FY 2015-16. Year 4 excess out-of-network costs have not yet been calculated; therefore, a placeholder in the amount of $26,333,000 for the non-federal share is estimated for FY 2016-17.
9. The Year 5 IGTs include the period July 1, 2015 through June 30, 2016 for both the GMC model and Two-Plan model counties. Payments are expected to occur in FY 2016-17. The actual IGTs have not yet been determined; therefore a placeholder in the amount of $239,325,000 for the non-federal share is estimated for FY 2016-17.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 113

(Dollars in Thousands)

FY 2015-16	TF	FFP	IGT
Year 3 (Jan – June 2014)	$39,500	$19,750	$19,750
Year 4 (July 2014 – June 2015)	$478,650	$239,325	$239,325
Total	**$518,150**	**$259,075**	**$259,075**

FY 2016-17	TF	FFP	IGT
Year 4 (July 2014 – June 2015)	$52,666	$26,333	$26,333
Year 5 (July 2015 – June 2016)	$478,650	$239,325	$239,325
Total	**$531,316**	**$265,658**	**$265,658**

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

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER:	115
IMPLEMENTATION DATE:	12/2015
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1895

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$190,077,000	$148,000,000
- STATE FUNDS	$92,998,000	$74,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$190,077,000	$148,000,000
STATE FUNDS	$92,998,000	$74,000,000
FEDERAL FUNDS	$97,079,000	$74,000,000

DESCRIPTION

Purpose:
This policy change estimates the amount of increased rate range payments to the managed care plans as a result of the extension of the Hospital Quality Assurance Fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

Of the grant amounts to public hospitals, SB 239 requires the Department to withhold specified amounts and use the amount as the nonfederal share for managed care rate range increases. Managed care plans must expend 100% of the rate range increases on hospital services.

Reason for Change from Prior Estimate:
FY 2015-16 costs have increased as FY 2014-15 rate range increases are now also expected to be paid in FY 2015-16.

Methodology:
1. Of the direct grant amounts to designated public hospitals, the Department shall withhold the following amounts:
   - $20,500,000 for FY 2013-14
   - $42,500,000 for FY 2014-15
   - $50,000,000 for FY 2015-16
   - $28,000,000 for FY 2016-17

HQAF RATE RANGE INCREASES

REGULAR POLICY CHANGE NUMBER: 115

2. Of the direct grant amounts to nondesignated public hospitals, the Department shall withhold the following amounts:
   - $10,000,000 for FY 2013-14
   - $20,000,000 for FY 2014-15
   - $24,000,000 for FY 2015-16
   - $14,000,000 for FY 2016-17

3. The Department expects to pay the FY 2013-14 and FY 2014-15 rate range increases using the corresponding withhold amounts in the second quarter of FY 2015-16.

4. The Department expects to pay the FY 2015-16 rate range increases using the corresponding withhold amount in FY 2016-17.

Payments for FY 2015-16 and FY 2016-17 are expected to be:

(Dollars in Thousands)

FY 2015-16	**TF**	**SF (HQARF) ***	**Regular FFP**	**Title 21 FFP**	**Family Planning FFP**	**Total FFP**
FY 2013-14 Increases	$65,077	$30,500	$29,063	$1,930	$3,585	$34,477
FY 2014-15 Increases	$125,000	$62,500	$52,318	$3,500	$6,683	$62,500
Total	**$190,077**	**$93,000**	**$81,381**	**$5,430**	**$10,268**	**$97,077**
FY 2016-17	**TF**	**SF (HQARF) ***	**Regular FFP**	**Title 21 FFP**	**Family Planning FFP**	**Total FFP**
FY 2015-16 Increases	$148,000	$74,000	$61,716	$4,144	$8,140	$74,000
Total	**$148,000**	**$74,000**	**$61,716**	**$4,144**	**$8,140**	**$74,000**

Funding:
*Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 1/2016
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1907

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$60,200,000	$207,000,000
- STATE FUNDS	$6,020,000	$20,700,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$60,200,000	$207,000,000
STATE FUNDS	$6,020,000	$20,700,000
FEDERAL FUNDS	$54,180,000	$186,300,000

DESCRIPTION

Purpose:
This policy change estimates the local assistance cost of a Health Home Program (HHP).

Authority:
AB 361 (Chapter 642, Statutes of 2013)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
The Medicaid Health Home State Plan Option is afforded to states under the Affordable Care Act (ACA). The ACA allows states to create Medicaid Health Homes to coordinate the full range of physical health, behavioral health, community-based long term services and supports, and other community-based services needed by beneficiaries with chronic conditions.

AB 361 authorizes the Department to create a HHP for beneficiaries with chronic conditions. The HHP will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

SB 75 establishes the Health Home Program Fund. The HHP Fund will be used to pay for the non-federal share of HHP costs.

Reason for Change from Prior Estimate:
FY 2015-16 costs are based on a 6-month phased in approach beginning January 1, 2016. Consequently, FY 2016-17 identifies increased costs based on full implementation.

Methodology:
1. Assume an equal phase-in over 6 months beginning January 1, 2016.

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 118

2. Capitation rates are assumed to be $65 for FY 2015-16 and FY 2016-17.

3. The Department will receive 90% federal reimbursement for FY 2015-16 and FY 2016-17. The remaining 10% will be funded by non-GF sources.

4. The costs for FY 2015-16 and FY 2016-17 are expected to be:

(Dollars in Thousands)	**TF**	**FF**	**HHP Fund***
FY 2015-16	**$60,200**	$54,200	$6,000
FY 2016-17	**$207,000**	$186,300	$20,700

Funding:
90% Title XIX FF (4260-101-0890)
10% HHP Fund (4260-601-0942)*

INLAND EMPIRE HEALTH PLAN SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 7/2015
ANALYST: Raman Pabla
FISCAL REFERENCE NUMBER: 1941

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$36,700,000	$0
- STATE FUNDS	$18,350,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$36,700,000	$0
STATE FUNDS	$18,350,000	$0
FEDERAL FUNDS	$18,350,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of a settlement agreement made between the Department and Inland Empire Health Plan (IEHP) regarding managed care rates.

Authority:
Settlement Agreement

Interdependent Policy Changes:
Not Applicable

Background:
The Department has entered into a settlement agreement with IEHP to settle notices of dispute (NODs) filed by IEHP regarding managed care capitation rates from 2004 through 2013. IEHP provides managed care services to beneficiaries in Riverside and San Bernardino counties. As part of the settlement, the Department has agreed to adjust capitation rates through use of IEHP's rate range for the 2013-14 rate year which total $36.7 million. There is no interest accrued on the settlement amount.

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

Methodology:
1. The FY 2015-16 settlement cost is $36,700,000 ($18,350,000 GF).

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

NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	7/1998
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	95

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change includes funds for settlement agreements for disputes between the Department and managed care plans.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Various managed care plans have filed grievances or appeals challenging the rates the Department has established for the managed care programs. Every six months the Department develops an estimate of likely settlements for these disputes.

The Department attempts to claim federal funding, however, this policy change adjusts for settlements that are beyond the federal claiming deadline. These settlements are budgeted at 100% General Fund.

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

Methodology:
Not Applicable

Funding:
100% General Fund (4260-101-0001)

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1652

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$183,000	$0
- STATE FUNDS	$91,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$183,000	$0
STATE FUNDS	$91,500	$0
FEDERAL FUNDS	$91,500	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by gross premium tax (GPT) proceeds resulting from the extension of the GPT. 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 125 Extend Gross Premium Tax – Funding Adjustment
PC 124 Extend Gross Premium Tax

Background:
AB 1422 Imposed a GPT on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue does not include amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The GPT imposed by AB 1422 was effective retroactively to January 1, 2009, through December 31, 2010. SB 853 extended the GPT through June 30, 2011. ABX1 21 extended the GPT through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period and will be matched with federal funds at the level in effect at that time.

SB 78 was signed by the Governor on June 27, 2013, and extended the gross premium tax through June 30, 2013, on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AHF, and 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. Some retroactive rate adjustments were paid in FY 2014-15, and the remainder of the associated FY 2012-13 gross premium tax payments will be paid in FY 2015-16.

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 123

The Managed Care Intergovernmental Transfer (IGT) provides for capitation rate increases to the managed care plans. Because a portion of the IGTs from prior periods won't occur until FY 2015-2016, the GPT applies to these payments and will be reflected in FY 2015-16 costs.

Reason for Change from Prior Estimate:
Due to processing delays, $183,000 in payments for some Two Plan rate range IGTs will be paid in FY 2015-16.

Methodology:

1. The GPT proceeds are required to be used to increase the capitation rates due to the payments made to the State that result directly from the imposition of the gross premium tax.

2. The GPT is estimated by using a 2.35% tax rate applied to projected managed care revenues.

3. Capitation rate increases due to the GPT are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the GPT Fund (Fund 3156) on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment policy change.

4. The costs of capitation rate increases related to the extension of the GPT sunset date are expected to be:

	TF	GF	FF
FY 2015-16	**$183,000**	$91,500	$91,500

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 124
IMPLEMENTATION DATE: 7/2013
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1647

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the Gross Premium Tax (GPT) Fund to the General Fund (GF) to be retained by the Department.

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

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extends the GPT sunset date that through June 30, 2013. Prior to October 1, 2012 transition of the Healthy Families Program to Medi-Cal, the portion of the GPT shown in this policy change was used to fund the Healthy Families Program. Beginning October 1, 2012, this portion of the tax will be retained by the Department to offset GF cost for the Medi-Cal program. This policy change estimates GF savings resulting from the extension of the GPT sunset date through June 30, 2013. Some retroactive rate adjustments were paid in FY 2014-15, and the remainder of the associated FY 2012-13 GPT payments will be paid in FY 2015-16.

Reason for Change from Prior Estimate:
The majority of payments for FY 2012-13 were made in FY 2014-15. Due to processing delays associated with PC 123 Extend Gross Premium Tax – Incr. Capitation Rates, the transfer of funds to the GF will occur in FY 2015-16.

Methodology:
1. The GPT is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. The FY 2012-13 impact of the increase in capitation payments related to the GPT is included in the Extend Gross Premium Tax – Incr. Capitation Rates policychange.

3. The total available GPT revenue in FY 2015-16 is estimated to be $91,500.

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 124

4. The GPT fund transfers to the GF are expected to be:

	TF	GF	GPT*
FY 2015-16	**$0**	**($92,000)**	**$92,000**

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

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 7/2013
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1655

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds from the Gross Premium Tax (GPT) Fund to the General Fund as a result of a proposal to extend the GPT.

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

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extended the collection of a GPT on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. The proceeds from the tax are used to offset capitation rates. Some retroactive rate adjustments were paid in FY 2014-15, and the remainder of the associated FY 2012-13 GPT payments will be paid in FY 2015-16.

Capitation rate increases due to the GPT are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the GPT Fund (Fund 3156) on a quarterly basis.

Reason for Change from Prior Estimate:
The majority of payments for FY 2012-13 were made in FY 2014-15. Due to processing delays associated with PC 123 Extend Gross Premium Tax – Incr. Capitation Rates, the transfer of fund to the GF will occur in FY 2015-16.

Methodology:
1. The GPT is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. Assume that transfers from the Department of Insurance take place three months after quarterly tax payments.

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 125

3. The GPT fund transfers to the GF are expected to be:

	TF	GF	GPT*
FY 2015-16	**$0**	**($92,000)**	**$92,000**

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

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER:	126
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1601

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

Authority:
AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Per AB 102, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15.

Reason for Change from Prior Estimate:
The policy change was revised to incorporate updated IGT amounts.

Methodology:
1. The fee will be 20% of each IGT.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 126

2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.

(Dollars In Thousands)	IGT amount subject to the fee	20% Admin. & Processing Fee	Support Cost Reimbursement to GF	Local Assistance Reimbursement to GF
FY 2015-16	$253,314	$50,663	$251	**$50,914**
FY 2016-17	$354,227	$70,845	$251	**$71,096**

Funding:
100% State GF (4260-101-0001)
Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1605

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Previously, DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided to the fee-for-service (FFS) members receiving services at a DPH facility. The transition of FFS SPDs to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while ensuring that there are not new state General Fund (GF) expenditures.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 127

In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

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

Methodology:

1. Determine the baseline of DPH inpatient services/costs in FFS that are subject to transition into managed care.

2. Account for managed care factors applied in the capitation rate development process.

3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization, which yields the calculated historical DPH allowable cost per day and related utilization.

4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rate for transitioned members.

5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates.

6. The IGTs prior to June 30, 2014, are complete. Any overpayments were applied against the subsequent year reimbursements.

7. The Year 4 reimbursement will include the period of July 1, 2014, through June 30, 2015, for both the GMC and the Two-Plan model counties. The reimbursement has not yet been calculated; therefore, a placeholder in the amount of $89,348,000 is estimated for FY 2015-16.

8. The Year 5 reimbursement will include the period of July 1, 2015, through June 30, 2016. The reimbursement has not yet been calculated; therefore, a placeholder in the amount of $89,348,000 is estimated for FY 2016-17.

(Dollars in Thousands)	**FY 2015-16**	**FY 2016-17**
Year 4 Reimbursement from DPHs	$89,348	$0
Year 5 Reimbursement from DPHs	$0	$89,348
Total Reimbursement	$89,348	$89,348
GF	($89,348)	($89,348)
Net Impact	**$0**	**$0**

Funding:
Reimbursement (4260-610-0995)
100% State GF (4260-101-1001)

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	7/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1782

	FY 2015-16	FY 2016-17
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 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 130 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:
FY 2015-16 estimates have changed due to updated tax revenues based on managed care premiums. No tax revenue has been assumed in FY 2016-17, however, due to a one quarter payment lag, some FY 2015-16 dollars are identified in FY 2016-17.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 129

Methodology:

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

2. The FY 2015-16 premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue. This policy change does not assume a FY 2016-17 tax.

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 2015-16	**$0**	**($542,935)**	**$542,935**
FY 2016-17	**$0**	**($132,164)**	**$132,164**

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:	130
IMPLEMENTATION DATE:	7/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1783

	FY 2015-16	FY 2016-17
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 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 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:
FY 2015-16 estimates have changed due to updated tax revenues based on managed care premiums. No tax revenue has been assumed in FY 2016-17, however, due to a one quarter payment lag, some FY 2015-16 dollars are identified in FY 2016-17.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 130

Methodology:

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

2. The FY 2015-16 premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue. This policy change does not assume a FY 2016-17 tax.

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 2015-16	**$0**	**($1,005,223)**	**$1,005,223**
FY 2016-17	**$0**	**($160,134)**	**$160,134**

Funding:

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

FORMER AGNEWS' BENEFICIARIES RECOUPMENT

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	1/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1935

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$5,687,000	$0
- STATE FUNDS	-$2,843,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$5,687,000	$0
STATE FUNDS	-$2,843,500	$0
FEDERAL FUNDS	-$2,843,500	$0

DESCRIPTION

Purpose:
This policy change estimates the recoupment of supplemental payments for the former Agnew beneficiaries who have transitioned into managed care plans.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
Between July 2007 and April 2009, a total of 327 residents of the Agnews Development Center were transitioned by the California Department of Developmental Services (CDDS) from residence in the Agnews Developmental Center to living arrangements in the community.

Pursuant to the Agnews Closure Plan, the Department developed agreements with Health Plan of San Mateo, Santa Clara Family Health Plan and Alameda Alliance for Health to accept Agnews beneficiaries who chose to enroll in managed care. These three plans received a supplemental payment in excess of the regular capitation rates for each of the Agnews beneficiaries.

In December 2010, the Department implemented capitation rates for Agnews beneficiaries retroactively to July 1, 2008 for the Health Plan of San Mateo and January 1, 2008 for Santa Clara Family Health Plan and the Alameda Alliance for Health. The capitation payment for these beneficiaries was originally based on the capitation rate for the beneficiary's assigned aid code and then a supplemental payment was made for the remainder of the Agnews rate.

Although this process was necessary when these beneficiaries were new to managed care, over time, their costs have been included into the plans' regular capitation rates and the supplemental payment was no longer necessary. The Department has proposed recoupment of the supplemental payments.

FORMER AGNEWS' BENEFICIARIES RECOUPMENT

REGULAR POLICY CHANGE NUMBER: 131

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

Methodology:

1. Actuaries from the Department determined the overlap of reported data for rate development purposes began for rate years in FY 2012-13.

2. Agnews supplemental payments to plans beginning July 1, 2012 (Health Plan of San Mateo) and October 1, 2012 (Santa Clara Family Health Plan and Alameda Alliance for Health) were extracted from plan payment data and summarized.

3. Total recoupment to date is $5,687,000.

4. Recoupment is expected to occur in FY 2015-16 only, beginning January 2016. Ongoing Agnews' supplemental payments have been discontinued.

FY 2015-16	TF	GF	FF
Alameda Alliance for Health	($1,339,000)	($669,500)	($669,500)
Health Plan of San Mateo	($789,000)	($394,500)	($394,500)
Santa Clara Family Health Plan	($3,559,000)	($1,779,500)	($1,779,500)
Total	**($5,687,000)**	**($2,843,500)**	**($2,843,500)**

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

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER:	132
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1641

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$6,783,616,000	-$7,716,973,000
- STATE FUNDS	-$3,391,808,000	-$3,858,486,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	91.81 %	84.68 %
APPLIED TO BASE		
TOTAL FUNDS	-$555,578,200	-$1,182,240,300
STATE FUNDS	-$277,789,080	-$591,120,130
FEDERAL FUNDS	-$277,789,080	-$591,120,130

DESCRIPTION

Purpose:
This policy change estimates the savings from transitioning dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries from fee-for-service (FFS) into Medi-Cal managed care health plans for their Medi-Cal Long-Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 109 CCI-Transfer of IHSS Costs to CDSS
PC 108 CCI-Managed Care Payments
PC 193 CCI-Transfer of IHSS Costs to DHCS
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolled dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 132

The CCI was implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The transitions and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS.

Reason for Change from Prior Estimate:
Opt-In enrollment percentages were updated based on data as of July 2015. Caseload data was updated based on actuals through April 2015. In addition, the FY 2015-16 and 2016-17 capitation rates for the CMC, non-CMC, and nondual populations were updated.

Methodology:

1. Dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional FFS model were passively enrolled into the CCI no later than January 1, 2015, except for Orange. Orange began August 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Dual eligibles in Medicare Advantage (MA) plans that are also CMC plans passively enrolled into the CCI on January 1, 2015, except for Orange. Orange began August 1, 2015. There is no phase-in assumed for this population.

3. Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) had their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange. Orange began August 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. In FY 2015-16, the Department estimates 1,291,651 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,291,651 average monthly beneficiaries, it is estimated 1,014,785 will be enrolled in a managed care plan.

5. In FY 2016-17, the Department estimates 1,318,044 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,318,044 average monthly beneficiaries, it is estimated 1,093,886 will be enrolled in a managed care plan.

6. Assume for participating dual eligibles, there will an overall average 2.31% savings in FY 2015-16 and 4.35% in FY 2016-17.

7. The Department performs reconciliation of IHSS category of service to actual IHSS expenditures paid out to providers by CDSS for the same quarter. The Department will determine the appropriate amount of reimbursement during reconciliation which will identify IHSS over/underpayments to CDSS or the managed care plans. Reconciliation will be operationalized in the capitated payment system in January 2016.

8. The Department re-casted capitation rates for plans participating in the CCI for full-benefit dual eligible beneficiaries. Preliminary data suggests the department will recoup the difference between the paid capitation rate and the re-casted rate from plans participating in CCI. The recoupment of payments in excess of plans re-casted capitation payments is for the period of April 2014 through December 2014. The recasts will continue to occur through the CCI demonstration period, which ends December 31, 2017. The Department anticipates recoupments beginning in April 2016.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 132

9. Estimated below is the overall impact of the CCI demonstration in FY 2015-16 and FY 2016-17.

(Dollars in Thousands)

FY 2015-16	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$9,889,062	$4,944,531	$4,944,531	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($6,783,616)	($3,391,808)	($3,391,808)	$0
Defer Managed Care Payment	($175,840)	($87,920)	($87,920)	$0
Total	**($6,959,456)**	**($3,479,728)**	**($3,479,728)**	**$0**
IHSS FFS Savings (In the Base)	($1,114,753)	$0	($1,114,753)	$0
Delay 1 Checkwrite (In the Base)	$24,401	$12,201	$12,201	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,114,753)	$0	$1,114,753
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,307,539	$0	$0	$2,307,539
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$29,062	$14,406	$14,657	$0
CCI IHSS Reconciliation (PC 173)	$60,000	$0	$60,000	$0
Retro MC Rate Adjustments (PC 133)	$198,881	($18,060)	($18,060)	$235,000
Total of CCI PCs including pass through	$4,434,737	$358,596	$418,847	$3,657,293

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$10,319,468	$5,159,734	$5,159,734	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($7,716,973)	($3,858,487)	($3,858,487)	$0
Defer Managed Care Payment	$1,708	$854	$854	$0
Total	**($7,715,265)**	**($3,857,633)**	**($3,857,633)**	**$0**
IHSS FFS Savings (In the Base)	($1,196,798)	$0	($1,196,798)	$0
Delay 1 Checkwrite (In the Base)	$6,872	$3,436	$3,436	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,196,798)	$0	$1,196,798
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,477,372	$0	$0	$2,477,372
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$19,823	$9,912	$9,912	$0
Retro MC Rate Adjustments (PC 133)	($428,219)	($214,110)	($214,110)	$0
Total of CCI PCs including pass through	$3,483,252	($95,459)	($95,459)	$3,674,170

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

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	1/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1788

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$1,094,480,000	-$3,510,424,000
- STATE FUNDS	$216,940,500	-$218,680,380
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,094,480,000	-$3,510,424,000
STATE FUNDS	$216,940,500	-$218,680,380
FEDERAL FUNDS	-$1,311,420,500	-$3,291,743,620

DESCRIPTION

Purpose:
This policy change estimates retroactive managed care capitation rate adjustments.

Authority:
Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:
Not applicable

Background:
Retroactive rate adjustments are due to the delay in implementation of the managed care FY 2015-16 rates. Additionally, this policy change also includes the California Department of Social Services (CDSS) Coordinated Care Initiative (CCI) calendar year 2014 In-Home Supportive Services (IHSS) reconciliation and the Affordable Care Act (ACA) Optional Expansion recoupment for the January-June 2015 rates.

Reason for Change from Prior Estimate:
This policy change includes rate adjustments for the FY 2015-16 base rates, the CCI IHSS reconciliation and CY 2014 recasting for full duals, the recoupment for the ACA Optional Expansion January-June 2015 rates, the MLK recoupment, and the primary care physician (PCP) retro adjustment.

