

MEDI-CAL
November 2015
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2015-16 *and* 2016-17



The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL
NOVEMBER 2015
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2015-16 and 2016-17**

Fiscal Forecasting Branch
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November 2015 Medi-Cal Estimate

Current Year (FY 2015-16) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

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

Medical Care Services	FY 2015-16 Appropriation	Nov 2015 Estimate	Change	
			Amount	Percent
Total Funds	\$86,671.2	\$87,917.9	\$1,246.7	1.4%
Federal Funds	\$55,567.1	\$57,560.5	\$1,993.4	3.6%
General Fund	\$17,078.2	\$16,680.2	(\$398.0)	-2.3%
Other Non-Federal Funds	\$14,025.9	\$13,677.2	(\$348.7)	-2.5%

County Administration	FY 2015-16 Appropriation	Nov 2015 Estimate	Change	
			Amount	Percent
Total Funds	\$3,885.0	\$3,973.9	\$88.9	2.3%
Federal Funds	\$3,053.3	\$3,156.2	\$102.9	3.4%
General Fund	\$805.6	\$799.9	(\$5.7)	-0.7%
Other Non-Federal Funds	\$26.1	\$17.8	(\$8.3)	-31.8%

Fiscal Intermediary	FY 2015-16 Appropriation	Nov 2015 Estimate	Change	
			Amount	Percent
Total Funds	\$471.4	\$485.5	\$14.1	3.0%
Federal Funds	\$315.3	\$319.7	\$4.4	1.4%
General Fund	\$156.1	\$165.8	\$9.7	6.2%
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	n/a

Total Expenditures	FY 2015-16 Appropriation	Nov 2015 Estimate	Change	
			Amount	Percent
Total Funds	\$91,027.5	\$92,377.3	\$1,349.8	1.5%
Federal Funds	\$58,935.7	\$61,036.4	\$2,100.7	3.6%
General Fund	\$18,039.9	\$17,645.9	(\$394.0)	-2.2%
Other Non-Federal Funds	\$14,052.0	\$13,695.0	(\$357.0)	-2.5%

Note: Totals may not add due to rounding.

November 2015 Medi-Cal Estimate

Budget Year (FY 2016-17) Projected Expenditures Compared to Current Year (FY 2015-16)

(Dollars in Millions)

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

Medical Care Services	FY 2015-16 Estimate	FY 2016-17 Estimate	Change	
			Amount	Percent
Total Funds	\$87,917.9	\$80,481.3	(\$7,436.6)	-8.5%
Federal Funds	\$57,560.5	\$50,504.3	(\$7,056.2)	-12.3%
General Fund	\$16,680.2	\$18,079.0	\$1,398.8	8.4%
Other Non-Federal Funds	\$13,677.2	\$11,898.0	(\$1,779.2)	-13.0%

County Administration	FY 2015-16 Estimate	FY 2016-17 Estimate	Change	
			Amount	Percent
Total Funds	\$3,973.9	\$4,100.4	\$126.5	3.2%
Federal Funds	\$3,156.2	\$3,239.6	\$83.4	2.6%
General Fund	\$799.9	\$851.1	\$51.2	6.4%
Other Non-Federal Funds	\$17.8	\$9.7	(\$8.1)	-45.5%

Fiscal Intermediary	FY 2015-16 Estimate	FY 2016-17 Estimate	Change	
			Amount	Percent
Total Funds	\$485.5	\$456.7	(\$28.8)	-5.9%
Federal Funds	\$319.7	\$302.7	(\$17.0)	-5.3%
General Fund	\$165.8	\$154.0	(\$11.8)	-7.1%
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	n/a

Total Expenditures	FY 2015-16 Estimate	FY 2016-17 Estimate	Change	
			Amount	Percent
Total Funds	\$92,377.3	\$85,038.5	(\$7,338.8)	-7.9%
Federal Funds	\$61,036.4	\$54,046.5	(\$6,989.9)	-11.5%
General Fund	\$17,645.9	\$19,084.1	\$1,438.2	8.2%
Other Non-Federal Funds	\$13,695.0	\$11,907.7	(\$1,787.3)	-13.1%

Note: Totals may not add due to rounding.

November 2015 Medi-Cal Estimate Management Summary

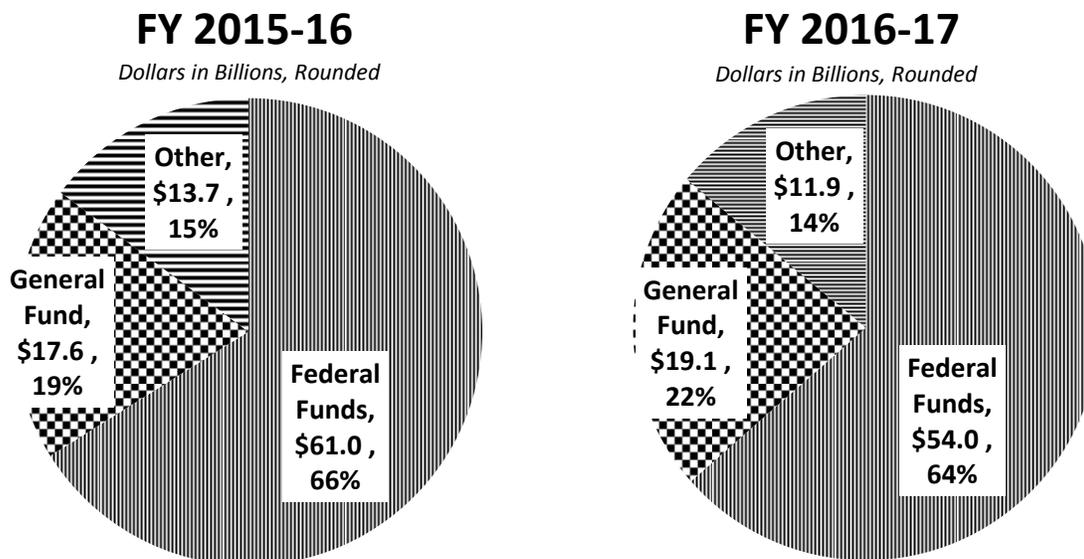
Medi-Cal, California's Medicaid program, provides health care to over 13 million Californians and utilizes Federal, State, and local government funding. Medi-Cal began in 1966 and celebrates 50 years in 2016. The Medi-Cal Local Assistance Estimate (Estimate) forecasts the current and budget year expenditures for the Medi-Cal program. Those expenditures are categorized as:

- **Benefits**: Expenditures for the care of Medi-Cal beneficiaries. These expenditures can be found in the following sections:
 - FFS Base
 - Base Policy Changes, and
 - Regular Policy Changes.

These estimated expenditures are summarized in the Current Year and Budget Year sections.

- **County Administration**: Expenditures for the counties to determine Medi-Cal eligibility, as well as, additional expenditures required to administer the Medi-Cal program. These estimated expenditures can be found in the following sections:
 - County Administration
 - Other Administration
- **Fiscal Intermediary**: Expenditures associated with the processing of medical claims. The expenditures can be found in the Other Administration section. Please see the Other Administration tab for a breakdown of the funding correlated to County Administration and Fiscal Intermediary components.

Medi-Cal spending is estimated to be \$92.4 billion in FY 2015-16 and \$85.0 billion in FY 2016-17. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.



The November 2015 Estimate for FY 2015-16 is \$394 million General Fund less than the FY 2015-16 Budget Appropriation.

	FY 2015-16		
	Appropriation	November 2015	Change
Medical Care Services	\$ 17,078.2	\$ 16,680.2	\$ (398.0)
County Administration	\$ 805.6	\$ 799.9	\$ (5.7)
Fiscal Intermediary	<u>\$ 156.1</u>	<u>\$ 165.8</u>	<u>\$ 9.7</u>
Total	\$ 18,039.9	\$ 17,645.9	\$ (394.0)

(Dollars in Millions, Rounded)

The Medi-Cal General Fund costs in FY 2016-17, as compared to updated FY 2015-16 costs, are estimated to increase by \$1,438.3 million.