Methodology:
1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2015-16 and FY 2016-17.

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 133

(Dollars in Thousands)

FY 2015-16	TF	GF	FF	Reimbursement
Retro Payments	$0	$0	$0	$0
CDSS Reconciliation	$235,000	$0	$0	$235,000
CCI Recast Recoupment	($36,119)	($18,060)	($18,060)	$0
ACA Optional Recoupment	($1,293,361)	$0	($1,293,361)	$0
Total FY 2015-16	**($1,094,480)**	**($18,060)**	**($1,311,421)**	**$235,000**

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Retro Payments	$26,015	$6,767	$19,248
MLK Recoupment	($8,476)	$0	($8,476)
CCI Recast Recoupment	($428,219)	($214,110)	($214,110)
ACA Optional Recoupment	($3,077,069)	$0	($3,077,069)
AB 97 Recoupment	($22,675)	($11,338)	($11,338)
Total FY 2016-17	**($3,510,424)**	**($218,680)**	**($3,291,744)**

Funding:
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
100% Title XIX Federal Share Only (4260-101-0890)
90% Family Planning / 10% GF (4260-101-0001/0890)
100% Reimbursement GF (4260-610-0995)

MEDICARE PART B PREMIUM INCREASE

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	1/2016
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1939

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$152,212,000	$356,916,000
- STATE FUNDS	$85,276,500	$199,962,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$152,212,000	$356,916,000
STATE FUNDS	$85,276,500	$199,962,500
FEDERAL FUNDS	$66,935,500	$156,953,500

DESCRIPTION

Purpose:
This policy change estimates the additional Medicare Part B Premium Increase expected in Calendar Year 2016 and 2017.

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

Interdependent Policy Changes:
Not Applicable

Background:
This policy change estimates the Medicare Part B premium increase for Part B dual eligibles (those Medi-Cal eligibles who also eligible for Medicare Part B). For these dual eligibles, Medi-Cal pays the full Part B premium. The Medicare Part B premium is determined by the Centers for Medicare and Medicaid (CMS) and is based on the projected increase in expenditures for Medicare Part B. While approximately 75% of the expenditures are paid by the federal general revenues, the other 25 percent is paid by the monthly premiums.

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

Methodology:

1. Social Security benefits are not expected to receive a Cost-of-Living Adjustment (COLA) in 2016. This triggers the Part B 'hold harmless, provision where approximately 30% of the Part B population will bear the full cost of the Part B cost increase.

2. Without a Social Security COLA, the 2016 Medicare Part B premium was estimated to be $159.30 per month. The Bipartisan Budget Act of 2015 changed the premium to $121.80 ($118.80 premium plus the $3.00 monthly surcharge).

MEDICARE PART B PREMIUM INCREASE

REGULAR POLICY CHANGE NUMBER: 134

3. The 2017 premium is estimated to be $126.96 and assumes a 4.35% growth, an average growth experienced in 2007 – 2013 absent the no COLA and no growth years. $118.80 x 1.0435 = $123.96 + $3.00 monthly surcharge = $126.96.

Year	Premium	% Increase
2007	$ 93.50	**5.65%**
2008	$ 96.40	**3.10%**
2012	$ 99.90	**3.63%**
2013	$ 104.90	**5.01%**
	Average	**4.35%**

4. The estimated expenditures due to the increase in the Medicare Part B Premium are:

Fiscal Year	Total Funds
2015-16	$ 152,212,000
2015-17	$ 356,916,000

Funding:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FF**
100% GF (4260-101-0001)	$20,746	$20,746	$0
100% Title XIX (4260-101-0890)	$2,405	$0	$2,405
50% Title XIX / 50% GF (4260-101-0001/0890)	$129,061	$64,530	$64,531
Total	**$152,212**	**$85,276**	**$66,935**

FY 2016-17	**TF**	**GF**	**FF**
100% GF (4260-101-0001)	$48,648	$48,648	$0
100% Title XIX (4260-101-0890)	$5,639	$0	$5,639
50% Title XIX / 50% GF (4260-101-0001/0890)	$302,629	$151,314	$151,315
Total	**$356,916**	**$199,962**	**$156,954**

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1185

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$252,417,000	$0
- STATE FUNDS	$103,750,800	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$252,417,000	$0
STATE FUNDS	$103,750,800	$0
FEDERAL FUNDS	$148,666,200	$0

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to dental managed care and Fee-for-Service rates impacting prior fiscal years.

Authority:
Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:
Not Applicable

Background:
The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in Denti-Cal or a prepaid health plan and to implement the new annual rates through an amendment or change order to the contract.

In the event there is any delay in a determination of rate changes, the amendment or change order may not be processed in time to permit payment of new rates commencing July 1. The payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

In August 2012, the Department terminated their contracts with one of the plans due to the plan's inability to maintain the requirements of their Knox Keene license. The Department also terminated their contracts with another plan which planned to cease operations effective June 1, 2012. The Department determined of the estimated $1.179 million owed, $879,000 has been collected. The remaining balance of $300,000 is still outstanding. Additionally, this amount may be uncollectable based on the financial status of the plan.

Reason for Change from Prior Estimate:
There are two changes: 1) changes due to updated monthly eligibles and existing rates, and 2) delays with the approval of change order (CO) 25 caused payments to shift from FY 2014-15 to FY 2015-16.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 135

Methodology:

1. Assume the retroactive rate adjustment from CO 25 and CO 26 will be made in FY 2015-16.

GMC and PHP Dental Rate Period	**Existing Rate**	**New Rate**	**Change**	**Eligible Months**	**Dental Retro Rate Adjustment**
GMC <21					
07/01/2014 – 06/30/2015	$11.05	$11.45	$0.40	2,548,637	$1,019,000
21+					
07/01/2014 – 06/30/2015	$7.71	$8.42	$0.71	1,791,030	$1,272,000
PHP <21					
07/01/2014 – 06/30/2015	$12.76	$12.95	$0.19	3,791,604	$720,000
21+					
07/01/2014 – 06/30/2015	$8.39	$7.80	($0.59)	1,922,511	($1,134,000)
Total Dental Retroactive Adjustments for GMC and PHP (CO 26)					$1,877,000

Delta Dental Rate Period	**Existing Rate**	**New Rate**	**Change**	**Eligible Months**	**Dental Retro Rate Adjustment**
Regular					
07/01/2014 – 06/30/2015	$7.41	$7.81	$0.40	120,578,005	$48,231,000
Refugees					
07/01/2014 – 06/30/2015	$6.90	$5.81	($1.09)	19,439	($21,000)
Total Dental Retroactive Adjustments for Delta Dental (CO 26)					$48,210,000

FY 2015-16 (cash basis)	**Dental Retro Rate Adjustment**
Total Dental Retroactive Payments for FY 2013-14 (CO 25*)	$964,000
Total Dental Retroactive Payments for FY 2014-15 (CO 25*)	$201,366,000
Total Dental Retroactive Payments for FY 2014-15 (CO 26)	$50,087,000
Total FY 2015-16	**$252,417,000**

*Amounts included in the change order documents.

Funding:

FY 2015-16		**TF**	**GF**
50%Title XIX / 50% GF	4260-101-0001/0890	$199,263,000	$99,631,000
65%Title XXI / 35% GF	4260-101-0001/0890	$5,802,000	$2,031,000
88%Title XXI / 12% GF	4260-101-0001/0890	$17,405,000	$2,089,000
100% Title XIX Federal Share	4260-101-0890	$29,947,000	$0
Total		**$252,417,000**	**$103,751,000**

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	7/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1329

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$243,261,000	$218,617,000
- STATE FUNDS	$121,630,500	$109,308,500
PAYMENT LAG	0.9805	0.9902
% REFLECTED IN BASE	0.49 %	0.56 %
APPLIED TO BASE		
TOTAL FUNDS	$237,348,700	$215,262,300
STATE FUNDS	$118,674,340	$107,631,150
FEDERAL FUNDS	$118,674,340	$107,631,150

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRCs) after a reconciliation audit has been completed.

Authority:
Welfare & Institutions Code, section 14170

Interdependent Policy Changes:
Not Applicable

Background:
For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, an interim rate is established and paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a final settlement with the clinic.

CBRCs, owned or operated by Los Angeles County, are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The FY 2010-11 audited levels were used to update the CBRC rates as of July 1, 2015. The Department is scheduled to complete the CBRC reconciliation audit for FY 2011-12 in FY 2015-16 and will complete FY 2012-13 in FY 2016-17. Interim rates will be adjusted to the FY 2011-12 audited levels beginning in FY 2015-16, and to the FY 2012-13 audited levels in FY 2016-17.

Interim rates are estimated and based on historical data. The clinics submit a reconciliation report annually to settle the cost of the wrap payments. The variance between the wrap payments and the interim payments is the clinic's settlement payment, which the Department pays in cash after a final reconciliation.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 136

Currently, there are 954 active FQHCs, 346 active RHCs and 29 active CBRCs.

Reason for Change from Prior Estimate:
A decrease in staff resulted in fewer completed reconciliations in FY 2015-16. LA CBRC rate increases were adjusted for FYs 2015-16 and FY 2016-17.

Methodology:

1. FY 2015-16 reconciliations are estimated on a three-year average and actuals from July 2013 through June 2015. FY 2016-17 reconciliations are also estimated on a three-year average and based on actuals from July 2014 through June 2016.

2. The estimate FQHC retroactive rate adjustment for FY 2015-16 of $48,710,000 and $56,785,000 for FY 2016-17 is based on a three year average of the previous year's Erroneous Payment Corrections (EPC) that have been implemented and paid. The three-year average is calculated by summing the number of EPCs for FY 2013-14, 2014-15, and 2015-16. Currently, the fiscal intermediary processes EPCs quarterly.

3. The FY 2015-16 LA CBRC reconciliation is based on the settlement of 91.2% of 2011 audited settlements, while the FY 2016-17 reconciliation is based on settlement of 95% of the 2012 reported settlements. Based on reported costs for fiscal years 2007-2015, reconciliations are expected to increase by 5.13% thereafter.

   Hospital closures and/or ancillary facilities no longer utilizing the hospitals' PPS rate may have attributed to the LA CBRC reconciliation decrease between FY 2015-16 and FY 2016-17.

4. The July 1, 2015 CBRC rate increase of $34,457,000 is based on the 2011 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2014-15. The estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary Reports for FY 2014-15.

5. The July 1, 2016 CBRC rate increase of $15,458,000 is based on the 2011 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2014-15. The estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary reports for FY 2014-15.

(Dollars in Thousands)	**FY 2015-16**	**FY 2016-17**
FQHCs Reconciliation	$89,213	$75,481
RHCs Reconciliation	$13,278	$10,933
FQHC Retroactive Rate Adjustment	$48,710	$56,785
LA CBRCs Reconciliation	$57,603	$25,503
July 2015 LA CBRC Rate Increase	$34,457	$34,457
July 2016 LA CBRC Rate Increase	$0	$15,458
Total	**$243,261**	**$218,617**

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	4/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1563

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$88,137,000	$88,137,000
- STATE FUNDS	$44,068,500	$44,068,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$88,137,000	$88,137,000
STATE FUNDS	$44,068,500	$44,068,500
FEDERAL FUNDS	$44,068,500	$44,068,500

DESCRIPTION

Purpose:
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding nursing facilities (NF-Bs) through the Special Fund.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for NF-Bs. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years, and also extended quality assurance fee (QAF) and the QASP at the 1% level until July 31, 2015.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change from Prior Estimate:
Updated CDPH administrative costs to reflect actual expenditures.

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. The estimated incoming funds for the Special Fund are:

	FY 2015-16	FY 2016-17
Penalties on Nursing Facilities	$600,000	$600,000
AB 1629 QAF Set Aside	$43,236,000	$43,236,000
PLI savings	$5,692,000	$5,692,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments will be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH annual administrative costs are $7,120,000 TF ($3,560,000 Special Fund) for FY 2015-16 and $7,120,000 TF ($3,560,000 Special Fund) for FY 2016-17.

5. The QASP will continue at FY 2014-15 levels, $90 million total funds, instead of setting aside a portion of the annual increase.

6. Supplemental payments are:

(Dollars in Thousands)

FY 2015-16	TF	GF	SF	FF
Supplemental Payments***	$88,137	$0	$44,068	$44,068
Transfer from GF* to Special Fund**	$0	$48,928	($48,928)	$0
Total	**$88,137**	**$48,928**	**($4,860)**	**$44,068**
FY 2016-17	**TF**	**GF**	**SF**	**FF**
Supplemental Payments***	$88,137	$0	$44,068	$44,068
Transfer from GF* to Special Fund**	$0	$48,928	($48,928)	$0
Total	**$88,137**	**$48,928**	**($4,860)**	**$44,068**

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

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Funding:
100% GF (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	8/2007
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1046

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$53,794,000	$109,161,000
- STATE FUNDS	$26,897,000	$54,580,500
PAYMENT LAG	0.8515	0.9763
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,805,600	$106,573,900
STATE FUNDS	$22,902,800	$53,286,940
FEDERAL FUNDS	$22,902,800	$53,286,940

DESCRIPTION

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part (DP) Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding (FS) Pediatric Subacute facilities. It also estimates the additional reimbursement for the projected Medi-Cal costs of complying with new State or federal mandates, referred to as “add-ons.”

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)
AB 119 (Chapter 17, Statutes of 2015)

Interdependent Policy Changes:
PC 146 Non-AB 1629 LTC Rate Freeze
PC 189 Funding Adjust.—ACA Opt. Expansion
PC 190 Funding Adjust.—OTLICP

Background:
Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

LTC RATE ADJUSTMENT

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Effective June 1, 2011, AB 97 requires the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, AB 97 extends this requirement to the other long term care facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and rate freeze at the 2008-2009 rate level, required by AB 97, with respect to DP/NF-Bs. On December 28, 2011, the federal court issued a preliminary injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. The Department will implement the AB 97 payment reduction and rate freeze retroactive to June 1, 2011. Due to access concern, on December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels in addition to the 10% payment reduction, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and 10% payment reduction, effective October 1, 2013.

Effective September 1, 2013, Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas are exempted from the rate freeze.

The Department also received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses.

Reason for Change from Prior Estimate:

- Updated rate information
- Delay in 2015-16 rate implementation
- Costs of add-ons implemented prior to FY 2015-16 are 100% in the base expenditures estimate and no longer budgeted in this policy change

Methodology:

1. Effective date for rate adjustments begins August 1. Implementation dates for 2015-16 and 2016-17 rates are November 1, 2015 and September 1, 2016, respectively.

2. Payments in FY 2015-16 include retroactive payments for 2013-14 and 2014-15. Retroactive payments for 2015-16 and 2016-17 will be paid in FY 2016-17.

3. No rate increase is assumed for NF-As, Rural Swing Beds that are not in a DP/NF-B located in a designated rural and frontier area, and FS Pediatric Subacute facilities during rate years (RYs) 2015-16 and 2016-17.

LTC RATE ADJUSTMENT

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4. The add-ons are negotiated on an annual basis and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are budgeted separately, as they will take two years to be reflected in the regular facility specific reimbursement rates, except for DP Adult Subacute where it will take three years to be reflected in their rates.

5. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze.

6. **DP Adult Subacute and DP Pediatric Subacute facilities**: These two facilities will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for these two facilities would negatively impact access to care. Therefore, the Department will be increasing reimbursement rates for these facility types under the "normal" rate setting process.

7. **DP/NF-B facilities:** The impact of implementation of rate freeze and exemption is budgeted in the Non-AB 1629 LTC Rate Freeze policy change.

8. **Rural Swing Bed Rates:** The impact of the implementation of the rate freeze and exemption for Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas is budgeted in the Non-AB 1629 LTC Rate Freeze policy change.

9. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities:** The Department implemented the 2014-15 final rate on June 22, 2015.

10. ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee (QAF) beginning January 1, 2012. Effective October 1, 2011, the QA fee cap is 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

11. AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020.

12. The estimated costs of managed care rate increase for FY 2015-16 and FY 2016-17 are already included in the FY 2015-16 and FY 2016-17 managed care capitation rates, respectively.

LTC RATE ADJUSTMENT

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13. The add-on descriptions are listed below:

Add-On	RY 2015-16	RY 2016-17
FUTA – 2014-15: Effective August 1, 2014, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.	$0.11 - $0.30	
FUTA – 2015-16: Effective August 1, 2015, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.	$0.11 - $0.15	$0.11
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.		$0.11
Minimum wage: Effective July 1, 2014, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour.	$0.07 - $6.07	$0.07 - $7.41
ACA employer mandate: Effective January 1, 2015, the ACA Employer Mandate requires Skilled Nursing Facility employers to offer health care coverage to 70% of their full time employees in 2015 and 95% in 2016 and beyond.	$2.34 - $6.51	$2.34
Paid sick leave: Effective July 1, 2015, AB 1522 (Chapter 317, Statutes of 2014) requires employers to provide employees paid sick days of no less than one hour for every 30 hours worked. Employees are limited to using 24 hours of sick leave during each year of employment.	$1.72 - $4.17	$1.72
ACA reporting requirements: Effective January 1, 2015, the United States Department of Health and Human Services issued regulations pursuant to the ACA, mandating new reporting requirements for monthly tracking of employee health insurance coverage.	$0.43 - $0.62	$0.54
International Classification of Disease, 10th Revision (ICD-10) transition: Effective October 1, 2015, the U.S. Department of Health and Human Services requires all providers covered by the Health Insurance Portability and Accountability Act (HIPAA) to start using the more specific ICD-10 for coding diseases, injuries, impairments, and health care encounter data. This one-time add-on reimburses long-term care facilities for preparation costs to transition from ICD-9 to ICD-10.	$0.47 - $0.71	

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 138

14. The LTC add-ons are included in the rate adjustment costs and are no longer displayed separately. The costs below reflect the incremental rate adjustments for each facility type.

Fee-for-Service	**FY 2015-16**	**FY 2016-17**
Rate Adjustment (15-16)		
DP/NF-B	$16,381,000	$24,571,000
Rural Swing Beds (non-exempt)	$15,000	$22,000
Rural Swing Beds (exempt)	$54,000	$81,000
DP Adult Subacute	$2,524,000	$3,785,000
NF-A	$339,000	$509,000
ICF/DDs	$28,355,000	$42,533,000
DP Pediatric Subacute	$679,000	$1,018,000
FS Pediatric Subacute	$92,000	$277,000
Rate Adjustment (16-17)		
DP/NF-B	$0	$9,045,000
Rural Swing Beds (non-exempt)	$0	($1,000)
Rural Swing Beds (exempt)	$0	$46,000
DP Adult Subacute	$0	$1,349,000
NF-A	$0	$35,000
ICF/DDs	$0	$5,356,000
DP Pediatric Subacute	$0	$613,000
FS Pediatric Subacute	$0	($12,000)
Retro Rate Adjustments		
DP/NF-B	($2,072,000)	$7,047,000
Rural Swing Beds (non-exempt)	$0	$5,000
Rural Swing Beds (exempt)	$0	$25,000
DP Adult Subacute	$1,152,000	$1,081,000
NF-A	$56,000	$131,000
ICF/DDs	$5,656,000	$11,169,000
DP Pediatric Subacute	$564,000	$316,000
FS Pediatric Subacute	$0	$160,000
Total FFS	$53,794,000	$109,161,000
Managed care	$0	$0
Total Cost	**$53,794,000**	**$109,161,000**

Funding:
50% Title XIX / 50% Title GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	8/2014
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1508

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$102,083,000	$251,005,000
- STATE FUNDS	$51,041,500	$125,502,500
PAYMENT LAG	0.8152	0.9635
% REFLECTED IN BASE	42.73 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$47,659,000	$241,843,300
STATE FUNDS	$23,829,490	$120,921,660
FEDERAL FUNDS	$23,829,490	$120,921,660

DESCRIPTION

Purpose:
This policy change estimates the cost of the AB 1629 rate increases and add-ons for freestanding skilled nursing facilities (NF-Bs), which is partially funded by the Quality Assurance Fee (QAF).

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1489 (Chapter 631, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)

Interdependent Policy Changes:
PC 189 Funding Adjust.—ACA Opt. Expansion
PC 190 Funding Adjust.—OTLICP

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on NF-Bs, including adult and pediatric subacute facilities. The QAF is used to offset the GF portion of the reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

To determine the QAF amount assessed to these facilities, the Department uses two-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is 6%, effective October 1, 2011. Changes in the amount of licensing and certification fees for NF-Bs, assessed by the California Department of Public Health (CDPH), affect the amount of QAF that can be collected in order to remain within the federal safe harbor limit.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 139

The rate methodology provides for facility-specific cost-based per diem payments for AB 1629 facilities based upon allowable audited costs and additional reimbursement for the projected Medi-Cal cost of complying with new state or federal mandates, referred to as "add-ons." The AB 1629 program add-ons are negotiated on an annual basis, and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific per-diem rates. These new mandated costs are budgeted for separately, as it will take two years to be reflected in the regular facility specific reimbursementrates.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the QAF collections will be deposited directly into the fund, rather than the state General Fund (GF), and will be used to offset provider reimbursement rate expenditures. AB 1489 implemented a 3% increase to the weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payments program (QASP) for freestanding nursing facilities (NF-Bs). The QASP will be tied to demonstrated quality of care improvements and paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2013-14 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning rate-year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

Reason for Change from Prior Estimate:

- Updated program expenditures.
- FY 2015-16 includes the rate year (RY) 2014-15 retroactive payment.
- Delay in RY 2015-16 implementation.
- **Add-ons**: AB 1629 add-ons previously budgeted in the AB 1629 Add-Ons policy change (PC 141) in the May 2015 estimate are now included in this policy change. In addition, other add-on changes from the prior estimate include:
    - Costs of add-ons implemented prior to FY 2015-16 are 100% in the base expenditures estimate and no longer budgeted in this policy change.
    - Inclusion of the following new add-ons:
        1) Federal Unemployment Tax Act (FUTA) 2014-15
        2) Affordable Care Act (ACA) reporting requirements
        3) International Classification of Disease, 10th Revision (ICD-10) transition

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 139

Methodology:

1. The effective date for the rate increase and add-ons is August 1st.

2. The 2014-15 final rates were implemented April 2015. The 2014-15 retroactive rate payment that covered August 1, 2014 to March 31, 2015 was implemented in July 2015.

3. Assume a 3.62% rate increase for the 2015-16 rate year, and a 3.62% rate increase for the 2016-17 rate year.

4. The 2015-16 interim rates will be implemented November 1, 2015 and the 2015-16 final rates will be implemented February 2016. The 2015-16 retroactive rate payment will cover August 2015 to January 2016 and will be implemented in July 2016.

5. The 2016-17 rates will be implemented on August 1, 2016.

6. The estimated managed care rate adjustment impact for RYs 2015-16 and 2016-17 are already included in the FY 2015-16 and FY 2016-17 managed care capitation rates, respectively.

7. The add-on descriptions are listed below:

Add-On	RY 2015-16	RY 2016-17
FUTA – 2014-15*: Effective August 1, 2014, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.	$0.22	
FUTA – 2015-16: Effective August 1, 2015, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.	$0.11	$0.11
FUTA – 2016-17: Effective August 1, 2016, the FUTA add-on increases annually and provides long term care facilities FUTA tax credit.		$0.11
Minimum wage: Effective July 1, 2014, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour.	$0.27	$0.35
ACA employer mandate: Effective January 1, 2015, the ACA Employer Mandate requires Skilled Nursing Facility employers to offer health care coverage to 70% of their full time employees in 2015 and 95% in 2016 and beyond.	$2.34	$2.34
Paid sick leave: Effective July 1, 2015, AB 1522 (Chapter 317, Statutes of 2014) requires employers to provide employees paid sick days of no less than one hour for every 30 hours worked. Employees are limited to using 24 hours of sick leave during each year of employment.	$1.72	$1.72
ACA reporting requirements: Effective January 1, 2015, the United States Department of Health and Human Services issued regulations pursuant to the ACA, mandating new reporting requirements for monthly tracking of employee health insurance coverage.	$0.54	$0.54
International Classification of Disease, 10th Revision (ICD-10) transition: Effective October 1, 2015, the U.S. Department of Health and Human Services requires all providers covered by the Health Insurance Portability and Accountability Act (HIPAA) to start using the more specific ICD-10 for coding diseases, injuries, impairments, and health care encounter data. This one-time add-on reimburses long-term care facilities for preparation costs to transition from ICD-9 to ICD-10.	$0.50	

*FUTA - 2014-15 implementation was delayed from FY 2014-15 to FY 2015-16

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 139

8. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FFP**
FFS (Rate Increase)	$31,354	$15,677	$15,677
RY 2014-15 Retro	$35,557	$17,779	$17,779
Add-Ons	$35,172	$17,586	$17,586
Managed Care	$0	$0	$0
Total*	**$102,083**	**$51,042**	**$51,042**
FY 2016-17	**TF**	**GF**	**FFP**
FFS (Rate Increase)	$116,059	$58,030	$58,030
RY 2015-16 Retro	$44,291	$22,146	$22,146
Add-Ons	$90,655	$45,328	$45,328
Managed Care	$0	$0	$0
Total*	**$251,005**	**$125,503**	**$125,503**

*Totals may differ due to rounding.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1612

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$19,700,000	$13,000,000
- STATE FUNDS	$9,850,000	$6,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,700,000	$13,000,000
STATE FUNDS	$9,850,000	$6,500,000
FEDERAL FUNDS	$9,850,000	$6,500,000

DESCRIPTION

Purpose:
This policy change estimates the Fee-for-Service (FFS) augmentation payments and the offset of General Fund (GF) of the Medi-Cal reimbursement rate for emergency medical air transportation services.

Authority:
AB 2173 (Chapter 547, Statutes of 2010), Government Code 76000.10
AB 215 (Chapter 392, Statutes of 2011)
SB 326 (Chapter 797, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2173 imposed an additional penalty of $4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill required the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Medical Air Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds will be used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund will be matched with federal funds and used to augment the rate for Medi-Cal emergency medical air transportation services.

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EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 140

SB 326 extended the sunset date for the assessment of penalties to January 1, 2018. Penalties assessed before this date will continue to be collected and administered, and augmentation payments will be made until June 30, 2019. EMATA has been extended to expire on January 1, 2020.

Reason for Change from Prior Estimate:

- Revised penalty collections.
- GF transfer from the first half of FY 2015-16 collections will be made in FY 2015-16.

Methodology:

1. Implementation date began November 2012.

2. FY 2015-16 estimated payments include:
   - FFS augmentation payments based on fees collected from the second half of FY 2014-15 and the first half of FY 2015-16.
   - GF transfer from the FY 2014-15 collections of $1.75 million.
   - GF transfer from the first half of FY 2015-16 collections of $1 million.

3. The FY 2016-17 estimated payments incorporate the impact from the SB 326 extension of the EMATA fund and include:
   - FFS augmentation payments based on fees collected from the second half of FY 2015-16 and the first half of FY 2016-17.
   - GF transfer from the second half of FY 2015-16 collections of $1 million.
   - GF transfer from the first half of FY 2016-17 collections of $1 million.

4. Based on estimated fee collections, the estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**EMATA**	**FFP**
GF Offset	$0	($2,750)	$2,750	$0
Fee-For-Service	$19,700	$0	$9,850	$9,850
Total	**$19,700**	**($2,750)**	**$12,600**	**$9,850**
FY 2016-17	**TF**	**GF**	**EMATA**	**FFP**
GF Offset	$0	($2,000)	$2,000	$0
Fee-For-Service	$13,000	$0	$6,500	$6,500
Total	**$13,000**	**($2,000)**	**$8,500**	**$6,500**

Funding:

100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA Fund (4260-101-3168)

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	10/2005
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	88

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$26,199,000	$27,153,000
- STATE FUNDS	$10,063,000	$10,429,500
PAYMENT LAG	0.9189	0.9192
% REFLECTED IN BASE	55.31 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,758,800	$24,959,000
STATE FUNDS	$4,132,440	$9,586,800
FEDERAL FUNDS	$6,626,350	$15,372,240

DESCRIPTION

Purpose:
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:
Section 1833 of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:
Costs increased due to changes in the Medi-Cal caseload, which increased the estimated number of FQHC/RHC visits in FY 2015-16 and FY 2016-17.

Methodology:
1. The projected visits are based on the average percent increase of the last 3 years actual visit counts.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 141

2. The annual MEI increase will be used as a trend factor to calculate the estimated cost per visit rate. The MEI increase percent for years 2014 to 2016 is 0.8%.

Rate Year	Projected Visits	Rate without MEI	Rate with MEI
2014	12,269,247	$149.89	$149.89 x (1+0.8%) = $151.09
2015	12,645,852	$151.09	$151.09 x (1+0.8%) = $152.30
2016	12,953,368	$152.30	$152.30 x (1+0.8%) = $153.52

3. The estimated expenditures are the estimated rate multiplied by the estimated visits. The annual expenditures due to MEI increase are:

(Dollars in Thousands)

Rate Year	Expenditures without MEI	Expenditures with MEI	MEI Increase
2014	$1,839,037	$1,853,760	$14,723
2015	$1,910,662	$1,925,963	$15,301
2016	$1,972,798	$1,988,601	$15,803

4. For FY 2015-16, the total MEI increase includes an annualized MEI increase for year 2014 of $14,723,000 and nine months of year 2015 MEI increase of $11,476,000.

5. For FY 2016-17, the total MEI increase includes an annualized MEI increase for year 2015 of $15,301,000 and nine months of year 2016 MEI increase of $11,852,000.

(Dollars in thousands)

FY 2015-16	TF	GF	FF
2014 MEI Increase	$14,723	$5,655	$9,068
2015 MEI Increase	$11,476	$4,408	$7,068
Total	**$26,199**	**$10,063**	**$16,136**

FY 2016-17	TF	GF	FF
2015 MEI Increase	$15,301	$5,877	$9,424
2016 MEI Increase	$11,852	$4,553	$7,299
Total	**$27,153**	**$10,430**	**$16,723**

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

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	10/2006
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	96

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$4,473,000	$9,285,000
- STATE FUNDS	$2,236,500	$4,642,500
PAYMENT LAG	0.7913	0.8898
% REFLECTED IN BASE	7.66 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,268,400	$8,261,800
STATE FUNDS	$1,634,180	$4,130,900
FEDERAL FUNDS	$1,634,180	$4,130,900

DESCRIPTION

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act

Interdependent Policy Changes:
PC 189 Funding Adjust.—ACA Opt. Expansion
PC 190 Funding Adjust.—OTLICP

Background:

1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

2. **Hospice Room and Board**
   The Department ties each hospice facility's room and board rate to 95% of the individual facility's affiliated rates for Nursing Facility – Level B (NF-B), which include Distinct Part (DP) or Freestanding; Nursing Facility – Level A (NF-A); Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 142

Pursuant to ABX4 5 (Chapter 5, Statutes of 2009), hospice room and board rates were frozen to 2008-09 levels for rate years 2009-10 and 2010-11, in those cases where the facility's per-diem rate was frozen. AB 97 (Chapter 3, Statutes of 2011) allows the Department to decide whether to implement further rate freezes and payment reductions for long-term care facilities (LTCs), effective June 1, 2011. The Department removed the rate freeze for certain LTCs.

Subsequently, SB 239 (Chapter 657, Statutes of 2013) required the Department to remove the DP/NF-B providers from the rate freeze and payment reductions on a prospective basis. Hospice room and board rates will increase based on the nursing facility rate increases.

Reason for Change from Prior Estimate:

- Updated hospice rates and expenditure data.
- 100% of FY 2014-15 expenditures are in the base.
- Retroactive recoupment for the 2014-15 hospice service rates was implemented July 2015.
- Retroactive recoupment for the 2015-16 hospice service rates is expected to be implemented April 2016.

Methodology:

1. The estimated weighted increase for hospice service rates for FY 2015-16 and FY 2016-17 are 2.14% and 2.06% respectively.

2. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP NF-Bs, and Freestanding Pediatric Subacute rates.

   The Department elected to not implement the rate freeze for some LTC facility types based on its access and utilization analyses. CMS approved the Department's request to not implement a rate freeze on DP Adult and Pediatric Subacute rates.

   Effective June 2014, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

   SB 239 (Chapter 657, Statutes of 2013) required the Department to remove prospectively the DP/NF-B providers from the rate freeze and payment reductions.

   Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 142

3. The weighted increase for hospice room and board rates for FY 2015-16 and FY 2016-17 is estimated to be 2.53%.

Cash Basis	FY 2015-16	FY 2016-17
FY 2014-15 - Retroactive Payments	$ 271,000	
FY 2015-16 - Retroactive Payments	$ 501,000	
FY 2015-16 - Hospice Services	$ 1,003,000	$ 2,006,000
FY 2015-16 - Room & Board	$ 2,698,000	$ 2,943,000
FY 2016-17 - Hospice Services		$ 1,568,000
FY 2016-17 - Room & Board		$ 2,768,000
TOTAL	**$ 4,473,000**	**$ 9,285,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 143
IMPLEMENTATION DATE: 7/2016
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1938

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$2,411,000
- STATE FUNDS	$0	$1,205,500
PAYMENT LAG	1.0000	0.8050
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,940,900
STATE FUNDS	$0	$970,430
FEDERAL FUNDS	$0	$970,430

DESCRIPTION

Purpose:
This policy change estimates the costs associated with a fee increase for newborn screening provided to Medi-Cal beneficiaries under the Genetic Disease Screening Program (GDSP).

Authority:
AB 1559 (Chapter 565, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1559 (Chapter 565, Statute of 2014) requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide screening of newborns to include screening for adrenoleukodystrophy (ALD) as soon as ALD screening is adopted by the federal Recommended Uniform Screening Panel (RUSP). GDSP expects the federal Discretionary Advisory Committee on Heritable Disorders in Newborns and Children to recommend inclusion of ALD by July 2016.

Once the ALD screening is adopted by the RUSP, GDSP will be required to add ALD to the Newborn Screening Program (NSP) and begin screening all babies in California for the disease. The addition of ALD to the NSP will require an estimated $11 per patient fee increase.

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

Methodology:
1. Effective July 1, 2016, GDSP will implement an $11 fee increase for the Newborn Screening Program.

2. Assume implementation will begin on July 1, 2016.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 143

3. CDPH estimates an annual birth rate of 497,083 babies for FY 2016-17. Approximately 45% of births are from the Medi-Cal population.

4. Assume 98% of claims submitted are paid.

497,083 x 45% x 98% x $11 = $2,411,000 TF (rounded)

5. The estimated costs for **FY 2016-17** on a cash basis are: **$2,411,000 TF** ($1,205,500 GF).

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

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1784

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$31,649,000	$0
- STATE FUNDS	-$31,649,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$31,649,000	$0
STATE FUNDS	-$31,649,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 119 (Chapter 17, Statutes of 2015)

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
AB 1762 (Chapter 230, Statutes of 2003) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA and ICF-DDs fees collected are deposited into the fund, rather than the state General Fund, which are used for LTC provider reimbursement rate expenditures.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 144

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020. Further, beginning rate-year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure to the QASP Program.

Reason for Change from Prior Estimate:
Updated LTC QA fee collection and transfer data.

Methodology:

1. Based on the most recent three years of LTC QA fee collection data, the average annual LTC QA fee revenue on a cash basis is $442,605,000 and the average growth rate is 1.79%.

2. Based on FY 2013-14 and FY 2014-15 actual QA fee transfer data, 89.44% of fee collection is transferred to GF in the current year. Assume the remaining QA fee will be transferred to GF in the next fiscal year.

3. The estimated fund adjustment from the LTCQAF to GF is:

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**LTCQAF**
FY 2014-15	($49,162)	($93,559)	$44,397
FY 2015-16	$17,513	($395,857)	$413,370
Total	**($31,649)**	**($489,416)**	**$457,767**
FY 2016-17	**TF**	**GF**	**LTCQAF**
FY 2015-16	$0	($46,748)	$46,748
FY 2016-17	$0	($402,925)	$402,925
Total	**$0**	**($449,673)**	**$449,673**

Funding:
Long Term Care Quality Assurance Fund (4260-101-3213)
100% General Fund (4260-101-0001)

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	5/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1579

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$13,824,000	-$23,087,000
- STATE FUNDS	-$6,912,000	-$11,543,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	77.66 %	46.50 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,088,300	-$12,351,500
STATE FUNDS	-$1,544,140	-$6,175,770
FEDERAL FUNDS	-$1,544,140	-$6,175,770

DESCRIPTION

Purpose:
This policy change estimates the savings due to the implementation of provider payment reductions applied to nursing and subacute facilities reimbursed under AB 1629 (Chapter 875, Statutes of 2004) reimbursement methodology, Nursing Facility - A (NF-A), Distinct Part Nursing Facility - B (DP/NF-B), Freestanding (FS) Adult Subacute Facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD - Nursing (N), and ICF/DD - Habilitative (H) providers based on AB 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 190 Funding Adjust.—OTLICP

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

Effective June 1, 2011, AB 97 required the Department to reduce payments to long-term care facilities by up to 10% in FFS and the actuarially equivalent of that amount in managed care. However, ABX1 19 required the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% below rate year 2008-09 rates.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 145

Additionally, under ABX1 19, the 10% payment reduction for AB 1629 facilities ended on July 31, 2012. The Department did not implement the 5.75% payment reduction for the Freestanding Pediatric Subacute facilities, because it determined access would be compromised.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97. On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunction. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.

On December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B providers located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B providers from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

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

Reason for Change from Prior Estimate:
Revised DP/NF-B recoupment and schedule based on updated data.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes.

2. **FFS:** The Department implements the FFS payment reduction in various phases.
   - **AB 1629 Facilities:** This phase includes FS NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.
   - **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H providers.
   - **DP/NF-Bs:** These are the previously enjoined providers.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 145

3. **Recoupment:** The Department will forgo the retroactive recoupment for ICF/DDs.

Facility Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date
ICF/DDs	6/1/2014	6/1/2014	N/A	N/A
NF-As	6/1/2011	7/1/2012	13	3/29/2013
		Payment Reduction Exempt Effective Date		
DP/NF-Bs				
Rural & Frontier	6/1/2011	9/1/2013	27	4/1/2016
Non Rural & Frontier	6/1/2011	10/1/2013	28	4/1/2016

4. The estimated savings (TF) due to the implementation of AB 97 payment reductions are:

Facility Type		FY 2015-16	FY 2016-17	Annual
AB 1629 Facilities	FFS	$0	$0	$0
ICF/DDs	FFS	($10,482,000)	($10,482,000)	($10,482,000)
	FFS Retro	$0	$0	$0
	ICF/DDs Total	($10,482,000)	($10,482,000)	
NF-As	FFS	($254,000)	($254,000)	($254,000)
	FFS Retro	$0	$0	$0
	NF-As Total	($254,000)	($254,000)	
DP/NF-Bs	FFS	$0	$0	$0
	FFS Retro	($3,088,000)	($12,351,000)	($12,351,000)
	DP/NF-Bs Total	($3,088,000)	($12,351,000)	
	Total FFS	($10,736,000)	($10,736,000)	($10,736,000)
	Total FFS Retro	($3,088,000)	($12,351,000)	($12,351,000)
	Total Managed Care	$0	$0	$0
Grand Total		**($13,824,000)**	**($23,087,000)**	

5. Implementation for the DP/NF recoupment will begin as soon as the CA-MMIS system is operationally ready.

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	11/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1597

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$4,592,000	-$20,839,000
- STATE FUNDS	-$2,296,000	-$10,419,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	1.30 %	0.05 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,532,300	-$20,828,600
STATE FUNDS	-$2,266,150	-$10,414,290
FEDERAL FUNDS	-$2,266,150	-$10,414,290

DESCRIPTION

Purpose:
This policy change estimates the savings due to the rate being frozen at 2008-09 levels for Distinct Part/Nursing Facility-Level B (DP/NF-B) and Rural Swing Bed (RSB) rates.

DP Adult Subacute and DP Pediatric Subacute facilities are not subject to the rate freeze.

Nursing Facility-Level A (NF-A), Freestanding Pediatric Subacute providers, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (H) and ICF/DD-Nursing (N) provider rates are currently reimbursed at the 2008-09 rate levels and are not impacted by this policy.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective August 1 of each year, LTC rates are re-determined for the following facility types: NF-A, DP/NF-B, RSB, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, ICF-DD, ICF/DD-H, and ICF/DD-N.

ABX4 5 eliminated rate increases for these facilities effective August 1, 2009. In the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, RSBs, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 24, 2010.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 146

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and freeze at the rates established in 2008-2009, required by AB 97, with respect to DP/NF-B facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On December 13, 2012, the United States Court of Appeal for the Ninth Circuit issued a decision in which it reversed the previous issued injunctions against AB 97 payment reductions and rate freezes. On January 28, 2013, the plaintiffs had requested a rehearing. On May 24, 2013, the Ninth Circuit denied the plaintiff's request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reductions and rate freezes retroactive to June 1, 2011.

The Department received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on their access and utilization analyses.

On December 20, 2013, the Department received CMS approval to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

RSBs in DP/NF-B facilities located in designated rural and frontier areas (Exempt RSBs) are exempted from the rate freeze effective September 1, 2013.

Reason for Change from Prior Estimate:

- Implementation of recoupment for DP/NF-B facilities is moved from August 2015 to April 2016 due to competing priority and caseload issues for Fiscal Intermediary.
- Revised refund amounts based on updated data.
- Revised DP/NF-B recoupment amounts and schedule based on updated data.

Methodology:

1. The effective date of AB 97 rate freeze is June 1, 2011.

2. **Rural Swing Bed rates**:
    - Effective July 22, 2013, All RSBs are paid at the 2008-09 level rate. Prior to this, the providers received the unfrozen 2010-11 level rate. The Department recovered the rate freeze retroactive savings over 24 months beginning November 2013. The savings covered the period from August 1, 2011, through July 21, 2013.
    - The Department implemented the unfrozen rates for the Exempt RSBs on June 22, 2015 and will refund the Exempt RSBs for the difference between the 2008-09 frozen rate and the appropriate unfrozen rates for the period from September 1, 2013 to June 30, 2015 in April 2016.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 146

3. **DP/NF-B facilities:** Effective September 1, 2013, rural and frontier designated DP/NF-B providers were paid at the 2013-14 level, and non-rural/frontier designated DP/NF-B providers were paid at the 2013-14 level, effective October 1, 2013. The Department will recover rate freeze retroactive savings beginning April 2016.

4. The estimated savings due to rate freeze are:

FY 2015-16	**TF**	**GF**
DP/NF-Bs Retro	($5,207,000)	($2,603,000)
Rural Swing Bed Retro	($60,000)	($30,000)
Rural Swing Bed Refund	$675,000	$338,000
Total	**($4,592,000)**	**($2,296,000)**
FY 2016-17	**TF**	**GF**
DP/NF-Bs Retro	($20,828,000)	($10,414,000)
Rural Swing Bed Retro	($11,000)	($6,000)
Total	**($20,839,000)**	**($10,419,000)**

*Totals may differ due to rounding.

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

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	12/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$22,656,000	-$30,878,000
- STATE FUNDS	-$11,328,000	-$15,439,000
PAYMENT LAG	0.8945	0.9946
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$20,265,800	-$30,711,300
STATE FUNDS	-$10,132,900	-$15,355,630
FEDERAL FUNDS	-$10,132,900	-$15,355,630

DESCRIPTION

Purpose:
This policy change estimates savings from a 10% payment reduction to clinical laboratories and laboratory services, and the savings from a new reimbursement methodology for these services.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 1494 (Chapter 28, Statutes of 2012)
AB 1124 (Chapter 8, Statutes of 2014)

Interdependent Policy Changes:
PC 189 Funding Adjust.—ACA Opt. Expansion
PC 190 Funding Adjust.—OTLICP

Background:
AB 1494 allows the Department to develop a new rate methodology for clinical laboratories and laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2012), AB 1494 allows payments to be reduced by 10% for clinical laboratories and laboratory services for dates of service on and after July 1, 2012 through June 30, 2015. The Family Planning, Access, Care, and Treatment Program (FPACT) and outpatient hospital services are exempt from the 10% provider payment reduction. Effective July 1, 2015, the new reimbursement methodology will be applicable to clinical laboratory and laboratory service codes, including FPACT and outpatient hospital services.

Reason for Change from Prior Estimate:
- Implementation date to recoup the retroactive saving of AB 1494 10% payment reduction has changed from November 2015 to March 2016.
- Implementation date for the new laboratory rate methodology has changed from July 2015 to December 2015.
- Implementation to recoup the five months of retroactive savings associated with the new methodology will begin March 2016.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 147

- Reduction in estimated savings associated with the new laboratory rate methodology based on updated program expenditure data.

Methodology:

1. Assume savings will begin upon California Medicaid Management Information System (CA-MMIS) system implementation.

2. The AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction will be assessed after the AB 1494 10% payment reduction and new laboratory rate methodology reduction.

3. Savings due to the AB 1494 10% payment reduction are projected to be $24,662,000 TF annually. The total amount for the retroactive AB 1494 10% savings from July 1, 2012 to June 30, 2015, is estimated to be $73,986,000 TF and is expected to be recovered over 72 months beginning March 2016.