	November 2015		
	FY 2015-16	FY 2016-17	Change
Medical Care Services	\$ 16,680.2	\$ 18,079.0	\$ 1,398.8
County Administration	\$ 799.9	\$ 851.1	\$ 51.2
Fiscal Intermediary	<u>\$ 165.8</u>	<u>\$ 154.1</u>	<u>\$ (11.7)</u>
Total	\$ 17,645.9	\$ 19,084.2	\$ 1,438.3

(Dollars in Millions, Rounded)

The following paragraphs briefly describe the major changes in both FY 2015-16 and FY 2016-17.

NEW ITEMS*Dollars in Millions*

Name	PC	Change from Appropriation		Change from FY 2015-16	
		FY 2015-16		FY 2016-17	
		TF	GF	TF	GF
BASE PCs					
-no new items-					
REGULAR PCs					
Beneficiary Outreach and Education Program	46	\$0.2	\$0.1	\$0.6	\$0.2
End of Life Services	199	\$0.0	\$0.0	\$2.3	\$2.3
SRP Prior Auth. & Preventive Dental Services	203	-\$0.1	\$0.0	-\$0.1	\$0.0
Orkambi Benefit	52	\$18.1	\$8.6	\$38.7	\$18.3
ADAP Ryan White MEDS Data Match	53	\$2.4	\$1.2	-\$1.8	-\$0.9
Residential Treatment Services Expansion	65	\$14.6	\$5.1	\$76.3	\$27.4
MHP Costs for Children and Youth in Foster Care	211	\$0.0	\$0.0	\$0.4	\$0.2
Public Hospital Redesign & Incentives in Medi-Cal	205	\$800.0	\$0.0	\$800.0	\$0.0
Global Payment Program	206	\$2,603.1	\$0.0	-\$110.5	\$0.0
Waiver 2020 Designated State Health Program	207	\$0.0	-\$37.5	\$0.0	-\$37.5
Waiver 2020 Whole Person Care Pilots	208	\$0.0	\$0.0	\$900.0	\$0.0
Waiver 2020 Dental Transformation Initiative	209	\$75.0	\$37.5	\$75.0	\$37.5
Inland Empire Health Plan Settlement	119	\$36.7	\$18.4	-\$36.7	-\$18.4
Former Agnews' Beneficiaries Recoupment	131	-\$5.7	-\$2.8	\$5.7	\$2.8
Palliative Care Services Implementation	202	\$0.0	\$0.0	\$9.4	\$4.7
Capitated Rate Adjustment for FY 2016-17	204	\$0.0	\$0.0	\$327.5	\$154.7
Medicare Part B Premium Increase	134	\$152.2	\$85.3	\$204.7	\$114.7
GDSP Newborn Screening Program Fee Increase	143	\$0.0	\$0.0	\$1.9	\$1.0
DP-NF Capital Project Debt Repayment	200	\$57.2	\$57.2	-\$57.2	-\$57.2

Dollars in Millions

Name	PC	Change from Appropriation		Change from FY 2015-16	
		FY 2015-16		FY 2016-17	
		TF	GF	TF	GF
FFP Repayment for CDDS Costs	210	\$0.0	\$0.0	\$0.0	\$0.0
COUNTY ADMINISTRATION PCs					
-no new items-					
OTHER ADMINISTRATION PCs					
PAVE System	12	\$14.6	\$1.9	-\$0.6	\$0.3
Actuarial Costs for Rate Development	18	\$9.1	\$4.4	\$7.8	\$3.8
Performance Outcomes System	99	\$0.0	\$0.0	\$23.7	\$11.9
Dental FI-Beneficiary Outreach & Ed Program - Admin	100	\$1.0	\$0.4	\$2.0	\$0.9

BASE PCs**REGULAR PCs***BENEFITS***Beneficiary Outreach and Education Program (PC 46)**

This outreach and education program seeks to increase utilization of dental services, particularly in counties where utilization levels are lowest.

End of Life Services (PC 199)

The End of Life Option Act, ABX2 -15 (Chapter 1, Statutes of 2015), allows a terminally ill adult patient, who meets certain qualifications, the legal right to obtain a prescription for an aid-in-dying drug from his/her attending physician to be self-administered with the intent of hastening his/her own death. The Act sunsets on January 1, 2026.

SRP Prior Authorization and Preventive Dental Services (PC 203)

Prior Authorization requirements will be implemented for Registered Dental Hygienists in Alternative Practice for scaling and root planing (SRP) services. Additionally, there is an increase in the frequency of prophylaxis and fluoride treatments allowed for residents of Skilled Nursing Facilities or Intermediate Care Facilities.

*PHARMACY***Orkambi Benefit (PC 52)**

The FDA approved drug, Orkambi, helps people with cystic fibrosis ages 12 and older who have specific defective or missing proteins resulting from mutations in a specific gene.

ADAP Ryan White MEDS Data Match (PC 53)

The cross-match will identify CDPH's Ryan White clients who are enrolled in Medi-Cal. Once identified, the clients will be unenrolled from ADAP and Medi-Cal will pay the HIV medication costs.

DRUG MEDI-CAL**Residential Treatment Services Expansion (PC 65)**

The November Estimate anticipates 22 counties would participate in providing Residential Treatment Services to the non-perinatal population in FY 2015-16. In FY 2016-17, 31 additional counties are anticipated to opt-in. The implementation plan assumes counties will phase in based on provider network and readiness. In the Appropriation, both the base and expansion costs for the Residential Treatment Services were included in PC 65 Residential Treatment Services. In the November 2015 Estimate, the base costs are reflected in PC 67 Residential Treatment Services and the expansion costs are in PC 65 Residential Treatment Services Expansion.

MENTAL HEALTH**MHP Costs for Children and Youth in Foster Care (PC 211)**

AB 403 (Chapter 773, Statutes of 2015) established a new community care licensure category that is a short-term residential treatment center (STRTC), licensed and regulated by the California Department of Social Services (CDSS). This policy change budgets the reimbursement to counties for participating in a child and family team (CFT) and providing assessments for seriously emotionally disturbed (SED) foster children.

1115 WAIVER**Medi-Cal 2020 Waiver (PC 82, 83, 87, 205, 206, 207, 208, 209)**

On October 31, 2015, CMS announced a conceptual agreement with the Department on the major components of the Medi-Cal 2020 Section 1115 Waiver renewal. The Bridge to Reform (BTR) Section 1115 Waiver was temporarily extended to December 31, 2015 while the Medi-Cal 2020 Special Terms and Conditions (STCs) were finalized. The Medi-Cal 2020 Waiver renewal includes total initial federal funding of \$6.218 billion with the potential for additional federal funding in the Global Payment Program to be determined after the first year. The major components are:

- **Public Hospital Redesign & Incentives in Medi-Cal (PRIME) (PCs 83, 205)**
PRIME is a redesigned delivery system transformation and alignment incentive program for Designated Public Hospitals (DPHs) and District/Municipal Hospitals (DMPHs). Total federal funding for PRIME is \$3 billion for DPHs and \$466.5 million for DMPHs over five years. This Estimate shifts funding from the existing BTR- DPH Delivery System Reform Incentive Pool policy change to the new PRIME policy change.
- **Global Payment Program (GPP) (PCs 82, 87, 206)**
The GPP converts existing Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding from a hospital-focused, cost-based system to one that is focused on value and improved care delivery. The funding includes five years of DSH funding that would have been allocated to DPHs along with \$236 million for one year of the SNCP component. SNCP component funding for years two through

five would be subject to an independent assessment of uncompensated care. This Estimate shifts funding from the existing MH/UCD & BTR – DSH Payments and BTR-Safety Net Care Pool policy changes to the new GPP policy change.

- **Waiver 2020 Dental Transformation Initiative (DTI) (PCs 207, 209)**
The DTI program consists of three domains: preventive services, Caries Risk Assessment and management, and continuity of care. Incentive payments will be made to participating fee-for-service (FFS) or Dental Managed Care (DMC) providers that qualify for the incentive payments. Federal claiming from the Waiver 2020 Designated State Health Program will provide for an offset to the GF costs for the DTI. Total federal funding is \$750 million over five years.
- **Waiver 2020 Whole Person Care (WPC) Pilots (PC 208)**
The WPC pilots will be country-based, voluntary programs that will allow a county or group of counties to integrate care for their high-risk vulnerable populations. Total federal funding is \$1.5 billion over five years.