4. The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015. Implementation of the new methodology will begin December 2015. Savings due to the new laboratory rate methodology are projected to be $18,546,000 TF annually. The total recoupment of retroactive savings from July 2015 to November 2015 will be implemented in March 2016.

5. Savings in FY 2015-16 will consist of four months of AB 1494 10% payment reductions recoupment, seven months of the new rate methodology savings, and the total retroactive recoupment of the new rate methodology savings.

6. Savings in FY 2016-17 will consist of 12 months of AB 1494 10% payment reductions recoupment and 12 months of the new rate methodology savings.

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FF**
New Rate Methodology Savings	($10,818)	($5,409)	($5,409)
Retroactive Savings	($11,838)	($5,919)	($5,919)
Total*	**($22,656)**	**($11,328)**	**($11,328)**
FY 2016-17	**TF**	**GF**	**FF**
New Rate Methodology Savings	($18,546)	($9,273)	($9,273)
Retroactive Savings	($12,332)	($6,166)	($6,166)
Total*	**($30,878)**	**($15,439)**	**($15,439)**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1580

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$184,615,000	-$196,963,000
- STATE FUNDS	-$92,307,500	-$98,481,500
PAYMENT LAG	0.9997	1.0000
% REFLECTED IN BASE	87.95 %	82.55 %
APPLIED TO BASE		
TOTAL FUNDS	-$22,239,400	-$34,370,000
STATE FUNDS	-$11,119,720	-$17,185,020
FEDERAL FUNDS	-$11,119,720	-$17,185,020

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)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
PC 190 Funding Adjust.—OTLICP

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 148

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

Reason for Change from Prior Estimate:

- Implementation date and schedule for the pharmacy recoupment has been updated.
  - The implementation date shifted from April 2016 to October 2015. Although the pharmacy recoupment process started August 28, 2015, recoupments are not expected to begin until October 2015.
  - The recoupment schedule is now estimated to take place over 36 months instead of 66 months.
- AB 97 dental savings are no longer in this policy change. In addition, the dental exemption costs that were budgeted in Elimination of Dental Provider Payment Reductions policy change (PC 217) in the May 2015 Estimate are now budgeted in the Dental Services policy change.

Methodology:

1. **Managed Care:** There are no retroactive savings for managed care payments recouped 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 and will take place on a prospective basis. 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 payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.
     - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
     - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 148

- **Phase II**: Phase II includes all the previously enjoined providers.
  - 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.
  - 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.
  - 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.
  - The 10% payment reduction for dental providers was implemented September 2013. Effective July 1, 2015, SB 75 (Chapter 18, Statutes of 2015) exempts dental providers from the 10% payment reductions. Refer to the Dental Services policy change for costs associated with the dental exemption.

- **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
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	10/1/2015	36
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 148

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

(Dollars in Thousands)

Provider Type		FY 2015-16	FY 2016-17	Annual
Phase I	FFS	($29,175)	($29,175)	($29,175)
	FFS Retro	$0	$0	$0
	Phase I Total	($29,175)	($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	($1,878)	($7,510)	($7,510)
Dental	FFS	$0	$0	$0
	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	($20,144)	($26,859)	($26,859)
	FFS	($131,004)	($131,004)	($131,004)
	FFS Retro	($22,022)	($34,369)	($34,369)
	Phase II Total	($153,026)	($165,373)	
Phase III (CHDP)	FFS	($2,414)	($2,414)	($2,414)
	FFS Retro	$0	$0	$0
	Phase III Total	($2,414)	($2,414)	
	FFS	($162,593)	($162,594)	($162,594)
	FFS Retro	($22,022)	($34,369)	($34,369)
	Managed Care	$0	$0	$0
	Grand Total	**($184,615)**	**($196,963)**	($196,963)

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	149
IMPLEMENTATION DATE:	8/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1505

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$50,282,000	-$52,078,000
- STATE FUNDS	-$25,141,000	-$26,039,000
PAYMENT LAG	0.8860	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$44,549,900	-$52,078,000
STATE FUNDS	-$22,274,930	-$26,039,000
FEDERAL FUNDS	-$22,274,930	-$26,039,000

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of a reduction to radiology reimbursement rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
PC 189 Funding Adjust.—ACA Opt. Expansion
PC 190 Funding Adjust.—OTLICP

Background:
SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates with dates of service on or after October 1, 2010. The Department submitted a State Plan Amendment (SPA) to reduce these rates below 80%; however, due to delay in federal approval, a two-year retroactive application of this reduction could adversely impact access to needed radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% reduction, and that federal approval of a reduction with a lengthy retroactive recoupment was extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010 to October 1, 2012.

Reason for Change from Prior Estimate:
- Implementation date change for new reduction rates from April 2015 to August 2015 due to competing priority and workload issues for the Fiscal Intermediary.
- Implementation date change for retroactive recoupment from April 2015 to January 2016 due to competing priority and workload issues for the Fiscal Intermediary.
- Recoupment schedule revised to occur over 12 months instead of 30 months.

Methodology:
1. Implementation of the new reduction rates began in August 2015.

2. Rate reductions are retroactive to October 1, 2012.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 149

3. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of 2012 Medicare rates.

4. Assume annual fee-for-service (FFS) savings $21,549,000.

   FFS Monthly Savings:
   $21,549,000 ÷ 12 months = $1,796,000.

5. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.

6. The total recoupment of retroactive savings from October 1, 2012 to July 31, 2015 is estimated to be $61,055,500 and is expected to occur over 12 months beginning January 2016. Monthly recoupment amount is based on 20% cap of monthly radiology reimbursements.

   Total recoupment of retroactive savings:
   $21,549,000 ÷ 12 months x 34 months = $61,055,500
   Monthly recoupment amount is $5,088,000

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FF**
FY 2015-16 Savings	($19,754)	($9,877)	($9,877)
Recoupment of Retro Savings	($30,528)	($15,264)	($15,264)
Total	**($50,282)**	**($25,141)**	**($25,141)**
FY 2016-17	**TF**	**GF**	**FF**
FY 2016-17 Savings	($21,550)	($10,775)	($10,775)
Recoupment of Retro Savings	($30,528)	($15,264)	($15,264)
Total	**($52,078)**	**($26,039)**	**($26,039)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 189 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 190 Funding Adjust.—OTLICP

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	150
IMPLEMENTATION DATE:	3/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1761

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$8,613,826,000	$7,150,333,000
- STATE FUNDS	$3,485,813,000	$2,831,982,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,613,826,000	$7,150,333,000
STATE FUNDS	$3,485,813,000	$2,831,982,000
FEDERAL FUNDS	$5,128,013,000	$4,318,351,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 115 HQAF Rate Range Increases
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014 and received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 150

Reason for Change from Prior Estimate:
The change is due to:

- The inclusion of NDPH intergovernmental transfer (IGT) and Affordable Care Act (ACA) optional population payments,
- The inclusion of the second Fee-for-Service (FFS) 2013-14 Designated Public Hospital grant payment, and
- Decreased managed care 2013-14 payments.

Methodology:

1. Per SB 239, the Hospital QAF program was extended from January 1, 2014 through December 31, 2016.

2. The first FFS payment was made in March 2015. This includes Designated Public Hospital and NDPH grant amounts.

3. The first managed care payment was made in August 2015.

4. On an accrual basis, the following is the total authorized amounts for grants and the managed care rate range increase.

DOS	Total Authorized	Total Grants Payments	Total Managed Care Rate Increase Authorized
FY 2013-14	$57,500,000	$27,000,000	$30,500,000
FY 2014-15	$118,000,000	$55,500,000	$62,500,000
FY 2015-16	$140,500,000	$66,500,000	$74,000,000
FY 2016-17	$80,000,000	$38,000,000	$42,000,000
Total	$396,000,000	$187,000,000	$209,000,000

5. The amounts paid towards the Managed Care rate range increases are not included in this policy change. This amount is budgeted in the HQAF Rate Range Increases policy change.

6. Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 payments previously made to NDPHs. In FY 2015-16, the Department has collected $12 million IGTs for FY 2013-14 from NDPHs. The Department will collect the following amounts from NDPHs:
    - To be collected in FY 2015-16: $28.45 million for FY 2014-15
    - To be collected in FY 2016-17: $27.45 million for FY 2015-16

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 150

7. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2015-16	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA
FFS					
FY 2013-14	$12,250	$12,250	$0	$0	$0
FY 2014-15	$1,063,011	$507,628	$555,383	$0	$0
FY 2015-16	$3,538,065	$1,582,132	$1,955,933	$0	$0
Total FFS	$4,613,326	$2,102,010	$2,511,316	$0	$0
Managed Care					
FY 2013-14	$1,146,000	$398,520	$730,374	$17,106	$0
FY 2014-15	$2,717,000	$944,833	$1,731,612	$40,555	$0
Total Managed Care	$3,863,000	$1,343,353	$2,461,986	$57,661	$0
NDPH IGT					
FY 2013-14	$35,200	$12,000	$12,000	$0	$11,200
FY 2014-15	$102,300	$28,450	$28,450	$0	$45,400
Total NDPH IGT	$137,500	$40,450	$40,450	$0	$56,600
Total FY 2015-16	**$8,613,826**	**$3,485,813**	**$5,013,752**	**$57,661**	**$56,600**

(Dollars in Thousands)

FY 2016-17	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA
FFS					
FY 2015-16	$1,209,605	$557,627	$651,978	$0	$0
FY 2016-17	$2,619,827	$1,138,190	$1,481,637	$0	$0
Total FFS	$3,829,432	$1,695,817	$2,133,615	$0	$0
Managed Care					
FY 2015-16	$3,224,999	$1,108,714	$2,055,373	$60,912	$0
NDPH IGT					
FY 2015-16	$95,900	$27,450	$27,450	$0	$41,000
Total FY 2016-17	**$7,150,331**	**$2,831,981**	**$4,216,438**	**$60,912**	**$41,000**

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-611-0890)
Title XXI FFP (4260-611-0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	4/2004
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	78

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$288,962,000	$234,312,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$288,962,000	$234,312,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$288,962,000	$234,312,000

DESCRIPTION

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:
AB 915 (Chapter 747, Statutes of 2002)

Interdependent Policy Changes:
Not Applicable

Background:
AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

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

- A delay in the FY 2003-04 reconciliation payment,
- The addition of payment adjustments and/or late claims for FY 2011-12 and FY 2012-13,
- An increase in FY 2013-14 payment adjustments and late claims,
- The addition of ACA payments for FY 2013-14 and FY 2014-15, and
- An increase in total FY 2014-15 payments to be made in FY 2015-16.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 151

Methodology:

1. Payments of $279,577,000 and $224,912,000 are expected to be made in FY 2015-16 and FY 2016-17, respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP. The reconciliation payments noted in Methodology #2 are not included in these amounts.

2. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2015-16. The following additional payments are expected to be made in FY 2015-16 and in FY 2016-17 as a result of the reconciliation:

Service Year 2002-03	$9,385,000
Service Year 2003-04	$9,400,000

Estimated costs are as follows:

(Dollars in Thousands)

FY 2015-16	TF	FFP	ACA
FY 2002-03 (Reconciliation)	$9,385	$9,385	
FY 2011-12 (Est. Adjustments)	$1,272	$1,272	
FY 2012-13 (Est. Adjustments & Late Claims)	$15,075	$15,075	
FY 2013-14 (Est. Adjustments, Late Claims, & ACA)	$50,789	$19,188	$31,601
FY 2014-15 (Est. Payments & ACA)	$212,441	$146,141	$66,300
Total FY 2015-16	**$288,962**	**$191,061**	**$97,901**

(Dollars in Thousands)

FY 2016-17	TF	FFP	ACA
FY 2003-04 (Reconciliation)	$9,400	$9,400	
FY 2014-15 (Est. Late Claims)	$2,061	$2,061	
FY 2015-16 (Est. Payments & ACA)	$222,851	$153,302	$69,549
Total FY 2016-17	**$234,312**	**$164,763**	**$69,549**

Funding:

100% Title XIX FFP (4260-101-0890)
ACA 100% FFP (2014-2016) (4260-101-0890)

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	9/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1475

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$264,597,000	$25,661,000
- STATE FUNDS	$162,701,000	$25,661,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$264,597,000	$25,661,000
STATE FUNDS	$162,701,000	$25,661,000
FEDERAL FUNDS	$101,896,000	$0

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the quality assurance fee (QAF) program.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
AB 188 (Chapter 645, Statutes of 2009)
AB 1653 (Chapter 218, Statutes of 2010)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. This QAF program is referred to as QAF I. AB 1653 revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

AB 188 established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011, based on a modified amount of payments to hospitals and an increased amount for children's health care coverage. This QAF program is referred to as QAF II.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. This QAF program is referred to as QAF III. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SB 920:

- Modified the QAF calculation and installment payment provisions, supplemental amounts paid to private hospitals for inpatient services,
- Increased the NDPH aggregate grant amounts for each fiscal year, and
- Reduced the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund (LIHP), and deleted NDPHs as recipients of money from the fund.

Reason for Change from Prior Estimate:

The changes are due to:

- Updated payment data for QAF II and
- Updated QAF funds available for transfer to the LIHP fund. The amount was reduced after the QAF III FFS and grant payments were reconciled.

Methodology:

1. Under ARRA, California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The first QAF program was effective April 1, 2009 through December 31, 2010 (QAF I); with a two-quarter extension through June 30, 2011 (QAF II). An additional 30-month QAF program is effective for the time period July 1, 2011 through December 31, 2013 (QAF III).

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

3. On an accrual basis, the QAF III program fee is expected to generate $4.3 billion in FY 2011-12, $4.5 billion in FY 2012-13, and $2.4 billion in FY 2013-14 in fee-for-service (FFS), managed care capitation, grant payments and mental health payments.

4. First FFS payment of the QAF III program to the hospitals occurred in August 2012.

5. QAF I program mental health plan payments of $15.9 million will be paid in FY 2015-16. The mental health payment is contingent on CMS approval of SPA 09-004.

6. QAF II program FFS payments of $827,000 will be paid in FY 2015-16.

7. QAF III program fees of $61 million and $25.7 million will be transferred to LIHP in FY 2015-16 and FY 2016-17, respectively.

8. QAF III program FFS payments and FFS grants of $186.7 million will be paid in FY 2015-16.

9. There are no managed care payments in this policy change.

10. On a cash basis, payments to the hospitals are estimated to be:

FY 2015-16	TF	SF(HQARF)	FF-TITLE 19	ARRA
QAF I (AB 1383)	$15,898,000	$6,106,000	$7,949,000	$1,843,000
QAF II (SB 90)	$827,000	$349,000	$413,000	$65,000
QAF III (SB 335)	$186,786,000	$95,160,000	$91,626,000	$0
QAF III (SB 335 LIHP)	$61,086,000	$61,086,000	$0	$0
Total	**$264,597,000**	**$162,701,000**	**$99,988,000**	**$1,908,000**

FY 2016-17	TF	SF(HQARF)	FF-TITLE 19	ARRA
QAF III (SB 335 LIHP)	$25,661,000	$25,661,000	$0	$0
Total	**$25,661,000**	**$25,661,000**	**$0**	**$0**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-101-0890)

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	5/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1140

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$210,610,000	$202,400,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$210,610,000	$202,400,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$210,610,000	$202,400,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to freestanding, non-hospital based clinics.

Authority:
AB 959 (Chapter 162, Statutes of 2006), Welfare & Institutions Code 14105.965

Interdependent Policy Change:
Not Applicable

Background:
Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down federal financial participation (FFP) is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

The State Plan Amendment (SPA) for this program was approved on August 8, 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to October 14, 2006.

Reason for Change from Prior Estimate:
The change is due to payment calculation adjustments based on updated Affordable Care Act (ACA) optional expansion estimates.

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 153

Methodology:

1. Supplemental payments for freestanding, non-hospital based clinics are expected to begin May 2016.

2. Providers will begin submitting cost reports January 2016.

3. Participation in this program is voluntary. Assuming full participation, annual supplemental payments to freestanding, non-hospital based clinics are expected to total between $47,300,000 and $86,700,000.

4. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

5. The ACA impact for FY 2013-14, FY 2014-15, and FY 2015-16 is estimated below using projected caseload trends that considers the ACA implementation and transition of Medi-Cal beneficiaries to Managed Care.

Program payment amounts are estimated to be:

(Dollars in Thousands)

FY 2015-16	TF	FF	ARRA	ACA
FY 2006-07	$47,250	$47,250	$0	$0
FY 2013-14	$86,720	$84,060	$0	$2,660
FY 2014-15	$76,640	$73,077	$0	$3,563
Total FY 2015-16	**$210,610**	**$204,387**	**$0**	**$6,223**

(Dollars in Thousands)

FY 2016-17	TF	FF	ARRA	ACA
FY 2007-08	$61,500	$61,500	$0	$0
FY 2008-09	$70,301	$60,036	$10,265	$0
FY 2015-16	$70,599	$67,690	$0	$2,909
Total FY 2016-17	**$202,400**	**$189,226**	**$10,265**	**$2,909**

Funding:

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

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	10/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1600

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$136,685,000	$100,498,000
- STATE FUNDS	$47,088,000	$46,687,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$136,685,000	$100,498,000
STATE FUNDS	$47,088,000	$46,687,000
FEDERAL FUNDS	$89,597,000	$53,811,000

DESCRIPTION

Purpose:
This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:
AB 113 (Chapter 20, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

Reason for Change from Prior Estimate:
- Children's Services payments were delayed due to the timing of the IGTs:
  - o FY 2013-14 and FY 2014-15 payments shifted from FY 2014-15 to FY 2015-16,
  - o FY 2015-16 payments shifted from FY 2015-16 to FY 2016-17,
- FY 2013-14 ACA optional Children's Services payments are no longer budgeted,
- A portion of the FY 2014-15 NDPH payments were delayed from FY 2014-15 to FY 2015-16, and
- Addition of FY 2014-15 and FY 2015-16 NDPH payments for the ACA optional population.

Methodology:
1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

2. The implementation of the ACA optional population, effective January 1, 2014, impacts the UPL calculation. The impact increased the UPL's available room, and it is assumed payments related to the ACA optional population will be made beginning in FY 2015-16.

3. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2015-16	TF	GF*	IGT**	FF	ACA***
FY 2013-14 Payments to NDPHs (ACA Optional Population)	$27,513	$0	$0	$0	$27,513
FY 2013-14 Children's Services	$0	($4,021)	$4,021	$0	$0
FY 2014-15 Payments to NDPHs	$1,176	$0	$588	$588	$0
FY 2014-15 Payments to NDPHs (ACA Optional Population)	$7,498	$0	$0	$0	$7,498
FY 2014-15 Children's Services	$0	($4,453)	$4,453	$0	$0
FY 2015-16 Payments to NDPHs	$93,000	$0	$46,500	$46,500	$0
FY 2015-16 Payments to NDPHs (ACA Optional Population)	$7,498	$0	$0	$0	$7,498
Total FY 2015-16	**$136,685**	**($8,474)**	**$55,562**	**$47,088**	**$42,509**

(Dollars in Thousands)

FY 2016-17	TF	GF*	IGT**	FF	ACA***
FY 2015-16 Children's Services	$0	($4,454)	$4,454	$0	$0
FY 2016-17 Payments to NDPHs	$93,000	$0	$46,500	$46,500	$0
FY 2016-17 Payments to NDPHs (ACA Optional Population)****	$7,498	$0	$187	$0	$7,311
Total FY 2016-17	**$100,498**	**($4,454)**	**$51,141**	**$46,500**	**$7,311**

Funding:

50% Title XIX /50% MIPA (4260-606-0834/4260-101-0890)**
100% GF (4260-101-0001)*
100% Title XIX ACA (4260-101-0890) ***
95% Title XIX / 5% MIPA (4260-606-0834/4260-101-0890) ****

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	6/2002
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	86

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$111,321,000	$103,366,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$111,321,000	$103,366,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$111,321,000	$103,366,000

DESCRIPTION

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals.

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

Interdependent Policy Changes:
Not Applicable

Background:
This program is designed to allow DP-NFs to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal beneficiaries.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013 to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013 for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013, pursuant to the provisions of SB 239 (Chapter 657, Statutes of 2013).

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 155

Reason for Change from Prior Estimate:
FY 2015-16 increased due to:

- A higher than previously expected FY 2009-10 reconciliation payment,
- A higher than previously expected FY 2014-15 interim payment,
- FY 2013-14 and FY 2015-16 interim payments are expected to be paid in FY 2015-16, and
- AB 97 adjustments for FY 2012-13 to be made in FY 2015-16. In addition, AB 97 adjustments for FY 2010-11 and FY 2012-13 previously scheduled to be paid in FY 2014-15 are delayed to FY 2016-17.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2015-16 and FY 2016-17 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Scheduled interim payments and reconciliation payments are represented below.

4. The AB 97 payment reduction/freeze will increase the uncompensated costs eligible for supplemental reimbursement under this program. The increased payments due to AB 97 payment reduction/rate freeze will be made in FY 2015-16 and FY 2016-17.

5. Based on a funding of historical data and AB 97 rate reduction calculations, an estimate of $111,321,000 FFP and $103,366,000 FFP will be available in FY 2015-16 and FY 2016-17, respectively.

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 155

FY 2015-16	Total FFP	FFP	ARRA
FY 2009-10 Reconciliation	$8,011,000	$6,502,000	$1,509,000
FY 2013-14	$19,088,000	$19,088,000	
FY 2014-15	$50,307,000	$50,307,000	
FY 2015-16	$2,516,000	$2,516,000	
AB 97 Adjustments			
FY 2012-13	$31,399,000	$31,399,000	
Total FY 2015-16	**$111,321,000**	$109,812,000	$1,509,000

FY 2016-17	Total FFP	FFP	ARRA
FY 2014-15	$5,590,000	$5,590,000	
FY 2015-16	$55,784,000	$55,784,000	
FY 2016-17	$2,433,000	$2,433,000	
AB 97 Adjustments			
FY 2010-11	$8,972,000	$8,841,000	$131,000
FY 2011-12	$22,406,000	$22,406,000	
FY 2013-14	$8,181,000	$8,181,000	
Total FY 2016-17	**$103,366,000**	$103,235,000	$131,000

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

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	11/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1899

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$107,293,000	$107,000,000
- STATE FUNDS	$52,776,560	$38,996,330
PAYMENT LAG	0.9821	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$105,372,500	$107,000,000
STATE FUNDS	$51,831,860	$38,996,330
FEDERAL FUNDS	$53,540,600	$68,003,670

DESCRIPTION

Purpose:
This policy change estimates inpatient Medi-Cal Fee-for-Service (FFS), Medi-Cal Managed Care, and supplemental payments to a new private nonprofit hospital, Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation.