MANAGED CARE

Inland Empire Health Plan Settlement (PC 119)

The Department reached a settlement agreement with Inland Empire Health Plan regarding managed care rates for the 2013-14 rate year.

Former Agnews' Beneficiaries Recoupment (PC 131)

This is a recoupment of supplemental payments made to health plans for the former Agnew beneficiaries who had transitioned into managed care plans.

Palliative Care Services Implementation (PC 202)

SB 1004 mandates the Department to provide guidance, training, and technical assistance on palliative care services for Medi-Cal managed care and fee-for-service delivery systems.

Capitated Rate Adjustment for FY 2016-17 (PC 204)

Managed care capitation rates will be rebased in FY 2016-17 as determined by the rate methodology based on more recent data. This policy change shows the increase in capitation rates from FY 2015-16 to FY 2016-17.

PROVIDER RATES

Medicare Part B Premium Increase (PC 134)

The Centers for Medicare and Medicaid increased the Medicare Part B premiums for 2016 by 16.1%. The Department is estimating premiums will increase again in 2017. Medi-Cal pays the Part B premiums for dual eligibles.

GDSP Newborn Screening Program Fee Increase (PC 143)

The California Department of Public Health's (CDPH) Genetic Disease Screening Program (GDSP) is expanding statewide screening of newborns to include screening for adrenoleukodystrophy (ALD) pursuant to the requirements of AB 1559 (Chapter 565, Statute of

2014). CDPH's GDSP will add ALD to the Newborn Screening Program (NSP) resulting in an estimated \$11 per patient fee increase to the NSP. Medi-Cal costs associated with the NSP fee increase are budgeted in FY 2016-17.

SUPPLEMENTAL PAYMENTS

DP-NF Capital Project Debt Repayment (PC 200)

SB 1128 (Chapter 757, Statutes of 1999) authorized Medi-Cal reimbursements to certain Distinct Part Skilled Nursing Facilities (DP-NF) for debt service incurred for the financing of eligible capital construction projects. The Department uses certified public expenditures to claim federal funds for this program. The Centers for Medicare and Medicaid Services (CMS) has deferred \$57.2 million in payments for ineligible costs for Laguna Honda Hospital and Rehabilitation Center and Edgemoor Geriatric Hospital. The Department will repay the deferred amounts to the federal government in FY 2015-16.

OTHER: REIMBURSEMENTS

FFP Repayment for CDDS Costs (PC 210)

Audit findings identified \$42.5 million (GF) are due to CMS in FY 2015-16. 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 \$3.8 million (GF) for FY 2016-17, to reflect the estimated costs for the 2011-12 audit. The Department expects to receive reimbursement from the Department of Developmental Services (DDS).

COUNTY ADMINISTRATION PCs

OTHER ADMINISTRATION PCs

PAVE System (OA 12)

The Provider Application and Validation for Enrollment (PAVE) system is an enterprise-wide enrollment portal to automate provider management activities to comply with provider integrity mandates under the Affordable Care Act (ACA). The Department is contracting with a new contractor for completing the design, development, and implementation (DDI) and ongoing maintenance and operations (M&O) of the PAVE system.

Actuarial Costs for Rate Development (OA 18)

The Department entered into a contract with an actuarial services consultant to meet our responsibility to develop actuarially sound capitation rates.

Performance Outcomes System (OA 99)

W&I Code, Section 14707.5 requires the Department to develop a Performance Outcomes System for Early, Periodic Screening, Diagnosis, and Treatment mental health services that will improve outcomes at the individual and system levels and to inform fiscal decision-making related to the purchase of services.

Dental FI – Beneficiary Outreach & Education Program – Admin (OA 100)

This outreach and education program seeks to increase utilization of dental services, particularly in counties where utilization levels are lowest. These costs are for implementation by the dental fiscal intermediary (FI).

SIGNIFICANT ITEMS

Dollars in Millions

Name	PC	Change from Appropriation		Change from FY 2015-16	
		FY 2015-16		FY 2016-17	
		TF	GF	TF	GF
BASE PCs					
Managed Care Base	105, 106, 107, 110	\$15,248.6	-\$78.7	-\$2,589.8	\$414.9
REGULAR PCs					
Undocumented Children Full Scope Expansion	7, OA 66	-\$6.4	-\$15.9	\$148.0	\$120.9
1% FMAP Increase for Preventive Services	24	\$0.0	\$33.2	\$0.0	\$15.4
Behavioral Health Treatment	35	-\$124.4	-\$67.3	\$101.9	\$43.4
Drug Rebates	32, 60, 61, 62	-\$482.2	-\$234.2	-\$188.7	-\$83.6
MH/UCD & BTR - DSH Payments	82	-\$1,525.8	\$5.7	-\$150.4	-\$3.3
BTR - DPH Delivery System Reform Incentive Pool	83	-\$607.4	\$0.0	-\$786.1	\$0.0
BTR - Safety Net Care Pool	87	-\$206.5	\$0.0	-\$19.7	\$0.0
BTR - Designated State Health Programs	94, 101, 103	-\$14.7	-\$19.0	-\$3.5	\$147.2
CCI	108,109, 132, 173, 193	-\$380.2	\$303.7	-\$393.1	-\$333.5
MCO Tax	111, 129, 130	\$682.7	\$155.1	-\$1,744.8	\$691.7
Mgd. Care Retro Mgd Care Adjustment	133	-\$1,094.5	-\$18.1	-\$2,415.9	-\$200.6
AB 1629 Facilities	137, 139	-\$16.3	-\$7.1	\$158.6	\$79.3
AB 97 Rate Reduction and Rate Freeze	145, 146, 148	\$63.1	\$31.5	-\$37.9	-\$19.0

Dollars in Millions

Name	PC	Change from Appropriation		Change from FY 2015-16	
		FY 2015-16		FY 2016-17	
		TF	GF	TF	GF
Laboratory Rate Methodology Change	147	\$27.4	\$13.7	-\$10.4	-\$5.2
Martin Luther King Jr. Community Hospital Payments	156	-\$25.7	\$2.0	\$1.6	-\$13.8
Extend Hospital QAF - Children's Health Care	194	\$0.0	\$0.0	\$0.0	\$140.0
COUNTY ADMINISTRATION PCs					
ACA Funding Augmentation	2	\$0.0	\$0.0	\$169.9	\$85.0
Enhanced Federal Funding	7	\$0.0	-\$3.3	\$0.0	-\$31.2
OTHER ADMINISTRATION PCs					
Postage and Printing	5, 39	\$12.3	\$6.2	-\$12.2	-\$6.2

BASE PCs**Managed Care Base (PC 105, 106, 107, 110)**

The Managed Care Base PCs estimate the managed care capitation costs of the four managed care models. These PCs, where appropriate, now include the ACA expansion population, Title XXI 88/12 funding, and the impact of CCI. Additionally, in BY, these PCs include the ACA 95/5 funding.

REGULAR PCs*ELIGIBILITY***Undocumented Children Full Scope Expansion (PC 7, OA 66)¹**

SB 75 (Chapter 18, Statutes of 2015) directs the Department to provide full-scope Medi-Cal coverage to eligible children under the age of 19, regardless of immigration status beginning May 1, 2016. Currently the Department provides limited-scope Medi-Cal coverage for emergency and pregnancy related issues only. The Department estimates a GF impact of \$20.4 million in FY 2015-16, and \$142.8 million in FY 2016-17.

*AFFORDABLE CARE ACT***1% FMAP Increase for Preventive Services (PC 24)**

The Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. In the November Estimate, the managed care

¹ In the Appropriation both benefits and administrative costs were included in one Policy Change.

estimate was revised using a more accurate methodology and updated capitation data; resulting in a savings decrease.