Authority:
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions (W&I) Code 14165.50
State Plan Amendment (SPA) 15-008

Interdependent Policy Changes:
Not Applicable

Background:
SB 857 requires specific funding requirements to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. Pursuant to W&I Code 14165.50, the cost-based reimbursement methodology for Medi-Cal FFS and managed care payments to the new MLK-LA hospital will provide compensation at a minimum of 100% of the projected costs for each fiscal year (FY), contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide, beginning the fiscal year MLK-LA opens through FY 2016-17, the non-federal share of a guaranteed level of 77% of the projected Medi-Cal cost for inpatient hospital services. Managed care rates must be adjusted to reflect the actuarial equivalent of those costs, subject to specified requirements. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of projected Medi-Cal costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156

Beginning FY 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72% of projected Medi-Cal costs. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 72% of projected Medi-Cal costs, the GF will be required to fund the non-federal share of the additional payments up to 72% of the costs.

In order to enable reimbursement for the MLK-LA to reach 100% of projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the Department shall seek further federal approval to enable MLK-LA to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100% minimum funding requirement may be sought through additional supplemental programs upon federal approval.

Reason for Change from Prior Estimate:

The changes are due to:

- Updating the effective date from May 2015 to June 2015 as a result of delayed Medi-Cal certification approval for MLK-LA,
- Delaying the implementation date from May 2015 to November 2015,
- Increased annual cost projections as submitted by MLK-LA,
- Updating the FFS and managed care percentage splits, and
- Managed care costs are no longer included in this policy change and will be budgeted in the Two Plan Model and the Retro MC Rate Adjustments policy changes.

Methodology:

1. MLK-LA began providing certain acute inpatient services on May 14, 2015. Medi-Cal certification for MLK-LA was received in September 2015.

2. Medi-Cal certification approval is retroactive to the effective date of June 30, 2015.

3. Assume Diagnosis Related Group (DRG) inpatient payments to MLK-LA will be implemented beginning November 2015 for dates of service on or after June 30, 2015.

4. Assume MLK-LA will receive the DRG statewide, wage adjusted, base rate.

5. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 77% Minimum Payment level.

6. MLK-LA estimates their annual Medi-Cal projected costs to be $110,542,614 TF.

7. Costs up to 77% of the Medi-Cal projected costs are estimated at $85,117,813 TF and costs up to 100% are estimated at $25,424,801 TF.

$85,117,813	Costs up to 77% of total Medi-Cal projected costs
$25,424,801	Costs up to 100% of total Medi-Cal projected costs
$110,542,614	**Total annual Medi-Cal projected costs**

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156

8. Assume 63% of the total Medi-Cal projected costs, or $69,641,847 TF payments, are for services to Medi-Cal beneficiaries that are already included in the Medi-Cal base estimate. As a result, $15,475,966 TF is the remaining net cost required to reach 77% of the Medi-Cal projected costs. The net annual Medi-Cal costs required to reach 100% of total Medi-Cal costs is now estimated at $40,900,767 TF.

$85,117,813	Costs up to 77% of total Medi-Cal projected costs
($69,641,847)	Less: Assumed hospital inpatient payments in the base
$15,475,966	**Net costs to reach 77%**

$15,475,966	Net costs to reach 77%
$25,424,801	Costs up to 100% of total Medi-Cal projected costs
$40,900,767	**Net Medi-Cal costs up to 100%**

9. Expenditures for costs up to 77% of total Medi-Cal projected costs will be paid through FFS DRG and managed care payments. It is estimated these payments will be 45% FFS DRG payments and 55% managed care payments.

10. Supplemental payments will be used to make payments necessary to meet the minimum funding of 100% of total Medi-Cal projected costs. Supplemental payments will also be used to make payments above the minimum funding requirement. The estimates are as follows:
    - FY 2014-15 supplemental payments are estimated to be $274,000 TF, of which $38,000 is attributed to the Affordable Care Act (ACA) optional population.
    - FY 2015-16 and FY 2016-17 supplemental payments are estimated to be $100,000,000 TF annually of which $14,000,000 is attributed to the ACA optional population for each respective year.
    - Federal approval of the ACA optional supplemental payments is expected in FY 2016-17. In FY 2015-16, the Department plans to pay the ACA optional supplemental payments for FY 2014-15 and FY 2015-16 with 50% GF/ 50% FF. Funding adjustments for the ACA FFP will be made in FY 2016-17.

11. In FY 2015-16, additional FFS DRG payments for FY 2014-15 are estimated to be $19,000 TF for services provided on June 30, 2015.

12. Managed care costs for MLK-LA are reflected in the managed care policy changes. The chart below shows the FY 2015-16 and FY 2016-17 totals with managed care for informational purposes only.
    - There are no managed care payments for FY 2014-15.
    - A retroactive payment for FY 2015-16 will be made in FY 2016-17 in PC 133 Retro MC Rate Adjustments.
    - The FY 2016-17 managed care payments are in PC 105 Two Plan Model.

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156

FY 2015-16	TF
FFS 2014-15	$19,000
FFS 2015-16	$7,000,000
Supplemental 2014-15	$274,000
Supplemental 2015-16	$100,000,000
Total (PC 156)	$107,293,000
Managed Care 2014-15	$0
Total FY 2015-16	$107,293,000

FY 2016-17	TF
FFS 2016-17	$7,000,000
Supplemental 2016-17	$100,000,000
Total (PC 156)	$107,000,000
Managed Care 2015-16 retro (PC 133)	$8,476,000
Managed Care 2016-17 (PC 105)	$8,476,000
Total Managed Care	$16,952,000
Total FY 2016-17	$123,952,000

13. The annual costs in FY 2015-16 and FY 2016-17 for this policy change are expected to be:

FY 2015-16	TF	GF	IGT*	Title XXI FF	Title XIX FF	ACA FF
FFS 2014-15	$19,000	$7,000	$0	$0	$7,000	$5,000
FFS 2015-16	$7,000,000	$2,632,000	$0	$119,000	$2,607,000	$1,642,000
Supplemental 2014-15	$274,000	$19,000	$118,000	$0	$137,000	$0
Supplemental 2015-16	$100,000,000	$7,000,000	$43,000,000	$0	$50,000,000	$0
Total	**$107,293,000**	**$9,658,000**	**$43,118,000**	**$119,000**	**$52,751,000**	**$1,647,000**

FY 2016-17	TF	GF	IGT*	Title XXI FF	Title XIX FF	ACA FF
FFS 2016-17	$7,000,000	$2,665,000	$0	$127,000	$2,607,000	$1,601,000
Supplemental 2014-15	$0	($19,000)	$0	$0	$0	$19,000
Supplemental 2015-16	$0	($7,000,000)	$0	$0	$0	$7,000,000
Supplemental 2016-17	$100,000,000	$0	$43,350,000	$0	$43,000,000	$13,650,000
Total	**$107,000,000**	**($4,354,000)**	**$43,350,000**	**$127,000**	**$45,607,000**	**$22,270,000**

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
50% Title XIX / 50% Reimbursement GF (4260-610-0995/4260-101-0890)*
100% Title XIX ACA (4260-101-0890)
100% GF (4260-101-0001)
95% Title XIX / 5% GF (4260-101-0001/0890)
95% Title XIX / 5% Reimbursement GF (4260-610-0995/4260-101-0890)*
65% Title XXI / 35% GF (4260-113-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 2/2006
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 104

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$101,793,000	$80,103,000
- STATE FUNDS	$50,896,500	$40,051,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$101,793,000	$80,103,000
STATE FUNDS	$50,896,500	$40,051,500
FEDERAL FUNDS	$50,896,500	$40,051,500

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:
Estimated payments for FY 2014-15 and FY 2015-16 were updated. FY 2014-15 payments previously scheduled to be made in FY 2014-15 was delayed to FY 2015-16. In addition, FY 2015-16 payments are now scheduled to be made in FY 2015-16 and FY 2016-17.

Methodology:
1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

(Dollars in Thousands)

FY 2015-16	TF	Special Deposit Fund	FF
FY 2014-15	$47,650	$23,825	$23,825
FY 2015-16	$54,143	$27,071	$27,072
Total FY 2015-16	**$101,793**	**$50,896**	**$50,897**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 157

(Dollars in Thousands)

FY 2016-17	TF	Special Deposit Fund	FF
FY 2015-16	$25,960	$12,980	$12,980
FY 2016-17	$54,143	$27,071	$27,072
Total FY 2016-17	**$80,103**	**$40,051**	**$40,052**

Funding Table:
50% Local Trauma Centers Fund / 50% Title XIX FFP (4260-601-0942142) / (4260-101-0890)

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	158
IMPLEMENTATION DATE:	7/1991
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	82

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$100,941,000	$102,317,000
- STATE FUNDS	$40,452,500	$41,140,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,941,000	$102,317,000
STATE FUNDS	$40,452,500	$41,140,500
FEDERAL FUNDS	$60,488,500	$61,176,500

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988)
SB 2665 (Chapter 1310, Statutes of 1990)
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013 due to the implementation of the Diagnosis Related Group payment methodology. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code. The Department claims federal funds using certified public expenditures from eligible DP-NFs. CMS approved SPA 00-010 on July 17, 2001, which maintains the Federal authority for SB 1128.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 158

Reason for Change from Prior Estimate:
The change is due to updated data that resulted in:

- FY 2013-14 hospital payments in FY 2015-16,
- Decreased FY 2014-15 hospital payments,
- Increased FY 2015-16 hospital payments, and
- Increased FY 2014-15 DP-NF payments.

Methodology:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Hospitals			
FY 2013-14	$3,202	$1,601	$1,601
FY 2014-15	$27,589	$13,794	$13,795
FY 2015-16	$50,114	$25,057	$25,057
DP-NFs			
FY 2014-15	$20,036	$0	$20,036
Total FY 2015-16	**$100,941**	**$40,452**	**$60,489**

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Hospitals			
FY 2015-16	$30,373	$15,186	$15,187
FY 2016-17	$51,908	$25,954	$25,954
DP-NFs			
FY 2015-16	$20,036	$0	$20,036
Total FY 2016-17	**$102,317**	**$41,140**	**$61,177**

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1661

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$61,611,000	$22,782,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$61,611,000	$22,782,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$61,611,000	$22,782,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) #09-024 on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

SB 75 may result in a modification of the GEMT program from CPE-based to an intergovernmental transfer program. The Department will be collaborating with stakeholders to develop the methodology during FY 2015-16. This modification is subject to CMS approval.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 159

Reason for Change from Prior Estimate:
The change is due to:

- A reduction in FY 2012-13 payments for payments that were made in FY 2014-15, and
- FY 2013-14 and FY 2014-15 were increased to include the increased federal financial participation (FFP) available for the New Adult Group eligible under the Affordable Care Act (ACA).

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The ACA allows for 100% FMAP for calendar years 2014-2016, for newly eligible Medi-Cal beneficiaries. The payments estimated in FY 2015-16 and FY 2016-17 are pending CMS approval. Accrual years FY 2013-14 and FY 2014-15 assumes 10.15% and 12.31%, respectively, for payments attributed to the ACA optional expansion population.

3. Payments estimated for FY 2015-16 and FY 2016-17 are CPE based.

The estimated payments on a cash basis are:

FY 2015-16	Total FFP	Regular FFP	ARRA	ACA	CPE
FY 2009-10	$15,000,000	$12,100,000	$2,900,000	$0	$24,200,000
FY 2010-11	$13,530,000	$11,100,000	$2,430,000	$0	$22,200,000
FY 2011-12	$3,560,000	$3,560,000	$0	$0	$7,120,000
FY 2012-13	$655,000	$655,000	$0	$0	$1,310,000
FY 2013-14	$6,084,000	$4,266,000	$0	$1,818,000	$8,967,000
FY 2014-15	$22,782,000	$17,788,000	$0	$4,994,000	$40,570,000
Total FY 2015-16	**$61,611,000**	**$49,469,000**	**$5,330,000**	**$6,812,000**	$104,367,000

FY 2016-17	Total FFP	Regular FFP	ACA	CPE
FY 2015-16	$22,782,000	$17,788,000	$4,994,000	$40,570,000
Total FY 2016-17	**$22,782,000**	**$17,788,000**	**$4,994,000**	$40,570,000

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 160
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1038

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2015-16	$10,000	$5,000	$5,000
FY 2016-17	$10,000	$5,000	$5,000

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	7/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1158

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$8,333,000	$8,333,000
- STATE FUNDS	$4,166,000	$4,166,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,333,000	$8,333,000
STATE FUNDS	$4,166,000	$4,166,000
FEDERAL FUNDS	$4,167,000	$4,167,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to non-SB 1100 hospitals.

Authority:
Welfare & Institutions Code 14164

Interdependent Policy Changes
Not Applicable

Background:
The Welfare & Institutions Code provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

The Selective Provider Contracting Program ended in June 2013. As part of the Private Hospital Supplemental Fund, the Centers for Medicare and Medicaid (CMS) approved State Plan Amendment (SPA) 14-008 on October 24, 2014 to authorize IGT distributions to eligible private hospitals. The Department will be submitting SPA 15-003 to CMS in FY 2015-16 to continue IGT distributions to eligible private hospitals.

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 161

Reason for Change from Prior Estimate:
FY 2015-16 decreased due to the utilization of a different budget methodology. Instead of using a four year rolling average, prior year's actual payment amounts are estimated for future payments.

Methodology:
1. Annual IGTs on an accrual basis are estimated to be $8,333,000 for FY 2015-16 and for FY 2016-17, which are based on actual payments made in the prior fiscal year. Cash basis payments vary from year-to-year based on when the IGTs are actually received.

2. Cash basis payments are estimated to be:

(Dollars In Thousands)

Fiscal Year	TF	IGT	FFP
FY 2015-16	$8,333	$4,166	$4,167
FY 2016-17	$8,333	$4,166	$4,167

Funding:
50% Reimbursement GF / 50% Title XIX (4260-610-0995 / 4260-101-0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 162
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1039

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides SRHs with increased reimbursement rates. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2015-16	$8,000	$4,000	$4,000
FY 2016-17	$8,000	$4,000	$4,000

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

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	163
IMPLEMENTATION DATE:	12/2010
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1616

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$6,063,000	$3,662,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,063,000	$3,662,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$6,063,000	$3,662,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

Interdependent Policy Changes:
Not Applicable

Background:
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

Reasons for Change from Prior Estimate:
Estimated payments for the FY 2014-15 and FY 2015-16 service years have decreased from the prior estimate. However, the overall estimate for FY 2015-16 payments has increased due to:

- Delaying FY 2014-15 payments to FY 2015-16, and
- Including an additional quarter of payments to FY 2015-16 interim payments.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:
1. Interim payments, which consist of 3 quarters of the service year,
2. Initial reconciliation payments, which consist of 1 quarter of the service year, and
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

FY 2015-16	FFP
FY 2014-15 Interim Payment	$2,520,000
FY 2014-15 Initial Reconciliation Payment	$880,000
FY 2015-16 Interim Payment	$2,663,000
Total	**$6,063,000**

FY 2016-17	FFP
FY 2015-16 Initial Reconciliation Payment	$887,000
FY 2016-17 Interim Payment	$2,775,000
Total	**$3,662,000**

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	12/2011
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1488

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$182,108,000	$127,681,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$182,108,000	$127,681,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$182,108,000	$127,681,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade (AIU) and meaningfully use (MU) Electronic Health records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The HITECH Act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must AIU and MU certified EHR technology in accordance with the HITECH Act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department plans to expand the current Medicaid Management Information Systems (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible providers. The payments are intended to accelerate AIU and encourage MU of the EHR technology by providers serving the Medi-Cal population. It is estimated that approximately 22,000 to 24,000 providers, and 400 hospitals, will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal financial participation (FFP).

The Medi-Cal Fiscal Intermediary (FI) continues to develop the SLR, a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

System costs are budgeted in the FI Estimate. Administrative costs for the State's Health Information Technology (HIT) program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change from Prior Estimate:
The expected incentive payment costs to providers have been increased and are based on actual expenditures.

Methodology:

1. Payments to the providers began in December 2011.

2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.

3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is $21,250. Incentive payments for years two through six are $8,500 per eligible year. The maximum incentive payment for a professional over the six year period is $63,750.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted up or down depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. The years do not have to be consecutive. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth payment eligibility years.

5. Assume for FY 2015-16 and FY 2016-17, the aggregate hospital incentive payment is $3,000,000. The first year eligibility incentive payment will average $1,500,000, the second year eligible incentive payment will average $900,000, and the third and fourth year eligibility incentive payments will average $300,000.

6. The estimated payments for FY 2015-16 and FY 2016-17 are based on a cash-basis. The estimate for FY 2015-16 includes actual payments up to July 2015.

(Dollars in Thousands)

FY 2015-16		**FF**
2,613 professionals x $21,250 = $55,526,000	Eligibility Year 1 Professional Payments	$55,526
2,931 professionals x $8,500 = $24,914,000	Eligibility Year 2 Professional Payments	$24,914
785 professionals x $8,500 = $6,673,000	Eligibility Year 3 Professional Payments	$6,673
1,651 professionals x $8,500 = $14,034,000	Eligibility Year 4 Professional Payments	$14,034
66 professionals x $8,500 = $561,000	Eligibility Year 5 Professional Payments	$561
13 hospitals x $1,500,000 = $19,500,000	Eligibility Year 1 Hospital Payments	$19,500
39 hospitals x $900,000 =$35,100,000	Eligibility Year 2 Hospital Payments	$35,100
45 hospitals x $300,000 = $13,500,000	Eligibility Year 3 Hospital Payments	$13,500
41 hospitals x $300,000 = $12,300,000	Eligibility Year 4 Hospital Payments	$12,300
FY 2015-16 Total		**$182,108**

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

((Dollars in Thousands)

FY 2016-17		FF
2,281 professionals x $21,250 = $48,471,000	Eligibility Year 1 Professional Payments	$48,471
2,622 professionals x $8,500 = $22,287,000	Eligibility Year 2 Professional Payments	$22,287
866 professionals x $8,500 = $7,361,000	Eligibility Year 3 Professional Payments	$7,361
1,106 professionals x $8,500 = $9,401,000	Eligibility Year 4 Professional Payments	$9,401
44 professionals x $8,500 = $374,000	Eligibility Year 5 Professional Payments	$374
22 professionals x $8,500 = $187,000	Eligibility Year 6 Professional Payments	$187
4 hospitals x $1,500,000 = $6,000,000	Eligibility Year 1 Hospital Payments	$6,000
20 hospitals x $900,000 = $18,000,000	Eligibility Year 2 Hospital Payments	$18,000
41 hospitals x $300,000 = $12,300,000	Eligibility Year 3 Hospital Payments	$12,300
11 hospitals x $300,000 = $3,300,000	Eligibility Year 4 Hospital Payments	$3,300
FY 2016-17 Total		**$127,681**

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	6/2011
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1232

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$155,709,000	$59,690,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$155,709,000	$59,690,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$155,709,000	$59,690,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
Beneficiaries that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2015-16. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 172

Reason for Change from Prior Estimate:
Updated expenditures reflect that prior year billings and ARRA payments will be complete by FY 2015-16.

Methodology:

1. FY 2015-16 includes a portion of payments for FY 2009-10, FY 2011-12, FY 2013-14, FY 2014-15, and FY 2015-16 expenditures. FY 2016-17 includes a portion of payments for FY 2015-16 and FY 2016-17 expenditures.

2. Updated estimates, on a cash basis, provided by CDDS:

(Dollars in Thousands)

CASH BASIS	TF	CDDS GF	FFP Regular	FFP ARRA	Total* FFP
FY 2015-16	$289,827	$134,118	$144,913	$10,796	**$155,709**
FY 2016-17	$119,381	$59,691	$59,690	$0	**$59,690**

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

*Amounts may differ due to rounding.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER:	173
IMPLEMENTATION DATE:	4/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1942

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$60,000,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$60,000,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$60,000,000	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans.

Authority:
Welfare & Institutions Code (W&I) 14132.275

Interdependent Policy Changes:
Not Applicable

Background:
The Coordinated Care Initiative (CCI) provides models of care to persons eligible for both Medicare and Medi-Cal. CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services will be provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. CDSS and the county social service offices provide the administration and payment of IHSS. The cost of IHSS is built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department reconciles the IHSS category of service, which is a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for the same quarter. The Department will determine the overpayments or underpayments to CDSS or the managed care plans during reconciliation. The CDSS reimbursement to the managed care plans is reflected in the Retro MC Rate Adjustments policy change.

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

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 173

Methodology:

1. Assume reconciliation and reimbursement for overpayments and underpayments will begin in April 2016.

2. Based on calendar year 2014 data, it is estimated that the Department will reimburse CDSS $60,000,000 FF for IHSS fee-for-service in the seven CCI counties.

Funding:

100% Title XIX (4260-101-0890)

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	174
IMPLEMENTATION DATE:	7/2008
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1340

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$50,929,000	$50,929,000
- STATE FUNDS	$25,464,500	$25,464,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$50,929,000	$50,929,000
STATE FUNDS	$25,464,500	$25,464,500
FEDERAL FUNDS	$25,464,500	$25,464,500

DESCRIPTION

Purpose:
This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:
Welfare & Institutions (W&I) Code 14170

Interdependent Policy Changes:
Not Applicable

Background:
All noncontract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the noncontract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.

Beginning July 1, 2013, with the implementation of the Diagnosis Related Group (DRG) hospital inpatient payment methodology, the Selective Provider Contracting Program (SPCP) contract and noncontract hospital per diem rate methodology was discontinued for private hospitals. Non-Designated Public Hospitals (NDPHs) transitioned to the DRG reimbursement methodology on January 1, 2014. Although the contract and noncontract hospital designations are eliminated under the DRG, noncontract hospital inpatient cost settlements for dates prior to the DRG implementation will continue as required by W&I Code 14170.

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 174

Reason for Change from Prior Estimate:
Updated estimate based on the average of actual cost settlements made in the last three fiscal years.

Methodology:
1. Payments for noncontract hospital inpatient cost settlements made in FY 2014-15 totaled $78,099,000 TF.

2. Based on a three-year average of actual cost settlements, noncontract hospital cost settlements are estimated to total $50,929,000 in FY 2015-16 and FY 2016-17.

(Dollars in Thousands)

	TF	GF	FF
FY 2015-16	$50,929	$25,464	$25,465
FY 2016-17	$50,929	$25,464	$25,465

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	7/2010
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1526

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$18,496,000	$10,738,000
- STATE FUNDS	$5,345,000	$4,836,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,496,000	$10,738,000
STATE FUNDS	$5,345,000	$4,836,000
FEDERAL FUNDS	$13,151,000	$5,902,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:
Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:
Not Applicable

Background:
The California Department of Developmental Services (CDDS) makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs, so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2015-16. Funding for services provided between October 1, 2008, through June 30, 2011, will be

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 178

reimbursed at the appropriate FMAP rate.