BENEFITS

Behavioral Health Treatment (PC 35)

SB 870 (Chapter 40, Statutes of 2014) directs the Department to implement Behavioral Health Treatment (BHT) services to the extent it is required by the federal government. The Department has implemented BHT for Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for children under age 21, effective September 15, 2014. The Department is working with the Department of Developmental Services (DDS) and stakeholders on a plan to transition existing Medi-Cal eligibles who are currently receiving BHT services through Regional Centers. Medi-Cal costs are not included for these eligibles because the transition plan is not complete. The Department anticipates the transition of responsibility from DDS regional centers will begin February 1, 2016. The Estimate assumes a decrease of \$67.3 million GF in FY 2015-16 due to updated capitation rates (from \$3,750 to \$1,640). The member months increase from 4,650 to 9,979 will increase the FY 2016-17 estimate by \$43.4 million GF.

PHARMACY

Drug Rebates (PCs 32, 60, 61, 62)

More recent drug rebate reports reflect an increase in the estimated savings.

1115 WAIVER

MH/UCD & BTR – DSH Payments (PC 82)

Funding previously budgeted in the MH/UCD & BTR – DSH Payments policy change shifted to the new Global Payment Program (GPP) policy change 206. There was no impact to the GF from this shift. Refer to the new Medi-Cal 2020 Waiver policy changes for discussion on the GPP.

BTR – DPH Delivery System Reform Incentive Pool (PC 83)

Funding previously budgeted in the BTR- DPH Delivery System Reform Incentive Pool policy change shifted to the new Public Hospital Redesign & Incentives in Medi-Cal (PRIME) policy change 205. There was no impact to the GF from this shift. Refer to the new Medi-Cal 2020 Waiver policy changes for discussion on the PRIME program.

BTR – Safety Net Care Pool (PC 87)

Funding previously budgeted in the BTR- Safety Net Care Pool policy changes shifted to the new Global Payment Program (GPP) policy change 206. There was no impact to the GF from this shift. Refer to the new Medi-Cal 2020 Waiver policy changes for discussion on the GPP.

BTR –Designated State Health Programs (PCs 94, 101, 103)

The California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration allows the Department to claim federal financial participation using the certified public expenditures (CPEs) of approved Designated State Health Programs (DSHP) and Designated Public Hospitals (DPHs) to achieve \$400 million in annual GF savings. The BTR was temporarily extended to December 31, 2015. The BTR DSHP savings are not assumed to continue in the Medi-Cal 2020

Waiver, however final reconciliations from the program will continue to be budgeted. In FY 2015-16, GF savings increased by \$19 million GF due to updated reimbursement to the California Department of Public Health, program expenditures, and final reconciliations. In FY 2016-17, costs are estimated to increase by \$147.2 million GF due to the end of the BTR DSHP.

MANAGED CARE

Coordinated Care Initiative (CCI) (PCs 108,109, 132, 173, 193)

These PCs estimate the impact from recasting blended managed care capitation payments to Medi-Cal managed care plans participating in the CCI. Rates were developed utilizing enrollment projections separated into four groupings representing differing levels of risk. Caseload projections were updated to include actual eligibles. Although rates are unchanged, the average weighted rate for all counties decreased due to shifts in the risk groupings.

MCO Tax (PCs 111, 129, 130)

In May, the estimated impact in FY 2015-16 from the MCO tax was calculated from the MCO Enrollee Tax model. While the 2015-16 proposal was not adopted in the 2015-16 budget, the proposal is still being considered in a special session; therefore, the Department is reverting back to the original revenue-based model for FY 2015-16. The cost impact has been revised to incorporate the revenue-based model and includes current revenue projections. Also, this estimate does not assume the MCO tax offsets to support the Medi-Cal programs in FY 2016-17. However, the tax continues as a major component of Medi-Cal program funding, so the Governor's Budget assumes an extension of the tax, and continues the restoration of the In-Home Supportive Services 7 percent reduction using tax proceeds. However, the remaining proceeds will be reserved in a special fund pending its passage.

Retro Managed Care Adjustment (PC 133)

This policy change includes rate adjustments for the FY 2015-16 base rates, the CCI IHSS reconciliation and CY 2014 recasting for full dual eligibles, the recoupment for the ACA Optional Expansion January-June 2015 rates, the MLK adjustment, and the primary care physician (PCP) retro adjustment.

PROVIDER RATES

AB 1629 Facilities (PCs 137, 139)

AB 119 (Chapter 17, Statutes of 2015) extends, for five years, the AB 1629 facility-specific rate methodology, Quality Assurance Fee (QAF), and Quality and Accountability Supplemental Payments Program (QASP) through July 31, 2020. 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. This Estimate updates rate implementation dates, program expenditures, and add-on costs.

AB 97 Rate Reduction and Rate Freeze (PCs 145, 146, 148)

AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions and rate freezes to certain long term care facilities. This Estimate updates the retroactive recoupment implementation dates and schedules for Pharmacy and Distinct Part Nursing Facilities – Level B (DP/NF-B)

providers. Additionally, the costs of the AB 97 exemption to Dental providers were adjusted from these policy changes and now included in the Dental policy changes.

Laboratory Rate Methodology Change (PC 147)

AB 1494 (Chapter 28, Statutes of 2012) required the Department to implement a new rate methodology for clinical laboratories and laboratory services. The Department received federal approval for the new rate methodology, effective July 2015. In addition to the 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2012), payments for clinical laboratories and laboratory services will also be reduced by 10% for dates of service on and after July 1, 2012 through June 30, 2015. This Estimate updates the savings estimate and implementation dates for the new rate methodology and retroactive recoupments.

Martin Luther King Jr. Community Hospital Payments (PC 156)

SB 857 (Chapter 31, Statutes of 2014) requires specific funding requirements to facilitate the financial viability of the new private nonprofit, Martin Luther King, Jr. Community Hospital (MLK Jr.). Pursuant to W&I Code 14165.50, the cost-based reimbursement methodology for Medi-Cal FFS and managed care payments to the new MLK Jr. Hospital will provide compensation at a minimum of 100% of the projected costs for each fiscal year (FY) as long as the county transfers the necessary public funds to the State for this purpose. The Department is seeking federal approval to enable MLK Jr. to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements and additional reimbursement exceeding the 100% minimum funding requirement. This Estimate updates the hospital's projected costs, delays the implementation date, and adds funding for the ACA optional population. In addition, Managed care costs are now included the managed care capitation rates and removed from this policy change.

SUPPLEMENTAL PAYMENTS

Extend Hospital QAF – Children's Health Care (PC 194)

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital Quality Assurance Fee (QAF) program for the period January 1, 2014 through December 31, 2016. Due to the sunset of the Hospital QAF, funding for children's health care coverage is assumed to end resulting in an increase of \$140 million GF in FY 2016-17.

COUNTY ADMINISTRATION PCs

Implementation of ACA (CA 2, CA 7)

Due to steady increases in enrollment in Medi-Cal, churn in the program's population, and the ongoing development of CalHEERS, the program and its administration have not reached a "steady state" by which the State can accurately assess and budget for this workload. Based on discussions with the counties and Finance, the Department is continuing to recommend a budget augmentation for FY 2016-17 until an agreed-upon methodology can be developed. The Centers for Medicare and Medicaid Services (CMS) does allow enhanced federal funding at 75% for certain eligibility determination costs including application, on-going case management and renewal functions. The enhanced funding is available to help fund the additional county administrations costs included in the Implementation of the ACA policy change.

OTHER ADMINISTRATION PCs**Postage and Printing (OA 5, 39)**

Under the Affordable Care Act, as a health coverage issuer, the Department is required to provide a Form 1095-B Proof of Minimum Essential Coverage (MEC) to Medi-Cal beneficiaries by January 31, 2016, for tax filing purposes. Pursuant to Federal Regulations, a reporting entity must furnish the 1095-B statement by sending it by first class mail to an individual's "last known permanent address, or if no permanent address is known, the temporary address." We have received first class mail cost estimates from the Department of General Services, Office of State Publishing for both the outreach notification letter and the Form 1095-B.

General Information

This estimate is based on actual payment data through July 2015. Estimates for both fiscal years are on a cash basis and include a two-week hold on weekly Fee-for-Service payments at the end of June and a one-month hold on Managed Care June payments. All held payments are anticipated to be paid in July of the following state fiscal year.

The Medi-Cal Program has many funding sources. These funding sources are shown by budget item number on the State Funds and Federal Funds pages of the Medi-Cal Funding Summary in the Management Summary tab. The budget items, which are made up of State General Fund, are identified with an asterisk and are shown in separate totals.

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

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

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

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

A 1% variation in total Medi-Cal Benefits expenditures would result in an \$879 million TF (\$176 million General Funds) change in expenditures in FY 2015-16 and \$804 million TF (\$191 million General Funds) in FY 2016-17.

Medi-Cal Funding Summary
November 2015 Estimate Compared to Appropriation
Fiscal Year 2015 - 2016

TOTAL FUNDS

	Total Appropriation	Nov 2015 Estimate	Difference Incr./(Decr.)
<u>MEDI-CAL Benefits:</u>			
4260-101-0001/0890(3)	\$63,196,926,000	\$65,109,863,000	\$1,912,937,000
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop 99 Hospital Svc. Acct.	\$92,129,000	\$92,129,000	\$0
4260-101-0233 Prop 99 Physician Svc. Acct	\$19,446,000	\$19,446,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,009,000	\$31,009,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$13,459,000	\$12,600,000	(\$859,000)
4260-101-3213 LTC QA Fund	\$457,767,000	\$457,767,000	\$0
4260-102-0001/0890 Capital Debt	\$77,508,000	\$80,906,000	\$3,398,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,357,000	\$2,356,000	(\$1,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$129,155,000	\$140,352,000	\$11,197,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-106-0890 Money Follows Person Federal Grant	\$26,187,000	\$16,090,000	(\$10,097,000)
4260-113-0001/0890 Healthy Families	\$3,153,367,000	\$3,091,455,000	(\$61,912,000)
4260-113-3055 County Health Initiative Match Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$39,350,000	\$50,897,000	\$11,547,000
4260-601-0942 Home Health Program Account	\$6,018,300	\$6,020,000	\$1,700
4260-601-3156 MCO Tax Fund	\$1,510,827,000	\$1,548,342,000	\$37,515,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$696,734,000	\$798,142,000	\$101,408,000
4260-601-7502 Demonstration DSH Fund	\$714,197,000	\$60,178,000	(\$654,019,000)
4260-601-7503 Health Care Support Fund	\$392,064,000	\$385,964,000	(\$6,100,000)
4260-602-0309 Perinatal Insurance Fund	\$40,650,000	\$19,621,000	(\$21,029,000)
4260-605-0001 SNF Quality & Accountability *	\$48,928,000	\$48,928,000	\$0
4260-605-3167 SNF Quality & Accountability	\$45,096,000	\$44,069,000	(\$1,027,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,928,000)	(\$48,928,000)	\$0
4260-606-0834 SB 1100 DSH	\$607,345,000	\$1,398,924,000	\$791,579,000
4260-607-8502 Low Income Health Program IGT	\$409,479,000	\$0	(\$409,479,000)
4260-610-0995 Reimbursements	\$5,238,720,000	\$4,573,776,000	(\$664,944,000)
4260-610-3158 Hospital Quality Assurance Revenue	\$0	\$0	\$0
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$101,583,000	\$93,664,000	(\$7,919,000)
4260-611-3158/0890 Hospital Quality Assurance	\$9,669,094,000	\$9,883,625,000	\$214,531,000
TOTAL MEDI-CAL Benefits	<u>\$86,671,181,300</u>	<u>\$87,917,909,000</u>	<u>\$1,246,727,700</u>
<u>COUNTY ADMINISTRATION:</u>			
4260-101-0001/0890(1)	\$3,733,885,000	\$3,822,765,000	\$88,880,000
4260-106-0890(1) Money Follow Person Fed. Grant	\$609,000	\$651,000	\$42,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$1,375,000	\$4,539,000	\$3,164,000
4260-113-0001/0890 Healthy Families	\$116,167,000	\$121,247,000	\$5,080,000
4260-117-0001/0890 HIPAA	\$6,881,000	\$6,881,000	\$0
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$17,768,000	\$7,989,000	(\$9,779,000)
4260-601-0942 Home Health Program Account	\$690,000	\$612,000	(\$78,000)
4260-602-0313 Major Risk Medical Ins Fund	\$1,000,000	\$2,593,000	\$1,593,000
4260-605-3167 SNF Quality & Accountability Admin.	\$3,358,000	\$3,560,000	\$202,000
4260-610-0995 Reimbursements	\$3,217,000	\$3,049,000	(\$168,000)
TOTAL COUNTY ADMIN.	<u>\$3,884,950,000</u>	<u>\$3,973,886,000</u>	<u>\$88,936,000</u>
<u>FISCAL INTERMEDIARY:</u>			
4260-101-0001/0890(2)	\$455,416,000	\$459,155,000	\$3,739,000
4260-113-0001/0890 Healthy Families	\$5,000,000	\$6,269,000	\$1,269,000
4260-117-0001/0890 HIPAA	\$10,976,000	\$20,108,000	\$9,132,000
4260-610-0995 Reimbursements	\$0	\$0	\$0
TOTAL FISCAL INTERMEDIARY	<u>\$471,392,000</u>	<u>\$485,532,000</u>	<u>\$14,140,000</u>
GRAND TOTAL - ALL FUNDS	<u>\$91,027,523,300</u>	<u>\$92,377,327,000</u>	<u>\$1,349,803,700</u>

Notes:

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

Medi-Cal Funding Summary
November 2015 Estimate Compared to Appropriation
Fiscal Year 2015 - 2016

STATE FUNDS

MEDI-CAL Benefits:	State Funds Appropriation	Nov 2015 Estimate	Difference Incr./(Decr.)
4260-101-0001(3) *	\$16,295,096,000	\$15,890,035,000	(\$405,061,000)
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop 99 Hospital Srv. Acct.	\$92,129,000	\$92,129,000	\$0
4260-101-0233 Prop 99 Physician Srv. Acct	\$19,446,000	\$19,446,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,009,000	\$31,009,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$13,459,000	\$12,600,000	(\$859,000)
4260-101-3213 LTC QA Fund	\$457,767,000	\$457,767,000	\$0
4260-102-0001 Capital Debt *	\$38,754,000	\$40,453,000	\$1,699,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,357,000	\$2,356,000	(\$1,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$129,155,000	\$140,352,000	\$11,197,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-113-0001 Healthy Families *	\$575,145,000	\$580,481,000	\$5,336,000
4260-113-3055 County Health Initiative Match Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$39,350,000	\$50,897,000	\$11,547,000
4260-601-0942 Home Health Program Account	\$6,018,300	\$6,020,000	\$1,700
4260-601-3156 MCO Tax Fund	\$1,510,827,000	\$1,548,342,000	\$37,515,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$696,734,000	\$798,142,000	\$101,408,000
4260-602-0309 Perinatal Insurance Fund	\$40,650,000	\$19,621,000	(\$21,029,000)
4260-605-0001 SNF Quality & Accountability *	\$48,928,000	\$48,928,000	\$0
4260-605-3167 SNF Quality & Accountability	\$45,096,000	\$44,069,000	(\$1,027,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,928,000)	(\$48,928,000)	\$0
4260-606-0834 SB 1100 DSH	\$607,345,000	\$1,398,924,000	\$791,579,000
4260-607-8502 Low Income Health Program IGT	\$409,479,000	\$0	(\$409,479,000)
4260-610-0995 Reimbursements	\$5,238,720,000	\$4,573,776,000	(\$664,944,000)
4260-610-3158 Hosp. Quality Assurance Revenue	\$0	\$0	\$0
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$101,583,000	\$93,664,000	(\$7,919,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$4,753,273,000	\$4,556,637,000	(\$196,636,000)
TOTAL MEDI-CAL Benefits	\$31,104,106,300	\$30,357,434,000	(\$746,672,300)
Total Benefits General Fund *	\$17,078,223,000	\$16,680,197,000	(\$398,026,000)
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	\$769,584,000	\$770,922,000	\$1,338,000
4260-113-0001 Healthy Families *	\$34,780,000	\$27,759,000	(\$7,021,000)
4260-117-0001 HIPAA *	\$1,216,000	\$1,216,000	\$0
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$17,768,000	\$7,989,000	(\$9,779,000)
4260-601-0942 Home Health Program Account	\$690,000	\$612,000	(\$78,000)
4260-602-0313 Major Risk Medical Ins Fund	\$1,000,000	\$2,593,000	\$1,593,000
4260-605-3167 SNF Quality & Accountability Admin.	\$3,358,000	\$3,560,000	\$202,000
4260-610-0995 Reimbursements	\$3,217,000	\$3,049,000	(\$168,000)
TOTAL COUNTY ADMIN.	\$831,613,000	\$817,700,000	(\$13,913,000)
Total Co. Admin. General Fund *	\$805,580,000	\$799,897,000	(\$5,683,000)
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	\$151,826,000	\$161,513,000	\$9,687,000
4260-113-0001 Healthy Families *	\$1,750,000	\$1,113,000	(\$637,000)
4260-117-0001 HIPAA *	\$2,517,000	\$3,162,000	\$645,000
4260-610-0995 Reimbursements	\$0	\$0	\$0
TOTAL FISCAL INTERMEDIARY	\$156,093,000	\$165,788,000	\$9,695,000
Total FI General Fund *	\$156,093,000	\$165,788,000	\$9,695,000
GRAND TOTAL - STATE FUNDS	\$32,091,812,300	\$31,340,922,000	(\$750,890,300)
Grand Total - General Fund *	\$18,039,896,000	\$17,645,882,000	(\$394,014,000)