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDS.

Reason for Change from Prior Estimate:
Updated expenditures reflect that prior year billings and ARRA payments will be complete by FY 2015-16.

Methodology:
Updated estimates, on a cash basis, provided by CDDS:

(In Thousands)

FY 2015-16*					
ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$2,196	$9,980	$20,670	$2,174	**$5,345**	**$13,151**

FY 2016-17*					
ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$936	$4,966	$11,672	$934	**$4,836**	**$5,902**

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

*Actuals may differ due to rounding.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	4/1998
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	111

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$5,545,000	$25,289,000
- STATE FUNDS	-$18,482,500	-$16,340,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,545,000	$25,289,000
STATE FUNDS	-$18,482,500	-$16,340,600
FEDERAL FUNDS	$24,027,500	$41,629,600

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to Native Americans eligible for Medi-Cal. It also estimates the reimbursement of Indian Health Services (IHS) memorandum of agreement (MOA) clinic facility reimbursement for Federally Qualified Health Center (FQHC) Services.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the IHS/MOA between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to Native Americans through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 179

Reason for Change from Prior Estimate:

- An increase in utilization,
- A rate increase from $342 to $350 for rate year 2015,
- A rate increase from $350 to $362 for rate year 2016,
- Two additional clinics opened, and
- The additional cost of reimbursing IHS/MOA clinic facilities for FQHC services.

Methodology:

1. Currently, there are 57 Indian health clinics participating in Medi-Cal.

2. In FY 2014-15, the Department spent $38,141,000 TF ($19,071,000 GF).

3. Recent changes posted in the Federal Register, Volume 80, Number 66, April 7, 2015 updated the per visit rate payable to Indian health clinics. Effective calendar year 2015, the per visit rate payable to Indian health clinics increased by $8; from $342 to $350.

4. The FY 2015-16 estimate includes an additional $446,000 due to the increased rate for the period of January 2015 through June 2015. The annual rate increase for the additional $8 is $892,000 TF.

5. The FY 2016-17 estimate includes an additional $669,000 TF due to the anticipated rate increase to $362 from $350 for the period of January 2016 through June 2016. This $12 annual rate increase is based on a five year average and is expected to cost an additional $1,338,000 TF.

	FY 2015-16	**FY 2016-17**
CY 2015 rate increase	$892,000	$892,000
CY 2016 rate increase	$0	$1,338,000
Retro Jan –June 2015 rate increase	$446,000	$0
Retro Jan –June 2016 rate increase	$0	$669,000
Total Rate increase	**$1,338,000**	**$2,899,000**
FY 2014-15 Base expenditures	$38,141,000	$38,141,000
Total expenditures	$39,479,000	$41,040,000

6. Assume beginning February 1, 2016, the Department will reimburse IHS/MOA clinic facilities for FQHC Services. IHS/MOA clinic facilities can claim for FQHC services retroactively to October 2015.

7. Assume the current rate for an IHS is $350 per visit.

8. Based on calendar year (CY) 2014 data, assume 41,685 users, 21 and over, used IHS. Of that population, assume 24,277 use FQHC services. 15,109 are estimated to be American Indian and 9,168 are estimated to be non-American Indian.

9. The Department will reimburse IHS/MOA clinic facilities 100% FF for FQHC services to American Indians and 50% General Fund (GF) and 50% FF for non-American Indians.

10. Assume the average visits per user are two per year.

11. A payment lag of .590 was used for FY 2015-16 and .957 for FY 2016-17.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 179

12. Reimbursement to IHS/MOA clinic facilities from October 2015 to January 2016 of $2,179,000 TF will be paid in FY 2016-17.

13. Assume newly qualified users under the Affordable Care Act receiving services at an IHS/MOA will be reimbursed at 100% FF.

	TF	GF	FF
FY 2015-16			
Non-Indian population	$1,176,000	$588,000	$588,000
Indian population	$2,600,000	$0	$2,600,000
Newly qualified ACA population	$431,000	$0	$431,000
FY 2015-16 Total	**$4,207,000**	**$588,000**	**$3,619,000**
FY 2016-17			
FY 2016-17 costs	$16,686,000	$2,426,000	$14,260,000
Non-Indian population	$4,690,000	$2,345,000	$2,345,000
Indian population	$10,312,000	$0	$10,312,000
Newly qualified ACA population	$1,684,000	$81,000	$1,603,000
Oct 2015 – Jan 2016 payments	$5,704,000	$304,000	$5,400,000
Non-Indian population	$608,000	$304,000	$304,000
Indian population	$3,525,000	$0	$3,525,000
Newly qualified ACA population	$1,571,000	$0	$1,571,000
FY 2016-17 Total	**$22,390,000**	**$2,730,000**	**$19,660,000**

(Dollars in Thousands)	TF	GF	FF
FY 2015-16			
IHS FY 2014-15 Base exp. (50% GF / 50% FF)	($38,141)	($19,071)	($19,071)
IHS total expenditures (100% FF)	$39,479	$0	$39,479
IHS Net Impact	$1,338	($19,071)	$20,409
IHS/MOA Reimbursement (50% GF / 50% FF)	$1,176	$588	$588
IHS/MOA Reimbursement (100% FF)	$3,031	$0	$3,031
IHS/MOA Reimbursement Total	$4,207	$588	$3,619
FY 2015-16 Total	**$5,545**	**($18,483)**	**$24,028**
FY 2016-17			
IHS FY 2014-15 Base exp. (50% GF / 50% FF)	($38,141)	($19,071)	($19,071)
IHS total expenditures (100% FF)	$41,479	$0	$41,040
IHS Net Impact	$2,899	($19,071)	$21,970
IHS/MOA Reimbursement (50% GF / 50% FF)	$5,298	$2,649	$2,649
IHS/MOA Reimbursement (100% FF)	$15,464	$0	$15,464
IHS/MOA Reimbursement (95% GF / 5% FF)	$1,628	$81	$1,546
IHS/MOA Reimbursement Total	$22,390	$2,730	$19,659
FY 2016-17 Total	**$25,289**	**($16,341)**	**$41,629**

*Totals may differ due to rounding.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 179

Funding:
50% Title XIX FFP/ 50% GF (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA / 5% GF (4260-101-0001/0890)

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER:	180
IMPLEMENTATION DATE:	7/2015
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1866

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$4,764,000	$2,625,000
- STATE FUNDS	$2,382,000	$1,312,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,764,000	$2,625,000
STATE FUNDS	$2,382,000	$1,312,500
FEDERAL FUNDS	$2,382,000	$1,312,500

DESCRIPTION

Purpose:
This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:
In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]

Interdependent Policy Changes:
Not Applicable

Background:
The WPCS benefit is designed to assist the waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled and receive personal care services through the federally funded State Plan Personal Care program in order to be eligible for WPCS benefits. There are approximately 3,500 WPCS providers that are paid via timesheets through the Case Management Information Payroll System (CMIPS II) who will be enrolled in workers' compensation. The Department of Social Services (CDSS) will pay for the insurance claims for the WPCS providers and the Department will reimburse CDSS for the costs.

Reason for Change from Prior Estimate:
Additional administrative costs for reimbursement to CDSS were added to the contract cost for FY 2015-16 and on.

Methodology:
1. Assume the Department will pay workers' compensation for providers beginning July 1, 2015, retroactive to FY 2014-15.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 180

2. Based on data provided by the CDSS, FY 2014-15 costs are estimated to be $2,264,000 and $2,500,000 in FY 2015-16. The total cost to be paid for workers' compensation in FY 2015-16 is $4,764,000. The estimated cost for FY 2016-17 is $2,625,000.

FY 2015-16	TF	GF	FF
FY 2014-15 costs	$2,264,000	$1,132,000	$1,132,000
FY 2015-16 costs	$2,500,000	$1,250,000	$1,250,000
FY 2015-16 Total	**$4,764,000**	**$2,382,000**	**$2,382,000**
FY 2016-17 Total	**$2,625,000**	**$1,313,000**	**$1,313,000**

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

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER:	181
IMPLEMENTATION DATE:	2/2016
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1852

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$4,231,000	$5,391,000
- STATE FUNDS	$2,115,500	$2,695,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,231,000	$5,391,000
STATE FUNDS	$2,115,500	$2,695,500
FEDERAL FUNDS	$2,115,500	$2,695,500

DESCRIPTION

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

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:
Implementation moved from October 2015 to February 2016. Prior estimates did not factor in the minimum wage increase authorized under AB 10 (Chaptered 351, Statutes of 2013).

Methodology:
1) Assume overtime and travel time costs will begin in February 2016.

2) Assume 1,700 WPCS providers will receive overtime in FY 2015-16 and 1,451 in FY 2016-17.

3) Assume the monthly cost for overtime in February through April 2016 is $1,077,000 and $1,000,000 for May through June 2016.

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 181

4) Assume the monthly cost for overtime in FY 2016-17 is $449,000.

5) The estimated cost for overtime and travel time for WPCS providers is **$4,231,000 TF ($2,116,000 GF)** in FY 2015-16 and **$5,391,000 TF ($2,696,000 GF)** in FY 2016-17.

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

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER:	182
IMPLEMENTATION DATE:	10/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1826

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,939,000	$0
- STATE FUNDS	$881,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,939,000	$0
STATE FUNDS	$881,500	$0
FEDERAL FUNDS	$2,057,500	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to Indian Health Services/Memorandum of Agreement 638 (IHS/MOA 638) clinics for services provided to Medicare/Medi-Cal crossover beneficiaries.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
Tribal health programs can elect to participate in Medi-Cal as IHS/MOA 638 providers and receive a federally established annual rate for Medi-Cal visits.

IHS/MOA 638 clinics did not receive the full federal per visit rate for services provided to Medi-Cal Crossover beneficiaries between calendar years (CYs) 2009 through 2012. The Department did not disperse the full amount of the Medicare and/or Medi-Cal payment for the billed procedure code 02. IHS/MOA 638 clinics were not required to provide the annual reconciliation reports during that time period. Due to the expansion of the Medi-Cal Managed Care program to all counties, IHS/MOA 638 clinics are now required to submit the reconciliation reports to the Department. The Department has made the proper payment adjustments for claims after CY 2012.

Reason for Change from Prior Estimate:
The changes are due to the shift of FY 2014-15 costs to FY 2015-16 for the three remaining clinic/corporations from a delay in the submission and the processing of reconciliation applications.

Methodology:
1. Assume a total of $2,939,000 was underpaid to three IHS/MOA 638 clinics for services rendered to crossover beneficiaries from CYs 2009 through 2012.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER: 182

2. $1,175,600, or 40% of the $2,939,000, is estimated to be eligible for 100% Federal Medical Assistance Percentage (FMAP). This estimate was based on a paid claims report where 40% of the beneficiaries were American Indians.

3. The remaining $1,176,400 will be funded at a regular 50% FMAP.

4. Reconciliation payments are to be made in FY 2015-16.

FY 2015-16	TF	GF	FF
FY 2008-09	$370,000	$111,000	$259,000
FY 2009-10	$748,000	$225,000	$523,000
FY 2010-11	$738,000	$222,000	$516,000
FY 2011-12	$720,000	$216,000	$504,000
FY 2012-13	$363,000	$109,000	$254,000
Total*	**$2,939,000**	**$883,000**	**$2,056,000**

*Totals may differ due to rounding.

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	2/2012
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1629

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$902,000	$902,000
- STATE FUNDS	$902,000	$902,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$902,000	$902,000
STATE FUNDS	$902,000	$902,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Developmental Services (CDDS) to pay claims for CDDS consumers whose dental services are no longer covered by Medi-Cal.

Authority:
Interagency Agreement (IA) 10-87244

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covered most dental services for adults 21 years of age and older, CDDS entered into an IAA with the Department to have the Medi-Cal dental Fiscal Intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of claims processing and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012. Select adult optional dental services were reinstated May 1, 2014.

This policy change estimates the reimbursement of benefit costs. The reimbursement of administration costs is budgeted in the Other Administration CDDS Dental Services policy change.

Reason for Change from Prior Estimate:
Expenditures have been updated based on actual invoices.

Methodology:
1. Assume the benefit costs will be $902,000 annually.

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	9/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	110

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$854,000	$854,000
- STATE FUNDS	$854,000	$854,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$854,000	$854,000
STATE FUNDS	$854,000	$854,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Public Law 95-452

Interdependent Policy Changes:
Not Applicable

Background:
The Department reached audit settlements with the Office of Inspector General (OIG):

- Federal audit A-09-13-02033 and A-09-13-02054 regarding unallowable Medi-Cal payments for items and services furnished, ordered, or prescribed by excluded providers. The OIG found Medi-Cal payments made to excluded providers that were not eligible for FFP.
- PERM Recovery FY 2013-14 was evaluated through the Improper Payments Information Act (IPIA) of 2002 which requires Federal agencies to review and estimate improper payments.

Reason for Change from Prior Estimate:
A placeholder in the amount of $854,000 was assumed for FY 2016-17.

Methodology:

FY 2015-16	Audit	Finding	TF
A-09-13-02033	Medical Transportation	Identified nonemergency transportation services that did not comply with Federal and State requirements	$376,000
A-09-13-02054	Medical Transportation	Identified nonemergency transportation services that did not comply with Federal and State requirements	$438,000

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

PERM Recovery FY 2013-14	California Medicaid Error Rates for FY 2013-14	Identified and estimated amount of improper payments for Medicaid	$15,000
PERM Recovery FY 2013-14	California CHIP Error Rates for FY 2013-14	Identified and estimated amount of improper payments for CHIP	$25,000
		Total	**$854,000**

A placeholder in the amount of $854,000 was assumed for FY 2016-17.

Funding:
100% GF (4260-101-0001)

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1843

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$325,000	$449,000
- STATE FUNDS	$162,500	$224,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$325,000	$449,000
STATE FUNDS	$162,500	$224,500
FEDERAL FUNDS	$162,500	$224,500

DESCRIPTION

Purpose:
This policy change estimates the costs associated with increasing rates for Homemaker Services provided under the AIDS Medi-Cal Waiver.

Authority:
AB 10 (Chapter 351, Statutes of 2013)
Section 1182.12 of the Labor Code

Interdependent Policy Changes:
Not Applicable

Background:
Local agencies, under contract with the California Department of Public Health's Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization. Homemaker services are a benefit provided to eligible clients under the AIDS Medi-Cal Waiver.

Homemaker services consist of general household activities performed when an individual who would otherwise be responsible for these activities is temporarily absent or unable to manage the home or care for themselves or others in the home. These services allow AIDS Medi-Cal Waiver participants, whose level of need is greater than others who receive only State Plan attendant services, to continue to live in an independent setting. Services rendered are in addition to, not in place of, services authorized under In-Home Supportive Services.

Reimbursement rates for homemaker services under the AIDS Medi-Cal Waiver have not increased since 2008. Subsequently, pursuant to AB 10 (Chapter 351, Statutes of 2013), the minimum wage increased from $8.00 to $9.00 per hour, effective July 1, 2014, and will increase to $10.00 per hour, effective January 1, 2016.

Reason for Change from Prior Estimate:
Rates increased in FY 2016-17.

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER: 188

Methodology:

1. Assume 824 beneficiaries in FY 2015-16 and 854 beneficiaries in FY 2016-17 use Homemaker Services through the AIDS Medi-Cal Waiver.

2. Beginning January 1, 2016, assume the new rate will increase $1.25 per hour from $9.25 per hour to $10.50 per hour. This is a total increase of $2.50 per hour (or $0.625 per 15 minute unit) increase from the prior $8.00 rate.

   $8.00 (prior rate) + $2.00 (min. wage increase) + $0.50 (fringe benefits) = $10.50 per hour

3. Assume the average utilization per beneficiary is 841 units.

4. Assume the total cost for the rate increase will be **$325,000 TF** (rounded) in FY 2015-16.

   <u>July 2015 – December 2015:</u>
   824 beneficiaries x 420 units x $0.3125 rate per unit = $108,000 TF

   <u>January 2016 – June 2016:</u>
   824 beneficiaries x 421 units x $0.625 rate per unit = $217,000 TF

5. Assume the total cost for the rate increase will be **$449,000 TF** (rounded) in FY 2016-17.

   854 beneficiaries x 841 units x $0.625 rate per unit = $449,000 TF

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

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER:	189
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1915

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,595,366,800	-$1,605,590,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,595,366,800	-$1,605,590,850
FEDERAL FUNDS	$1,595,366,800	$1,605,590,850

DESCRIPTION

Purpose:
This policy change estimates the graduated decreased percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population from 100% in FY 2015-16 to 90% in FY 2020-21. This is an adjustment to accurately reflect the federal match.

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 139-AB 1629 Rate Adjustments Due to QA Fee
FFS Base Expenditures
PC 197-Base Recoveries
PC 138-LTC Rate Adjustment
PC 142-Hospice Rate Increases
PC 92-MH/UCD & BTR—DPH Interim Rate Growth
PC 43-Allied Dental Professionals Enrollment
PC 61-Aged and Disputed Drug Rebates
PC 53-ADAP Ryan White MEDS Data Match
PC 54-Hepatitis C Revised Clinical Guidelines
PC 149-Reduction to Radiology Rates
PC 147-Laboratory Rate Methodology Change
PC 69 - Annual Rate Adjustment
PC 204 - Capitated Rate Adjustment
PC 209 - Dental Transformations Initiative

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

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 189

result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and mandatory expansions.

The federal match for optional expansion adults is 100% through 2016, and phases down gradually to 90% by 2020.

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

Methodology:

1) The department identified funds allocated to Newly beneficiaries in the Newly aid category that were Title XIX funding with 50% federal match in the policy change in which they originated.

2) The federal match for FY 2015-16 is 100%. The federal match for FY 2016-17 is 100% through calendar year (CY) 2016 and drops to 95% for CY 2017.

3) The total amount of unadjusted ACA Newly funding for all policy changes in FY 2015-16 is estimated as $3,196,055,047 and in FY 2016-17, it is estimated as $3,376,522,841. These amounts are credited to the Title XIX fund.

4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

FY 2015-16	GF	FF
PC 139-AB 1629 Rate Adjustments Due to QA Fee	($1,359)	$1,359
FFS Base Expenditures	($1,650,367)	$1,650,367
PC 197-Base Recoveries	$30,104	($30,104)
PC 138-LTC Rate Adjustment	($322)	$322
PC 142-Hospice Rate Increases	($64)	$64
PC 92-MH/UCD & BTR—DPH Interim Rate Growth	($5,423)	$5,423
PC 43-Allied Dental Professionals Enrollment	($151)	$151
PC 61-Aged and Disputed Drug Rebates	$36,438	($36,438)
PC 53-ADAP Ryan White MEDS Data Match	($293)	$293
PC 54-Hepatitis C Revised Clinical Guidelines	($265)	$265
PC 149-Reduction to Radiology Rates	$3,932	($3,932)
PC 147-Laboratory Rate Methodology Change	$2,145	($2,145)
PC 209 - Dental Transformations Initiative	($9,742)	$9,742
Totals	**($1,595,367)**	**$1,595,367**

(Dollars in Thousands)

FY 2016-17	GF	FF
PC 139-AB 1629 Rate Adjustments Due to QA Fee	($6,498)	$6,498
FFS Base Expenditures	($1,576,407)	$1,576,407
PC 197-Base Recoveries	$26,761	($26,761)
PC 138-LTC Rate Adjustment	($868)	$868

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 189

PC 142-Hospice Rate Increases	($145)	$145
PC 92-MH/UCD & BTR—DPH Interim Rate Growth	($16,030)	$16,030
PC 43-Allied Dental Professionals Enrollment	$0	$0
PC 61-Aged and Disputed Drug Rebates	$35,929	($35,929)
PC 53-ADAP Ryan White MEDS Data Match	($72)	$72
PC 54-Hepatitis C Revised Clinical Guidelines	($263)	$263
PC 149-Reduction to Radiology Rates	$4,376	($4,376)
PC 147-Laboratory Rate Methodology Change	$3,015	($3,015)
PC 69 - Annual Rate Adjustment	($101)	$101
PC 204 - Capitated Rate Adjustment	($56,686)	$56,686
PC 209 - Dental Transformations Initiative	($18,602)	$18,602
Totals	**($1,605,591)**	**$1,605,591**

Funding:
100% Title XIX Federal Share (4260-101-0890)
95% FF / 5% GF Title XIX Federal Share (4260-101-0890)

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER:	190
IMPLEMENTATION DATE:	7/2015
ANALYST:	Katy Clay
FISCAL REFERENCE NUMBER:	1926

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$100,237,360	-$122,771,420
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$100,237,360	-$122,771,420
FEDERAL FUNDS	$100,237,360	$122,771,420

DESCRIPTION

Purpose:
This policy change estimates the additional federal funding (FF) extended to the Children's Health Insurance Program (CHIP).

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 145-10% Payment Reduction for LTC Facilities
PC 148-10% Provider Payment Reduction
PC 139-AB 1629 Rate Adjustments Due To QA Fee
PC 031-ACA Redeterminations
PC 053-ADAP Ryan White MEDS Data Match
PC 061-Aged and Disputed Drug Rebates
PC 043-Allied Dental Professionals Enrollment
PC 141-Annual MEI Increase for FQHCS/RHCS
FFS Base Expenditures
PC 197 –Base Recoveries
BIS Data Adjustment
Dental Transition Initiative
PC 062-Federal Drug Rebate Program
PC 054-Hepatitis C Revised Clinical Guidelines
PC 142-Hospice Rate Increases
PC 179-Indian Health Services
PC 119-Inland Empire Health Plan Settlement
PC 147-Laboratory Rate Methodology Change
LEA Backout
PC 138-LTC Rate Adjustment
PC 149-Reduction to Radiology Rates

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 190

Background:
The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA has extended enhanced federal funding for Title XXI through the end of the Federal Fiscal year of 2015. Effective October 1, 2015, the ACA will extend and increase the enhanced federal matching rate for the CHIP program by 23 percent. Currently, the California FMAP is 65% FF and 35% General Fund (GF). Beginning in October, 2015, the new enhanced federal match will increase to 88% FF and 12% GF. The enhanced federal matching rate will continue until September 30, 2019.

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

Methodology:
1) The Department identified funds allocated to CHIP beneficiaries in the POV 250 aid category that were not adjusted for additional Title XXI funding in the policy change in which they originated.
2) The total amount of unadjusted CHIP funding for all policy changes in FY 2015-16 is estimated as $330,593,000 and in FY 2016-17, it is estimated at $341,240,000. These amounts are credited to the Title XIX fund.
3) The funds are then broken out according to reimbursement rates based on when the Department estimates the expenditure.
    a. In FY 2015-16, the Department estimates the additional CHIP funding will offset GF spending by $100,237,660.
    b. In FY 2016-17, the Department estimates the additional CHIP funding will offset GF spending by $122,771,316.
4) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
PC 145-10% Payment Reduction for LTC Facilities	$ -	$ -	$ -
PC 148-10% Provider Payment Reduction	$ -	$ 86	$ (86)
PC 139-AB 1629 Rate Adjustments Due To QA Fee	$ -	$ (2)	$ 2
PC 031-ACA Redeterminations	$ -	$ 5,196	$ (5,196)
PC 053-ADAP Ryan White MEDS Data Match	$ -	$ (60)	$ 60
PC 061-Aged and Disputed Drug Rebates	$ -	$ 2,239	$ (2,239)
PC 043-Allied Dental Professionals Enrollment	$ -	$ (16)	$ 16
PC 141-Annual MEI Increase for FQHCS/RHCS	$ -	$ (143)	$ 143
FFS Base Expenditures	$ -	$ (124,830)	$ 124,830
PC 197 –Base Recoveries	$ -	$ 2,309	$ (2,309)
BIS Data Adjustment	$ -	$ (458)	$ 458
Dental Transition Initiative	$ -	$ (1,055)	$ 1,055
PC 062-Federal Drug Rebate Program	$ -	$ 10,167	$ (10,167)
PC 054-Hepatitis C Revised Clinical Guidelines	$ -	$ (17)	$ 17
PC 142-Hospice Rate Increases	$ -	$ (53)	$ 53
PC 179-Indian Health Services	$ -	$ 722	$ (722)
PC 119-Inland Empire Health Plan Settlement	$ -	$ (881)	$ 881
PC 147-Laboratory Rate Methodology Change	$ -	$ 336	$ (336)

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 190

LEA Backout	$ -	$ 5,756	$ (5,756)
PC 138-LTC Rate Adjustment	$ -	$ (1)	$ 1
PC 149-Reduction to Radiology Rates	$ -	$ 468	$ (468)
Totals	$ -	**$ (100,237)**	**$ 100,237**

(Dollars in Thousands)

FY 2016-17	**TF**	**GF**	**FF**
PC 145-10% Payment Reduction for LTC Facilities	$ -	$ -	$ -
PC 148-10% Provider Payment Reduction	$ -	$ 134	$ (134)
PC 139-AB 1629 Rate Adjustments Due To QA Fee	$ -	$ (11)	$ 11
PC 031-ACA Redeterminations	$ -	$ 7,156	$ (7,156)
PC 053-ADAP Ryan White MEDS Data Match	$ -	$ (19)	$ 19
PC 061-Aged and Disputed Drug Rebates	$ -	$ 2,612	$ (2,612)
PC 043-Allied Dental Professionals Enrollment	$ -	$ -	$ -
PC 141-Annual MEI Increase for FQHCS/RHCS	$ -	$ (380)	$ 380
FFS Base Expenditures	$ -	$ (153,216)	$ 153,216
PC 197 –Base Recoveries	$ -	$ 2,798	$ (2,798)
BIS Data Adjustment	$ -	$ (534)	$ 534
Dental Transition Initiative	$ -	$ (2,111)	$ 2,111
PC 062-Federal Drug Rebate Program	$ -	$ 12,900	$ (12,900)
PC 054-Hepatitis C Revised Clinical Guidelines	$ -	$ (19)	$ 19
PC 142-Hospice Rate Increases	$ -	$ (149)	$ 149
PC 179-Indian Health Services	$ -	$ 1,107	$ (1,107)
PC 119-Inland Empire Health Plan Settlement	$ -	$ -	$ -
PC 147-Laboratory Rate Methodology Change	$ -	$ 545	$ (545)
LEA Backout	$ -	$ 5,822	$ (5,822)
PC 138-LTC Rate Adjustment	$ -	$ (3)	$ 3
PC 149-Reduction to Radiology Rates	$ -	$ 597	$ (597)
Totals	$ -	**$ (122,771)**	**$ 122,771**

Funding:
100% State GF (4260-101-0001)
10% State GF (4260-101-0001(3))
50% Title XIX FF / 50% GF (4260-101-0001/0890)
65% Title XXI FF / 35% GF (4260-113-0890/0001)
88% Title XXI FF / 12% GF (4260-113-0890/0001)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	1/2006
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1087

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2014-15 and FY 2015-16. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change also estimates the CTPS/Proposition 99 funding added by the Budget Act of 2010, which provides additional funding for Medi-Cal hospital outpatient services.

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

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 191

Methodology:

FY 2015-16	
Hospital Services Account	$92,129,000
Physicians' Services Account	$19,446,000
Unallocated Account	$31,009,000
Total CTPS/Prop. 99	**$142,584,000**
GF	**($142,584,000)**
Net Impact	**$0**

FY 2016-17	
Hospital Services Account	$107,243,000
Physicians' Services Account	$27,055,000
Unallocated Account	$51,252,000
Total CTPS/Prop. 99	**$185,550,000**
GF	**($185,550,000)**
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	7/2005
ANALYST:	Peter Bjorkman
FISCAL REFERENCE NUMBER:	1633

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change appropriates the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:
Health & Safety Code, Sections 105305, 105310, and 124075
Interagency Agreement (IA) #13-20109 (DHCS # 13-90360)

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The state share of cost for the lead testing component is partly funded by the CLPP Fund. The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate. This policy change adjusts the CLPP funding.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products, and collected by the Board of Equalization.

Reason for Change from Prior Estimate:
No change.

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 192

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.

2. The current IA with the Department of Public Health began October 29, 2013. The term of the IA will be from July 1, 2013 through June 30, 2016, and the CLPP funding allocated for FY 2015-16 is $714,000. A new IA for FY 2016-17 is assumed to be continued at the existing level.

Funding:

FY 2015-16

100% CLPP Fund (4260-111-0080)	$ 714,000
100% GF (4260-101-0001)	**$ (714,000)**
Net Impact	**$ -**

FY 2016-17

100% CLPP Fund (4260-111-0080)	$ 714,000
100% GF (4260-101-0001)	**$ (714,000)**
Net Impact	**$ -**

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1654

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Social Services (CDSS) to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department transitioned care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning April 1, 2014.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation was increased to include IHSS services to this population. This policy change reflects the transfer of General Fund and county funds to the Department to be used to increase managed care capitation rates. An additional policy change, Transfer of IHSS Costs to CDSS, addresses the transfer of IHSS costs from managed care rates to the Department which will in turn transfer the funds to CDSS to pay the IHSS providers.

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 193

Reason for Change from Prior Estimate:
Opt-In enrollment percentages were updated based on data as of July 2015. Caseload data was updated based on actuals through April 2015. In addition, the FY 2015-16 and 2016-17 capitation rates for the CMC, non-CMC, and non-dual populations were updated.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2015-16 and FY 2016-17.

(Dollars in Thousands)

FY 2015-16	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$9,889,062	$4,944,531	$4,944,531	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($6,783,616)	($3,391,808)	($3,391,808)	$0
Defer Managed Care Payment	($175,840)	($87,920)	($87,920)	$0
Total	($6,959,456)	($3,479,728)	($3,479,728)	$0
IHSS FFS Savings (In the Base)	($1,114,753)	$0	($1,114,753)	$0
Delay 1 Checkwrite (In the Base)	$24,401	$12,201	$12,201	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	**$0**	**($1,114,753)**	**$0**	**$1,114,753**
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,307,539	$0	$0	$2,307,539
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$29,062	$14,406	$14,657	$0
CCI IHSS Reconciliation (PC 173)	$60,000	$0	$60,000	$0
Retro MC Rate Adjustments (PC 133)	$198,881	($18,060)	($18,060)	$235,000
Total of CCI PCs including pass through	$4,434,737	$358,596	$418,847	$3,657,293

(Dollars in Thousands)

FY 2016-17	TF	GF	FFP	Reimbursement
CCI-Managed Care Payments (PC 108):				
Total Managed Care Payments	$10,319,468	$5,159,734	$5,159,734	$0
CCI-Savings and Deferral (PC 132):				
Total FFS Savings	($7,716,973)	($3,858,487)	($3,858,487)	$0
Defer Managed Care Payment	$1,708	$854	$854	$0
Total	($7,715,265)	($3,857,633)	($3,857,633)	$0
IHSS FFS Savings (In the Base)	($1,196,798)	$0	($1,196,798)	$0
Delay 1 Checkwrite (In the Base)	$6,872	$3,436	$3,436	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	**$0**	**($1,196,798)**	**$0**	**$1,196,798**
CCI-Transfer of IHSS Costs to CDSS (PC 109)	$2,477,372	$0	$0	$2,477,372
CCI-Admin Costs, HCO Costs (OA 15, 18, 65)	$19,823	$9,912	$9,912	$0
Retro MC Rate Adjustments (PC 133)	($428,219)	($214,110)	($214,110)	$0
Total of CCI PCs including pass through	$3,483,252	($95,459)	($95,459)	$3,674,170

Funding:

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 193

100% Reimbursement (4260-610-0995)
General Fund (4260-101-0001)

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	4/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1760

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 to December 31, 2016.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 130 MCO Tax Managed Care Plans

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014. The Department received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 194

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

Methodology:
1. Payments for children's health care are estimated through the period ending December 31, 2016 in this policy change.

2. On an accrual basis, annual funds for children's health care coverage are:
   - FY 2013-14: $310,000,000
   - FY 2014-15: $726,400,000
   - FY 2015-16: $844,700,000
   - FY 2016-17: $464,000,000

   SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program. The FY 2014-15, FY 2015-16, and FY 2016-17 amounts are the initial children's health care coverage funds calculation and may be adjusted based on the final reconciliation.

3. On a cash basis, the payments to health care coverage for children are:

(Dollars in Thousands)

FY 2015-16	TF	GF	Hosp. QA Rev Fund
FY 2014-15	$0	($181,600)	$181,600
FY 2015-16	$0	($633,525)	$633,525
Total FY 2015-16	**$0**	**($815,125)**	**$815,125**

(Dollars in Thousands)

FY 2016-17	TF	GF	Hosp. QA Rev Fund
FY 2015-16	$0	($211,175)	$211,175
FY 2016-17	$0	($464,000)	$464,000
Total FY 2016-17	**$0**	**($675,175)**	**$675,175**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1746

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$2,558,000	-$262,406,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,558,000	-$262,406,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$2,558,000	-$262,406,000

DESCRIPTION

Purpose:
This policy change estimates the savings associated with reducing the hours of service for In-Home Supportive Services (IHSS) recipients.

Authority:
Welfare & Institutions Code 12301.02

Interdependent Policy Changes:
Not Applicable

Background:
Personal care services are rendered under the administrative direction of the California Department of Social Services (CDSS) for the IHSS program. In accordance with the IHSS Settlement Agreement, filed March 28, 2013, IHSS service hours were reduced by 8% (net impact 6.79%) effective July 1, 2013. This reduction was lowered to 7% (net impact 6.47%) effective July 1, 2014. Effective October 2015, the 7% reduction to IHSS services hours will be restored. The restoration of service hours will be funded by the General Fund.

Due to the Department not including the Managed Care Organization tax continuing into FY 2016-17, the Department assumes the reduction in IHSS hours beginning again on July 1, 2016.

Reason for Change from Prior Estimate:
The implementation for restoration in service hours begins October 1, 2015. For FY 2015-16 the reduction in service hours from July 1, 2015 through September 30, 2015 is captured in this policy change. In FY 2016-17 the reduction in service hours will be implemented July 1, 2016.

Methodology:
The estimated savings are provided by CDSS.

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

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1906

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$17,449,000	-$17,449,000
- STATE FUNDS	-$17,449,000	-$17,449,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$17,449,000	-$17,449,000
STATE FUNDS	-$17,449,000	-$17,449,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of county funds to the state.

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 authorized the transition of all Health Family Program (HFP) subscribers into the Medi-Cal program. Effective January 1, 2013, HFP subscribers transitioned into Medi-Cal through a phase-in methodology.

Of the subscribers, an estimated 23,381 California Children Services (CCS) – HFP eligibles shifted to CCS-Medi-Cal in FY 2013-14. CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under Medi-Cal.

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

Methodology:
1. The county share (17.5%) for CCS-Medi-Cal is estimated to be $17,449,000 TF in FY 2015-16 and FY 2016-17.

Funding:
100% State GF (4260-113-0001)

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 198
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1717

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$3,783,000	$2,175,000
- STATE FUNDS	$0	$1,970,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,783,000	$2,175,000
STATE FUNDS	$0	$1,970,000
FEDERAL FUNDS	$3,783,000	$205,000

DESCRIPTION

Purpose:
This policy change estimates the cost of claims that are submitted by county mental health plans for late eligibility determinations.

Authority:
Title 22, California Code of Regulations 50746 and 51008.5
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:
Not Applicable

Background:
County mental health plans have submitted Medi-Cal specialty mental health service claims for clients with Letters of Authorization for late eligibility determinations. When an over one-year claim is determined as eligible by the Department, the county has 60 days to submit the claim for payment.

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

Methodology:

1. One-year claims are based on actual claims received from the counties.

2. Assume reimbursement will be provided to pay claims in FY 2016-17 that exceed the federal claiming limit.

	TF	FFP	County	Reimbursement
FY 2015-16	$7,566,000	**$3,783,000**	$3,783,000	$0
FY 2016-17	$2,175,000	**$205,000**	$2,174,000	**$1,970,000**

*TF does not include County Funds.

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 198

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)
Reimbursement GF (4260-610-0995)

END OF LIFE SERVICES

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	7/2016
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1943

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$2,330,000
- STATE FUNDS	$0	$2,330,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,330,000
STATE FUNDS	$0	$2,330,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost associated with the End of Life Option Act.

Authority:
ABx2-15 (Chapter 1, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
ABx2-15 would allow a terminally ill adult patient, who meets certain qualifications, the legal right to obtain a prescription for an aid-in-dying drug from his or her attending physician to be self-administered with the intent of hastening his or her own death. Two physicians, attending and consulting, are required to perform various activities, including confirming an eligible diagnosis and prognosis, and determining a patient's competency. The Act sunsets on January 1, 2026.

California's End of Life Option Act and Oregon's Death with Dignity Act (DWDA) are virtually identical in language as well as scope. The Department anticipates the End of Life services will mirror Oregon's trend of very low utilization. Based on 2014 data, a total of 155 Oregon residents obtained prescriptions from their physicians for self-administration of lethal medications in 2014, or .0000498 percent of the adult population. If the same percentage of California's adult population requested End of Life services, 1,476 would request and obtain prescriptions from their physicians. Approximately 30 percent of California's adult residents are eligible for Medi-Cal. It is assumed, based on Oregon's DWDA utilization, no greater than 443 Medi-Cal eligible adults will request End of Life services.

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

Methodology:
1. Assume 443 beneficiaries will request End of Life services per year.

END OF LIFE SERVICES

REGULAR POLICY CHANGE NUMBER: 199

2. Two physician visits are required, per beneficiary, at a cost of $126.

3. Assume 9 of the 443 beneficiaries will be referred for formal mental health evaluations, two visits, at a cost of $159 each visit.

4. Assume the End of Life drug cost, per beneficiary, is $5,403.

5. Assume all 443 beneficiaries will complete the entire process in order to obtain the End of Life prescription drug, regardless of the final decision to take, or not to take, the medication.

6. Assume the implementation date is July 1, 2016.

7. FY 2016-17 costs for End of Life services is estimated to be $2,330,000 TF.

Funding:
100% GF (4260-101-0001)

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER:	200
IMPLEMENTATION DATE:	10/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1936

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$57,224,000	$0
- STATE FUNDS	$57,224,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$57,224,000	$0
STATE FUNDS	$57,224,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation repayment to the Centers for Medicare and Medicaid Services (CMS) for ineligible claims made through the distinct part skilled nursing facility (DP-NF) Capital Project Debt Reimbursement supplemental payment program.

Authority:
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1128 authorized a DP-NF of a public acute care hospital providing specified services and other specific conditions as specified in Section 14105.26 of the Welfare and Institutions Code, to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The Department claims federal funds using certified public expenditures. To be eligible for payments, the capital projects must be completed and have been issued a certificate of occupancy.

On June 16, 2015, CMS notified the Department that it denied the “good cause” waiver request, thus deferring total payments of $57,224,000 for payments that were made to Edgemoor Geriatric Hospital and Laguna Honda Hospital and Rehabilitation Center for costs prior to the certificate of occupancy and/or were not made within the two-year claiming limit.

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

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER: 200

Methodology:

1. The Department will reimburse the federal funds, totaling $57,224,000, in the second quarter of FY 2015-16.

(Dollars in Thousands)

Facility Name	TF	GF
Edgemoor Geriatric Hospital	$1,317	$1,317
Laguna Honda Hospital and Rehabilitation Center	$55,907	$55,907
FY 2015-16	**$57,224**	**$57,224**

Funding:

100% GF (4260-101-0001)

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 202
IMPLEMENTATION DATE: 7/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1947

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$9,364,000
- STATE FUNDS	$0	$4,682,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$9,364,000
STATE FUNDS	$0	$4,682,000
FEDERAL FUNDS	$0	$4,682,000

DESCRIPTION

Purpose:
This policy change estimates the overall net impact of the first year of implementation of Medi-Cal palliative care, as well as the Department providing technical assistance to Medi-Cal managed care plans for delivering palliative care services.

Authority:
SB 1004 (Chapter 574, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) defines palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.” Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

SB 1004 requires the Department to:

- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services.
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis.
- Define palliative care services as a continuum of care based on the patient’s needs.
- Provide access to curative care for beneficiaries eligible for palliative care.

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

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 202

Methodology:

1. Assume as of July 1, 2016, beneficiaries with specific diagnoses will be eligible to begin receiving palliative care services.

2. It is estimated there are approximately 6,000 managed care and 4,000 fee-for-service (FFS) beneficiaries eligible for this program. Assume 50% of managed care (3,000) and 25% of FFS (1,000) beneficiaries will take-up coverage in FY 2016-17.

3. Assume the average length of participation is six months with an estimated annual cost of $5,700 per beneficiary.

4. Assume emergency room (ER) admissions and the number of inpatient days will decrease as result of participating in the palliative care program. The estimated annual savings is $6,840 per beneficiary.

5. Assume there will be a ramp-up period for managed care plans and providers in FY 2016-17. As result, the estimated savings per beneficiary has been reduced by 50% in the first year.

6. The Department estimates initial training of providers will cost $244,000 TF in FY 2016-17.

7. The FY 2016-17 costs for this program are estimated to be:

(Dollars in Thousands)	**FY 2016-17**		
Medi-Cal Costs	**TF**	**GF**	**FF**
Palliative care costs	$22,800	$11,400	$11,400
Initial provider training costs	$244	$122	$122
Subtotal	$23,044	$11,522	$11,522
Offsetting Savings			
Reduction in ER and Inpatient Costs	($13,680)	($6,840)	($6,840)
Net Impact to the State	**$9,364**	**$4,682**	**$4,682**

Funding:

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

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	203
IMPLEMENTATION DATE:	1/2016
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1933

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	-$96,000	-$195,000
- STATE FUNDS	-$48,000	-$97,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$96,000	-$195,000
STATE FUNDS	-$48,000	-$97,500
FEDERAL FUNDS	-$48,000	-$97,500

DESCRIPTION

Purpose:
This policy change estimates the cost savings that will occur as a result of implementing prior authorization requirements for Registered Dental Hygienists in Alternative Practice (RDHAPs) for scaling and root planing services (SRP). This policy change also estimates the cost that will occur as a result of increasing the prophylaxis and fluoride treatments to the residents who reside in Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) to once every four (4) months rather than once per year as is the current adult dental benefit.

Authority:
Title 22, California Code of Regulations (CCR), Section 51003

Interdependent Policy Changes:
Not Applicable

Background:
The Department will be requiring Registered Dental Hygienists in Alternative Practice (RDHAPs) to abide by the submission requirements in the Denti-Cal Manual of Criteria for Medi-Cal Authorization for Dental services for SRP, procedure codes D4341 and D4342. This would also impact the periodontal maintenance (D4910) services.

A prophylaxis is a dental cleaning and does not require pre-treatment radiographs or prior authorization. Fluoride treatments help to prevent decay, especially along the root surfaces which is more exposed in adult populations. These treatments are provided once a year to beneficiaries age 21 and over as part of the current Medi-Cal full-scope benefit package for long term care patients. This policy change is intended to provide needed oral hygiene treatment to beneficiaries residing in SNFs or ICFs. It is recognized that in many cases these residents may not receive daily oral care and have very poor oral hygiene. The Department recommends an increase in the frequency of prophylaxis and fluoride treatments for residents who reside in these facilities to once every four (4) months rather than once per year as is the current adult benefit. This proposal would allow residents to be treated on a more regular basis. However, should it be determined that based on the presence of periodontal disease that SRP procedures is the appropriate course of treatment, the dental provider will need to submit radiographs and proceed through the prior authorization process so that the Medi-Cal Dental

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 203

Services Program may determine the medical necessity for such services.

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

Methodology:
Prior Authorization

1. Assume the estimated number of beneficiaries going to receive these treatments from RDHAPs is 15,835.

2. Assume the prior authorization approval rate for RDHAPs for SRP services will be the same as enrolled dentists' approval rate of 57.5%.

3. The total amount billed for SRP and periodontal maintenance for RDHAPs in FY 2013-14 was $8,170,000.

4. Assume the estimated expenditures for FY 2015-16 without prior authorization would have been $8,466,000. The estimated expenditures for FY 2015-16 with prior authorization would have been $4,868,000. The estimated cost savings as a result of implementing prior authorization requirements for RDHAPs is:

   FY 2015-16: $8,466,000 - $4,868,000 = ($3,598,000)

5. Assume the implementation date is January 1, 2016. The cost savings for FY 2015-16 will be ($1,799,000).

6. Assume the estimated growth factor is 1.018. The estimated cost savings as a result of implementing prior authorization requirements for RDHAPs is:

   FY 2016-17: ($3,598,000) x 1.018 = ($3,663,000)

Increase in Prophylaxis and Fluoride Treatments

7. Assume the rate of beneficiaries being denied SRP in all settings by RDHAPS and non-RDHAPS (dentists) is 43%.

8. In FY 2013-14 the number of beneficiaries denied SRP services by both RDHAPS and dentists is:

   RDHAPS: 17,595 denied beneficiaries
   Dentists: 968 denied beneficiaries

9. Assume the denied beneficiaries will be utilizing the prophylaxis and fluoride treatments, and the number of beneficiaries treated in SNF/ICF settings is:

   SRP services performed by RDHAPS: 90% x 17,595 beneficiaries = 15,835
   SRP services performed by Dentists: 79% x 968 beneficiaries = 765

10. Assume the maximum reimbursement for the proposed policy change of increasing the of prophylaxis and fluoride treatment to three (3) each per year for two (2) years is as follows:
    - $40 per treatment x 6 prophylaxis treatments = $240
    - $6 per treatment x 6 fluoride treatments = $36
    - $20 per facility visit x 6 visits = $120

SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 203

The total cost for one year is:
$240 +$36 +$20 = $396/2 = $198.