Notes:

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

Medi-Cal Funding Summary
November 2015 Estimate Compared to Appropriation
Fiscal Year 2015 - 2016

FEDERAL FUNDS

	Federal Funds Appropriation	Nov 2015 Estimate	Difference Incr./Decr.)
<u>MEDI-CAL Benefits:</u>			
4260-101-0890(3)	\$46,901,830,000	\$49,219,828,000	\$2,317,998,000
4260-102-0890 Capital Debt	\$38,754,000	\$40,453,000	\$1,699,000
4260-106-0890 Money Follows Person Federal Grant	\$26,187,000	\$16,090,000	(\$10,097,000)
4260-113-0890 Health Families	\$2,578,222,000	\$2,510,974,000	(\$67,248,000)
4260-601-7502 Demonstration DSH Fund	\$714,197,000	\$60,178,000	(\$654,019,000)
4260-601-7503 Health Care Support Fund	\$392,064,000	\$385,964,000	(\$6,100,000)
4260-611-0890 Hospital Quality Assurance	\$4,915,821,000	\$5,326,988,000	\$411,167,000
TOTAL MEDI-CAL Benefits	<u>\$55,567,075,000</u>	<u>\$57,560,475,000</u>	<u>\$1,993,400,000</u>
<u>COUNTY ADMINISTRATION:</u>			
4260-101-0890(1)	\$2,964,301,000	\$3,051,843,000	\$87,542,000
4260-106-0890(1) Money Follows Person Fed. Grant	\$609,000	\$651,000	\$42,000
4260-107-0890 Prevention of Chronic Disease (MIPCD)	\$1,375,000	\$4,539,000	\$3,164,000
4260-113-0890 Healthy Families	\$81,387,000	\$93,488,000	\$12,101,000
4260-117-0890 HIPAA	\$5,665,000	\$5,665,000	\$0
TOTAL COUNTY ADMIN.	<u>\$3,053,337,000</u>	<u>\$3,156,186,000</u>	<u>\$102,849,000</u>
<u>FISCAL INTERMEDIARY:</u>			
4260-101-0890(2)	\$303,590,000	\$297,642,000	(\$5,948,000)
4260-113-0890 Healthy Families	\$3,250,000	\$5,156,000	\$1,906,000
4260-117-0890 HIPAA	\$8,459,000	\$16,946,000	\$8,487,000
TOTAL FISCAL INTERMEDIARY	<u>\$315,299,000</u>	<u>\$319,744,000</u>	<u>\$4,445,000</u>
 GRAND TOTAL - FEDERAL FUNDS	 <u>\$58,935,711,000</u>	 <u>\$61,036,405,000</u>	 <u>\$2,100,694,000</u>

Medi-Cal Funding Summary
November 2015 Estimate Comparison of FY 2015-16 to FY 2016-17

TOTAL FUNDS

	FY 2015-16	FY 2016-17	Difference
	<u>Estimate</u>	<u>Estimate</u>	<u>Incr./.(Decr.)</u>
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	\$65,109,863,000	\$61,153,858,000	(\$3,956,005,000)
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$92,129,000	\$107,243,000	\$15,114,000
4260-101-0233 Prop 99 Physician Srvc. Acct	\$19,446,000	\$27,055,000	\$7,609,000
4260-101-0236 Prop 99 Unallocated Account	\$31,009,000	\$51,252,000	\$20,243,000
4260-101-3168 Emergency Air Transportation Fund	\$12,600,000	\$8,500,000	(\$4,100,000)
4260-101-3213 LTC QA Fund	\$457,767,000	\$449,673,000	(\$8,094,000)
4260-102-0001/0890 Capital Debt	\$80,906,000	\$82,282,000	\$1,376,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,356,000	\$1,900,000	(\$456,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$140,352,000	\$129,101,000	(\$11,251,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-106-0890 Money Follows Person Federal Grant	\$16,090,000	\$20,949,000	\$4,859,000
4260-113-0001/0890 Healthy Families	\$3,091,455,000	\$2,712,508,000	(\$378,947,000)
4260-113-3055 County Health Initiative Match Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$50,897,000	\$40,052,000	(\$10,845,000)
4260-601-0942 Home Health Program Account	\$6,020,000	\$20,700,000	\$14,680,000
4260-601-3156 MCO Tax Fund	\$1,548,342,000	\$292,298,000	(\$1,256,044,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$798,142,000	\$800,000,000	\$1,858,000
4260-601-7502 Demonstration DSH Fund	\$60,178,000	\$0	(\$60,178,000)
4260-601-7503 Health Care Support Fund	\$385,964,000	\$52,086,000	(\$333,878,000)
4260-602-0309 Perinatal Insurance Fund	\$19,621,000	\$12,597,000	(\$7,024,000)
4260-605-0001 SNF Quality & Accountability *	\$48,928,000	\$48,928,000	\$0
4260-605-3167 SNF Quality & Accountability	\$44,069,000	\$44,069,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,928,000)	(\$48,928,000)	\$0
4260-606-0834 SB 1100 DSH	\$1,398,924,000	\$1,297,433,000	(\$101,491,000)
4260-607-8502 Low Income Health Program IGT	\$0	\$0	\$0
4260-610-0995 Reimbursements	\$4,573,776,000	\$5,142,655,000	\$568,879,000
4260-610-3158 Hospital Quality Assurance Revenue	\$0	\$0	\$0
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$93,664,000	\$35,246,000	(\$58,418,000)
4260-611-3158/0890 Hospital Quality Assurance	\$9,883,625,000	\$7,999,169,000	(\$1,884,456,000)
TOTAL MEDI-CAL Benefits	<u>\$87,917,909,000</u>	<u>\$80,481,340,000</u>	<u>(\$7,436,569,000)</u>
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	\$3,822,765,000	\$3,963,007,000	\$140,242,000
4260-106-0890(1) Money Follow Person Fed. Grant	\$651,000	\$978,000	\$327,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$4,539,000	\$80,000	(\$4,459,000)
4260-113-0001/0890 Healthy Families	\$121,247,000	\$120,446,000	(\$801,000)
4260-117-0001/0890 HIPAA	\$6,881,000	\$6,128,000	(\$753,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$7,989,000	\$4,975,000	(\$3,014,000)
4260-601-0942 Home Health Program Account	\$612,000	\$0	(\$612,000)
4260-602-0313 Major Risk Medical Ins Fund	\$2,593,000	\$578,000	(\$2,015,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$3,560,000	\$3,560,000	\$0
4260-610-0995 Reimbursements	\$3,049,000	\$660,000	(\$2,389,000)
TOTAL COUNTY ADMIN.	<u>\$3,973,886,000</u>	<u>\$4,100,412,000</u>	<u>\$126,526,000</u>
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	\$459,155,000	\$439,345,000	(\$19,810,000)
4260-113-0001/0890 Healthy Families	\$6,269,000	\$5,474,000	(\$795,000)
4260-117-0001/0890 HIPAA	\$20,108,000	\$11,923,000	(\$8,185,000)
4260-610-0995 Reimbursements	\$0	\$0	\$0
TOTAL FISCAL INTERMEDIARY	<u>\$485,532,000</u>	<u>\$456,742,000</u>	<u>(\$28,790,000)</u>
GRAND TOTAL - ALL FUNDS	<u>\$92,377,327,000</u>	<u>\$85,038,494,000</u>	<u>(\$7,338,833,000)</u>