11. The estimated annual expenditure for RDHAPS in FY 2013-14 is $198 x 15,835 = $3,136,000

12. The estimated annual expenditure for non-RDHAPS in FY 2013-14 is $198 x 765 = $151,000

13. Assuming a 1.018 estimated growth factor, the estimated annual expenditure for FY 2015-16 and FY 2016-17 is as follows;

    RDHAPS:
    FY 2015-16: $3,192,000 projected expenditure for FY 2014-15 x 1.018 = $3,250,000
    FY 2016-17: $3,250,000 projected expenditure for FY 2015-16 x 1.018 = $3,308,000

    Dentists:
    FY 2015-16: $154,000 projected expenditure for FY 2014-15 x 1.018 = $157,000
    FY 2016-17: $157,000 projected expenditure for FY 2015-16 x 1.018 = $160,000

14. Assume the implementation date is January 1, 2016. The total estimated costs that will occur as a result of increasing the prophylaxis and fluoride treatments by both RDHAPS and non-RDHAPS is:

FY	FY 2015-16	FY 2016-17
RDHAPS	$1,625,000	$3,308,000
Non-RDHAPS	$78,000	$160,000
Total	**$1,703,000**	**$3,468,000**

15. The total cost of increasing the prophylaxis and fluoride treatments combined with the cost savings realized by implementing prior authorization requirements for RDHAPS is:

FY 2015-16	TF	GF	FF
Savings from prior authorization	($1,799,000)	($899,500)	($899,500)
Cost from increased treatments	$1,703,000	$851,500	$851,500
Total	**($96,000)**	**($48,000)**	**($48,000)**

FY 2016-17	TF	GF	FF
Savings from prior authorization	($3,663,000)	($1,831,500)	($1,831,500)
Cost from increased treatments	$3,468,000	$1,734,000	$1,734,000
Total	**($195,000)**	**($97,500)**	**($97,500)**

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

CAPITATED RATE ADJUSTMENT FOR FY 2016-17

REGULAR POLICY CHANGE NUMBER:	204
IMPLEMENTATION DATE:	7/2016
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1338

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$327,480,000
- STATE FUNDS	$0	$154,660,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$327,480,000
STATE FUNDS	$0	$154,660,500
FEDERAL FUNDS	$0	$172,819,500

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2016-17.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 105 Two Plan Model
PC 106 County Organized Health Systems
PC 107 Geographic Managed Care
PC 110 Regional Model

Background:
Managed care capitation rates will be rebased in FY 2016-17 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types.

This policy change shows the increase in capitation rates from FY 2015-16 to FY 2016-17.

Reason for Change from Prior Estimate:
This a new policy change which assumes FY 2016-17 managed care rates will increase by 2.52% compared to the FY 2015-16 rates. The Affordable Care Act (ACA) Optional Expansion rates were excluded from the rate increase.

CAPITATED RATE ADJUSTMENT FOR FY 2016-17

REGULAR POLICY CHANGE NUMBER: 204

Methodology:

(Dollars in Thousands)	Cost by Plan	Rate Adjustment	Rate Increase
Two Plan	$7,374,395	2.52%	$87,820
COHS	$3,484,923	2.52%	$35,589
GMC	$1,412,247	2.52%	$18,237
Regional	$723,690	2.52%	$185,835
Total (Rounded)	**$12,995,255**	2.52%	**$327,480**

Funding:

(Dollars in Thousands)

FY 2016-17	Two Plan	COHS	GMC	Regional	Total
Title XIX 50/50 FFP (4260-101-0001/0890)	$172,563	$79,714	$32,447	$16,722	$301,445
State GF (4260-101-0001)	$525	$281	$98	$98	$1,002
Family Planning 90/10 GF (4260-101-0001-0890)	$1,958	$835	$386	$219	$3,398
Title XXI 88/12 GF (4260-101-0001/0890)	$10,789	$6,991	$2,658	$1,198	$21,635
Total Funds	$185,835	$87,820	$35,589	$18,237	**$327,480**
Total FFP	$97,538	$46,760	$18,909	$9,612	**$172,820**
Total GF	$88,297	$41,060	$16,679	$8,625	**$154,661**

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER:	205
IMPLEMENTATION DATE:	5/2016
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1950

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$800,000,000	$1,600,000,000
- STATE FUNDS	$400,000,000	$800,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$800,000,000	$1,600,000,000
STATE FUNDS	$400,000,000	$800,000,000
FEDERAL FUNDS	$400,000,000	$800,000,000

DESCRIPTION

Purpose:
This policy change estimates the payments to fund the delivery system transformation and alignment incentive program, known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME).

Authority:
Waiver 2020
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
California will fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects will be reported on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. To promote greater stability, 50 percent of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55 percent by January 2019; and 60 percent by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems (DPH) and district/municipal public hospitals (DMPH) to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to $1.4 billion annually for the DPH systems and up to $200 million annually for the DMPH systems for the first three years of the demonstration. The pool will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.

Reason for Change from Prior Estimate:

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 205

This is a new policy change.

Methodology:

1. Assumes two semi-annual reports are due: the first report will be due in March for the July to December period and the second report is due in September for the January to June period.

2. Assumes half of the allocation is paid based on the first semi-annual report and the remaining balance is paid based on the second semi-annual report.

(Dollars in Thousands)

FY 2015-16	TF	IGT*	FF
DPH	$700,000	$350,000	$350,000
DMPH	$100,000	$50,000	$50,000
Total FY 2015-16	**$800,000**	**$400,000**	**$400,000**

FY 2016-17	TF	IGT*	FF
FY 2015-16			
DPH	$700,000	$350,000	$350,000
DMPH	$100,000	$50,000	$50,000
Total	$800,000	$400,000	$400,000
FY 2016-17			
DPH	$700,000	$350,000	$350,000
DMPH	$100,000	$50,000	$50,000
Total	$800,000	$400,000	$400,000
Total FY 2016-17	**$1,600,000**	**$800,000**	**$800,000**

Funding:

50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)*

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	206
IMPLEMENTATION DATE:	11/2015
ANALYST:	Joy Oda
FISCAL REFERENCE NUMBER:	1951

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$2,603,064,000	$2,492,584,000
- STATE FUNDS	$1,301,532,000	$1,246,292,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,603,064,000	$2,492,584,000
STATE FUNDS	$1,301,532,000	$1,246,292,000
FEDERAL FUNDS	$1,301,532,000	$1,246,292,000

DESCRIPTION

Purpose:
This policy change estimates the payments to fund California's remaining uninsured population.

Authority:
Waiver 2020
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waiver's Safety Net Care Pool (SNCP) and Medicaid Disproportionate Share Hospital (DSH) funding. These two funding sources have been provided through a cost-based system that has resulted in prolonged periods of cost reconciliations. The Waiver 2020's redesigned Global Payment Program (GPP) will include funding from the former SNCP and the State's DSH allotment (related to the DPHs), and is designed with preset reductions to the overall funding amounts in the latter demonstration years to coincide with the Medicaid DSH reductions required in the Affordable Care Act (ACA). This safety net stabilization program will provide an innovative approach to financing care to California's remaining uninsured population served by DPH systems by unifying the DSH and the successor SNCP funding streams into a DPH-specific global payment system. The GPP incentive and utilization based program will steer funding to those who are providing actual inpatient and/or outpatient services to uninsured Californians' who are most in need. Rather than continue payments to inpatient facilities based upon the current SNCP and DSH system that provides funding based on the volume of hospitalizations, the GPP would promote the right care, at the right time, in the right setting for uninsured Californians served by the DPH systems.

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

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 206

Methodology:

1. FY 2015-16 assumes federal funding from the DPH portion of the 2015-16 DSH allotment of $1.095 billion and Demonstration Year (DY) 2015-16 SNCP funding of $206.5 million.

2. FY 2016-17 assumes federal funding from the DPH portion of the 2015-16 DSH allotment of $99.5 million and DY 2015-16 SNCP funding of $29.5 million. In addition, FY 2016-17 adds $1.117 billion of federal funds from the DPH portion of the 2016-17 DSH allotment.

3. DY 2016-17 SNCP funding will be determined after the first DY.

(Dollars in Thousands)

FY 2015-16	TF	IGT*	FF
DY 2015-16	$2,603,064	$1,301,532	$1,301,532
Total	**$2,603,064**	**$1,301,532**	**$1,301,532**

FY 2016-17	TF	IGT*	FF
DY 2015-16	$258,096	$129,048	$129,048
DY 2016-17	$2,234,488	$1,117,244	$1,117,244
Total	**$2,492,584**	**$1,246,292**	**$1,246,292**

Funding:

50% Title XIX / 50% MIPA (4260-101-0890/4260-606-0834)*

WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 207
IMPLEMENTATION DATE: 3/2016
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1952

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$37,500,000	-$75,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$37,500,000	-$75,000,000
FEDERAL FUNDS	$37,500,000	$75,000,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the new Waiver 2020. General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative.

Authority:
Waiver 2020
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
AIDS Drug Assistance Program (ADAP)
Breast & Cervical Cancer Treatment Program (BCCTP)
California Children Services (CCS)
Department of Developmental Services (DDS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Mental Health Loan Assumption Program (MHLAP) • Song-Brown HealthCare Workforce Training • Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)

WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 207

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

Methodology:

FY 2015-16	TF	GF	FF
ADAP	$0	($7,412,500)	$7,412,500
BCCTP	$0	($250,000)	$250,000
CCS	$0	($7,500,000)	$7,500,000
DDS	$0	($13,125,000)	$13,125,000
GHPP	$0	($5,625,000)	$5,625,000
MIA-LTC	$0	($1,875,000)	$1,875,000
PCTP	$0	($125,000)	$125,000
MHLAP	$0	($625,000)	$625,000
Song-Brown	$0	($687,500)	$687,500
STLRP	$0	($275,000)	$275,000
Total	**$0**	**($37,500,000)**	**$37,500,000**

FY 2016-17	TF	GF	FF
ADAP	$0	($14,825,000)	$14,825,000
BCCTP	$0	($500,000)	$500,000
CCS	$0	($15,000,000)	$15,000,000
DDS	$0	($26,250,000)	$26,250,000
GHPP	$0	($11,250,000)	$11,250,000
MIA-LTC	$0	($3,750,000)	$3,750,000
PCTP	$0	($250,000)	$250,000
MHLAP	$0	($1,250,000)	$1,250,000
Song-Brown	$0	($1,375,000)	$1,375,000
STLRP	$0	($550,000)	$550,000
Total	**$0**	**($75,000,000)**	**$75,000,000**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

WAIVER 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 208
IMPLEMENTATION DATE: 7/2016
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1953

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$900,000,000
- STATE FUNDS	$0	$450,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$900,000,000
STATE FUNDS	$0	$450,000,000
FEDERAL FUNDS	$0	$450,000,000

DESCRIPTION

Purpose:
This policy change estimates the costs related to Medi-Cal 2020 Waiver Whole Person Care Pilots.

Authority:
Waiver 2020
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:

Under the Medi-Cal 2020 Waiver, the Centers for Medicare and Medicaid Services (CMS) has approved funding for Whole Person Care (WPC) and Housing & Supportive Services pilot programs.

These pilots will allow a county or group of counties to integrate services for their high-risk, high-utilizing beneficiaries to promote an integrated health system that is designed to maximize health care value and is sustainable over the long-term. Pilots will allow county, state, and federal entities as well as managed care plans, hospitals, and provider organizations to align communication and integrate services to prevent fragmentation of the delivery system that can result in duplicative or inappropriate care for Medi-Cal beneficiaries.

Proposals for Whole-Person Care Pilots will include specific strategies to:

1. Increase integration among entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC pilots over the long term.

2. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries and reduce inappropriate emergency department utilization.

WAIVER 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 208

3. Improve data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements.

Proposals may also focus on Housing & Supportive Services which include (but are not limited to):

1. Access to housing
2. Tenancy-based care management services
3. County Housing Pools

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

Methodology:
1. Assume counties will submit pilot proposals and the Department will determine the program awards in FY 2015-16. The payments are assumed to begin in FY 2016-17.

(Dollars in Thousands)

	TF	IGT*	FF
FY 2016-17	$900,000	$450,000	$450,000
Total	**$900,000**	**$450,000**	**$450,000**

Funding:

100% FFP Title XIX (4260-101-0890)
*Reimbursement GF (4260-610-0995)

WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER:	209
IMPLEMENTATION DATE:	1/2016
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1954

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$75,000,000	$150,000,000
- STATE FUNDS	$37,500,000	$75,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$75,000,000	$150,000,000
STATE FUNDS	$37,500,000	$75,000,000
FEDERAL FUNDS	$37,500,000	$75,000,000

DESCRIPTION

Purpose:
This policy change estimates the dental-related costs for Medi-Cal 2020 Waiver. These costs include the estimated increase in utilization, and continuity of care incentive payments for participating billing providers and dental providers.

Authority:
Waiver 2020
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:

Under the Medi-Cal program, dental services are provided to approximately twelve million adult and child Medi-Cal beneficiaries. The provision of dental services for the fee-for-service (FFS) and dental managed care (DMC) delivery systems involves, but is not limited to: ensuring access to care; providing beneficiary and provider customer service through telephone service center operations and correspondence controls; encouraging and maintaining dental provider participation; beneficiary and provider outreach and education; monitoring provider network adequacy and beneficiary utilization; and reporting to stakeholders and other government entities of both federal and state governments.

Through the Department's Dental Fiscal Intermediary contract oversight and overall administration of the Medi-Cal Dental program, the goal of the Medi-Cal 2020 Waiver is to:

- Improve the beneficiary's experience to enable them to easily access high quality dental services,
- Develop effective, efficient, and sustainable health care delivery systems,
- Maintain effective, open communication and engagement with the public, and other stakeholders, and
- Hold providers, plans, and partners accountable for performance.

WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 209

The operation of the Medi-Cal 2020 Waiver programs for dental services is intended to encourage access to care for the beneficiaries, encourage provider participation, and hold the contractor(s) responsible for being active and proactive participants in ensuring the delivery of medically necessary services to the Medi-Cal beneficiary population. These programs include:

(1) Increase Preventative Services Utilization for Children,
(2) Caries Risk Assessment and Management (CRA), and
(3) Increase the Continuity of Care.

The Increase Preventative Services Utilization for Children program aims to increase the statewide proportion of children ages twenty and under enrolled in Medi-Cal who receive a preventative dental service by ten percentage points over a five year period. The Department will provide incentive payments to increase preventative oral care to Medi-Cal children. These payments will be in the form of annual supplemental payments for additional preventative services provided.

The Caries Risk Assessment and Management program enables eligible Denti-Cal dentists to receive bundled payments by completing pre-identified treatment plans for children under the age of seven, based upon the beneficiary's risk level as determined by the dentist via a caries risk assessment. This program emphasizes the provision of preventative services in lieu of more invasive and costly procedures.

The Increase the Continuity of Care program aims to encourage the continuity of care among Medi-Cal beneficiaries aged 0 to 20. Providers who have maintained the continuity of care for the enrolled beneficiaries will be eligible for an annual supplemental incentive payment.

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

Methodology:
Assume 50% of the estimated annual costs for each FY will be paid in the same FY, and the remainder in the following FY.

<u>Increase Preventative Services Utilization for Children</u>

1. Assume Calendar Year 2014 was utilized for the baseline year data.

2. The incentive payment for preventative services will equate to a supplemental payment of an additional thirty percent above of the Schedule of Maximum Allowances (SMA). Incentive payments will be made annually following the appropriate claims processing runout period.

3. Statewide Medi-Cal eligibles are expected to grow at 2.5 percent annually.

<u>Caries Risk Assessment and Management</u>

4. Annual population growth is expected at 2.5 percent for demonstration years two through five.

5. Assume all beneficiaries fall into the high risk category.

6. The incentive program will only be available for services performed on child beneficiaries under seven years old.

7. The pre-identified treatment plans will be composed of the following procedures: Caries Risk

WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 209

Assessment, topical fluoride varnish application, and prophylaxis. To be eligible for the incentive payments, dentists must complete a CRA and the corresponding treatment plan in its entirety.

8. Dentists will receive flat rate payments on an annual basis for each beneficiary they successfully assess and treat. Dentists that fail to complete both required components will receive the standard reimbursement rate for the services provided, but will not receive the additional flat rate incentive.

Increase the Continuity of Care

9. This incentive program will be available to service office locations that provide examinations (D0120, D0150, or D0145) to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.

10. Incentive payment amounts will be tiered based on the length of time a beneficiary maintains continuity of care with the same service office location. Tier one (1) payments will be based on the percentage of beneficiaries who receive an examination from the same service office location for two (2) consecutive years. Tiers two through five will be 25% higher than each prior tier for beneficiaries that maintain additional years of care continuity.

11. On a cash basis, total demonstration costs are estimated to be:

(Dollars in Thousands)

Demonstration Year	**TF**	**GF**	**FF**
Year 1 FY 2015-16	$75,000	$37,500	$37,500
Year 2 FY 2016-17	$150,000	$75,000	$75,000
Year 3 FY 2017-18	$150,000	$75,000	$75,000
Year 4 FY 2018-19	$150,000	$75,000	$75,000
Year 5 FY 2019-20	$150,000	$75,000	$75,000
FY 2020-21	$75,000	$37,500	$37,500
Total	$750,000	$375,000	$375,000

Funding:

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

FFP REPAYMENT FOR CDDS COSTS

REGULAR POLICY CHANGE NUMBER:	210
IMPLEMENTATION DATE:	1/2016
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1956

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$42,537,000	$3,800,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$42,537,000	$3,800,000
FEDERAL FUNDS	-$42,537,000	-$3,800,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Developmental Services (CDDS) and payment to the Centers for Medicare and Medicaid Services (CMS) for an overpayment of CDDS Medi-Cal eligible costs.

Authority:
Federal Regulations

Interdependent Policy Changes:
Not Applicable

Background:
Audit findings identified $42,537,000 General Funds (GF) are due to CMS in FY 2015-16 to remain in compliance with federal regulations. The overpayment is related to audit findings in FY 2008-09, 2009-10, and 2010-11 for Medi-Cal services provided in intermediate care facilities for the developmentally disabled. The Department has included $3,800,000 GF for FY 2016-17, to reflect the 2011-12 audit findings.

The Department expects to receive reimbursement from CDDS in FY 2015-16 and FY 2016-17 and will make a federal fund repayment for FY 2015-16 in January 2016.

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

FFP REPAYMENT FOR CDDS COSTS

REGULAR POLICY CHANGE NUMBER: 210

Methodology:
1. Reimbursement and costs are as follows:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF	Reimbursement
CDDS Reimbursement	$0	($42,537)	$0	$42,537
CMS Payment	$0	$42,537	($42,537)	$0
Total	**$0**	$0	**($42,537)**	**$42,537**

FY 2016-17	TF	GF	FF	Reimbursement
CDDS Reimbursement	$0	($3,800)	$0	$3,800
CMS Payment	$0	$3,800	($3,800)	$0
Total	**$0**	$0	**($3,800)**	**$3,800**

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

MHP COSTS FOR CHILDREN AND YOUTH IN FOSTER CARE

REGULAR POLICY CHANGE NUMBER: 211
IMPLEMENTATION DATE: 1/2017
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1957

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	$0	$416,000
- STATE FUNDS	$0	$208,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$416,000
STATE FUNDS	$0	$208,000
FEDERAL FUNDS	$0	$208,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to counties for participating in a child and family team (CFT) and providing assessments for seriously emotionally disturbed (SED) foster children.

Authority
AB 403 (Chapter 773, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
AB 403 is part of an effort to reform congregate care in California. AB 403 establishes a new community care licensure category that is a short-term residential treatment center (STRTC). STRTCs are licensed and regulated by the California Department of Social Services (CDSS). STRTCs that provide specialty mental health services (SMHS) are certified by the Department.

Two criteria must be met before a child or youth may be placed in an STRTC that is certified to provide SMHS. The county mental health department must complete a mental health assessment that determines if the child or youth has a serious emotional disturbance, or meets medical necessity criteria for SMHS for eligible beneficiaries under the age of 21 (Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)). Either a CFT or an interagency placement council (IPC) must decide that a STRTC is the appropriate level of care for the child or youth.

STRTCs that are certified to provide SMHS are intended to serve children and youth who would have been placed in a group home with a rate classification level of 10-12 or 14. County mental health departments currently participate in a CFT and complete mental health assessments for children and youth who are being considered for placement in a group home with a rate classification level (RCL) of 14. AB 403 requires county mental health departments to perform the following additional workload for children and youth who would have otherwise been placed in an RCL 10-12 group home:

MHP COSTS FOR CHILDREN AND YOUTH IN FOSTER CARE

REGULAR POLICY CHANGE NUMBER: 211

- Participating in the CFT to determine whether or not a child or youth meets criteria to be placed in an STRTC; and

- Assessing prior to placement in an STRTC to determine if the child or youth has a serious emotional disturbance, or meets medical necessity criteria for eligible beneficiaries under the age of 21.

These activities are expected to begin January 2017. Since counties are expected to meet additional, new requirements, the Department will be responsible for the non-federal share (Prop. 30) of the related costs.

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

Methodology:
Participation in a Child and Family Team (CFT)

1. Assume mental health staff will work with each child for two hours to determine whether or not a child or youth meets criteria to be placed in an STRTC.

2. Based on CDSS' estimated number of children who are currently in a rate classification level (RCL) 10 to12 or 14 residential group home, assume 393 children would phase in and transition to an STRTC in FY 2016-17.

3. Based on filed cost reports for mental health, the average cost for treatment planning is $3.77 per minute, or $226.20 per hour, for mental health staff to participate in the CFT.

4. Assume two hours are spent, by mental health staff, in a CFT to determine whether a child or youth meets the criteria to be placed in a STRTC.

5. The estimated cost for participation in a child and family team is:

   393 x $226.20 x 2 = $177,793

Placement Assessments

1. Assume it will take mental health staff four hours per client to complete a mental health assessment.

   393 x $226.20 x 4 = $355,586

2. Based on Short Doyle/Medi-Cal paid claims data, the Department will pay 78% of current year claims in the year the services occur and 22% in the following year.

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
CFT	$139	$69	$70
Placement Assessments	$277	$139	$138
Total	**$416**	**$208**	**$208**

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