Notes:

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

Medi-Cal Funding Summary
November 2015 Estimate Comparison of FY 2015-16 to FY 2016-17

STATE FUNDS

	<u>FY 2015-16</u> <u>Estimate</u>	<u>FY 2016-17</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
<u>MEDI-CAL Benefits:</u>			
4260-101-0001(3) *	\$15,890,035,000	\$17,592,286,000	\$1,702,251,000
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$92,129,000	\$107,243,000	\$15,114,000
4260-101-0233 Prop 99 Physician Srvc. Acct	\$19,446,000	\$27,055,000	\$7,609,000
4260-101-0236 Prop 99 Unallocated Account	\$31,009,000	\$51,252,000	\$20,243,000
4260-101-3168 Emergency Air Transportation Fund	\$12,600,000	\$8,500,000	(\$4,100,000)
4260-101-3213 LTC QA Fund	\$457,670,000	\$449,673,000	(\$8,094,000)
4260-102-0001 Capital Debt *	\$40,453,000	\$41,141,000	\$688,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,356,000	\$1,900,000	(\$456,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$140,352,000	\$129,101,000	(\$11,251,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-113-0001 Healthy Families *	\$580,481,000	\$276,319,000	(\$304,162,000)
4260-113-3055 County Health Initiative Match Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$50,897,000	\$40,052,000	(\$10,845,000)
4260-601-0942 Home Health Program Account	\$6,020,000	\$20,700,000	\$14,680,000
4260-601-3156 MCO Tax Fund	\$1,548,342,000	\$292,298,000	(\$1,256,044,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$798,142,000	\$800,000,000	\$1,858,000
4260-602-0309 Perinatal Insurance Fund	\$19,621,000	\$12,597,000	(\$7,024,000)
4260-605-0001 SNF Quality & Accountability *	\$48,928,000	\$48,928,000	\$0
4260-605-3167 SNF Quality & Accountability	\$44,069,000	\$44,069,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,928,000)	(\$48,928,000)	\$0
4260-606-0834 SB 1100 DSH	\$1,398,924,000	\$1,297,433,000	(\$101,491,000)
4260-607-8502 Low Income Health Program IGT	\$0	\$0	\$0
4260-610-0995 Reimbursements	\$4,573,776,000	\$5,142,655,000	\$568,879,000
4260-610-3158 Hosp. Quality Assurance Revenue	\$0	\$0	\$0
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$93,664,000	\$35,246,000	(\$58,418,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$4,556,637,000	\$3,606,818,000	(\$949,819,000)
TOTAL MEDI-CAL Benefits	\$30,357,434,000	\$29,977,052,000	(\$380,382,000)
Total Benefits General Fund *	\$16,680,197,000	\$18,078,974,000	\$1,398,777,000
<u>COUNTY ADMINISTRATION:</u>			
4260-101-0001(1) *	\$770,922,000	\$825,553,000	\$54,631,000
4260-113-0001 Healthy Families *	\$27,759,000	\$24,404,000	(\$3,355,000)
4260-117-0001 HIPAA *	\$1,216,000	\$1,122,000	(\$94,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$7,989,000	\$4,975,000	(\$3,014,000)
4260-601-0942 Home Health Program Account	\$612,000	\$0	(\$612,000)
4260-602-0313 Major Risk Medical Ins Fund	\$2,593,000	\$578,000	(\$2,015,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$3,560,000	\$3,560,000	\$0
4260-610-0995 Reimbursements	\$3,049,000	\$660,000	(\$2,389,000)
TOTAL COUNTY ADMIN.	\$817,700,000	\$860,852,000	\$43,152,000
Total Co. Admin. General Fund *	\$799,897,000	\$851,079,000	\$51,182,000
<u>FISCAL INTERMEDIARY:</u>			
4260-101-0001(2) *	\$161,513,000	\$150,591,000	(\$10,922,000)
4260-113-0001 Healthy Families *	\$1,113,000	\$657,000	(\$456,000)
4260-117-0001 HIPAA *	\$3,162,000	\$2,823,000	(\$339,000)
4260-610-0995 Reimbursements	\$0	\$0	\$0
TOTAL FISCAL INTERMEDIARY	\$165,788,000	\$154,071,000	(\$11,717,000)
Total FI General Fund *	\$165,788,000	\$154,071,000	(\$11,717,000)
 GRAND TOTAL - STATE FUNDS	 \$31,340,922,000	 \$30,991,975,000	 (\$348,947,000)
Grand Total General Fund *	\$17,645,882,000	\$19,084,124,000	\$1,438,242,000

Notes:

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

Medi-Cal Funding Summary
November 2015 Estimate Comparison of FY 2015-16 to FY 2016-17

FEDERAL FUNDS

	<u>FY 2015-16</u> <u>Estimate</u>	<u>FY 2016-17</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
<u>MEDI-CAL Benefits:</u>			
4260-101-0890(3)	\$49,219,828,000	\$43,561,572,000	(\$5,658,256,000)
4260-102-0890 Capital Debt	\$40,453,000	\$41,141,000	\$688,000
4260-106-0890 Money Follows Person Federal Grant	\$16,090,000	\$20,949,000	\$4,859,000
4260-113-0890 Health Families	\$2,510,974,000	\$2,436,189,000	(\$74,785,000)
4260-601-7502 Demonstration DSH Fund	\$60,178,000	\$0	(\$60,178,000)
4260-601-7503 Health Care Support Fund	\$385,964,000	\$52,086,000	(\$333,878,000)
4260-611-0890 Hospital Quality Assurance	\$5,326,988,000	\$4,392,351,000	(\$934,637,000)
TOTAL MEDI-CAL Benefits	<u>\$57,560,475,000</u>	<u>\$50,504,288,000</u>	<u>(\$7,056,187,000)</u>
<u>COUNTY ADMINISTRATION:</u>			
4260-101-0890(1)	\$3,051,843,000	\$3,137,454,000	\$85,611,000
4260-106-0890(1) Money Follows Person Fed. Grant	\$651,000	\$978,000	\$327,000
4260-107-0890 Prevention of Chronic Disease (MIPCD)	\$4,539,000	\$80,000	(\$4,459,000)
4260-113-0890 Healthy Families	\$93,488,000	\$96,042,000	\$2,554,000
4260-117-0890 HIPAA	\$5,665,000	\$5,006,000	(\$659,000)
TOTAL COUNTY ADMIN.	<u>\$3,156,186,000</u>	<u>\$3,239,560,000</u>	<u>\$83,374,000</u>
<u>FISCAL INTERMEDIARY:</u>			
4260-101-0890(2)	\$297,642,000	\$288,754,000	(\$8,888,000)
4260-113-0890 Healthy Families	\$5,156,000	\$4,817,000	(\$339,000)
4260-117-0890 HIPAA	\$16,946,000	\$9,100,000	(\$7,846,000)
TOTAL FISCAL INTERMEDIARY	<u>\$319,744,000</u>	<u>\$302,671,000</u>	<u>(\$17,073,000)</u>
 GRAND TOTAL - FEDERAL FUNDS	 <u>\$61,036,405,000</u>	 <u>\$54,046,519,000</u>	 <u>(\$6,989,886,000)</u>

MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2015-16

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
I. BASE ESTIMATES			
A. C/Y FFS BASE	\$17,076,552,830	\$8,538,276,410	\$8,538,276,410
B. C/Y BASE POLICY CHANGES	\$44,156,208,010	\$31,821,567,180	\$12,334,640,830
C. BASE ADJUSTMENTS	-\$170,478,000	-\$203,274,400	\$32,796,400
D. ADJUSTED BASE	<u>\$61,062,282,840</u>	<u>\$40,156,569,190</u>	<u>\$20,905,713,650</u>
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	\$736,493,770	\$521,327,430	\$215,166,350
B. AFFORDABLE CARE ACT	\$1,979,316,240	\$2,220,791,730	-\$241,475,490
C. BENEFITS	\$639,253,000	\$541,197,020	\$98,055,980
D. PHARMACY	-\$2,655,627,510	-\$1,604,492,030	-\$1,051,135,480
E. DRUG MEDI-CAL	\$17,597,000	\$12,500,500	\$5,096,500
F. MENTAL HEALTH	\$352,728,000	\$314,439,000	\$38,289,000
G. WAIVER--MH/UCD & BTR	\$6,394,396,960	\$4,214,672,980	\$2,179,723,980
H. MANAGED CARE	\$8,108,351,100	\$2,493,767,030	\$5,614,584,070
I. PROVIDER RATES	\$730,981,730	\$395,849,520	\$335,132,210
J. SUPPLEMENTAL PMNTS.	\$10,085,338,460	\$6,176,165,600	\$3,909,172,860
K. OTHER	\$466,795,000	\$2,117,686,660	-\$1,650,891,660
L. TOTAL CHANGES	<u>\$26,855,623,770</u>	<u>\$17,403,905,440</u>	<u>\$9,451,718,320</u>
III. TOTAL MEDI-CAL ESTIMATE	<u><u>\$87,917,906,600</u></u>	<u><u>\$57,560,474,640</u></u>	<u><u>\$30,357,431,970</u></u>

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
ELIGIBILITY				
1	FAMILY PACT PROGRAM	\$460,031,000	\$346,082,900	\$113,948,100
2	MEDI-CAL ADULT INMATE PROGRAMS	\$148,598,000	\$148,598,000	\$0
3	BREAST AND CERVICAL CANCER TREATMENT	\$101,577,000	\$52,919,750	\$48,657,250
5	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	\$46,958,000	\$46,958,000	\$0
6	PREGNANT WOMEN FULL SCOPE EXPANSION 60-13/	\$30,024,000	\$15,012,000	\$15,012,000
7	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSI/	\$26,193,000	\$5,773,000	\$20,420,000
9	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	\$3,634,700	\$2,989,580	\$645,120
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$2,383,000	\$1,959,960	\$423,040
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	\$201,893,790	-\$201,893,790
13	NEW QUALIFIED IMMIGRANTS	\$0	-\$388,613,000	\$388,613,000
14	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$110,502,990	-\$110,502,990
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$43,872,980	-\$43,872,980
16	INCARCERATION VERIFICATION PROGRAM	-\$4,935,040	-\$4,123,840	-\$811,200
17	PARIS-VETERANS	-\$5,058,880	-\$2,529,440	-\$2,529,440
18	TLICP PREMIUMS	-\$72,911,000	-\$59,969,240	-\$12,941,760
	ELIGIBILITY SUBTOTAL	\$736,493,780	\$521,327,430	\$215,166,350
AFFORDABLE CARE ACT				
19	COMMUNITY FIRST CHOICE OPTION	\$1,399,733,000	\$1,399,733,000	\$0
20	ACA OPTIONAL EXPANSION	\$793,495,000	\$792,932,000	\$563,000
21	HEALTH INSURER FEE	\$258,130,000	\$174,777,210	\$83,352,790
22	ACA MANDATORY EXPANSION	\$85,609,000	\$49,229,990	\$36,379,010
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$4,154,960	\$4,154,960	\$0
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$24,295,000	-\$24,295,000
25	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$0	-\$349,000	\$349,000
26	ACA MAGI SAVINGS	\$0	\$0	\$0
27	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$0	\$134,502,500	-\$134,502,500
30	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$1,891,000	-\$945,500	-\$945,500
31	ACA REDETERMINATIONS	-\$172,914,710	-\$100,575,380	-\$72,339,340
32	MANAGED CARE DRUG REBATES	-\$387,000,000	-\$256,963,050	-\$130,036,950
	AFFORDABLE CARE ACT SUBTOTAL	\$1,979,316,250	\$2,220,791,730	-\$241,475,490
BENEFITS				
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$273,219,000	\$273,219,000	\$0
34	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$131,198,000	\$131,198,000	\$0
35	BEHAVIORAL HEALTH TREATMENT	\$104,304,000	\$57,202,900	\$47,101,100
36	CCS DEMONSTRATION PROJECT PILOTS	\$41,388,000	\$20,694,000	\$20,694,000
37	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$20,232,000
38	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$21,252,000	\$11,996,740	\$9,255,260
39	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$20,537,000	\$18,351,000	\$2,186,000
40	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FO	\$9,118,000	\$4,794,980	\$4,323,020
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,126,000	\$5,104,000	\$22,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
BENEFITS				
42	CCT FUND TRANSFER TO CDSS AND CDDS	\$3,803,000	\$3,803,000	\$0
43	ALLIED DENTAL PROFESSIONALS ENROLLMENT	\$1,153,000	\$576,500	\$576,500
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$697,000	\$363,600	\$333,400
45	CHDP PROGRAM DENTAL REFERRAL	\$606,000	\$305,280	\$300,720
46	BENEFICIARY OUTREACH AND EDUCATION PROGR/	\$216,000	\$149,340	\$66,660
47	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$156,000	\$156,000	\$0
48	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$143,000	\$143,000	\$0
49	WOMEN'S HEALTH SERVICES	\$25,000	\$19,800	\$5,200
50	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVI	-\$1,642,000	-\$857,120	-\$784,880
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$12,414,000	-\$6,207,000	-\$6,207,000
203	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICE:	-\$96,000	-\$48,000	-\$48,000
	BENEFITS SUBTOTAL	\$639,253,000	\$541,197,020	\$98,055,980
PHARMACY				
52	ORKAMBI BENEFIT	\$18,077,490	\$9,489,480	\$8,588,020
53	ADAP RYAN WHITE MEDS DATA MATCH	\$2,400,000	\$1,200,000	\$1,200,000
54	HEPATITIS C REVISED CLINICAL GUIDELINES	\$2,166,000	\$1,083,000	\$1,083,000
55	NON FFP DRUGS	\$0	-\$221,500	\$221,500
56	BCCTP DRUG REBATES	-\$16,000,000	-\$10,400,000	-\$5,600,000
57	MEDICAL SUPPLY REBATES	-\$29,518,000	-\$16,825,500	-\$12,692,500
58	LITIGATION SETTLEMENTS	-\$36,262,000	\$0	-\$36,262,000
59	FAMILY PACT DRUG REBATES	-\$54,527,000	-\$47,687,100	-\$6,839,900
60	STATE SUPPLEMENTAL DRUG REBATES	-\$185,506,000	-\$110,949,100	-\$74,556,900
61	AGED AND DISPUTED DRUG REBATES	-\$300,000,000	-\$150,012,000	-\$149,988,000
62	FEDERAL DRUG REBATE PROGRAM	-\$2,056,458,000	-\$1,280,169,300	-\$776,288,700
	PHARMACY SUBTOTAL	-\$2,655,627,510	-\$1,604,492,030	-\$1,051,135,480
DRUG MEDI-CAL				
65	RESIDENTIAL TREATMENT SERVICES EXPANSION	\$14,561,000	\$9,464,500	\$5,096,500
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$3,036,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$17,597,000	\$12,500,500	\$5,096,500
MENTAL HEALTH				
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	\$232,291,000	\$232,291,000	\$0
73	ELIMINATION OF STATE MAXIMUM RATES	\$78,309,000	\$78,309,000	\$0
74	TRANSITION OF HFP - SMH SERVICES	\$53,804,000	\$53,804,000	\$0
75	KATIE A. V. DIANA BONTA	\$35,954,000	\$35,954,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$24,000,000	\$24,000,000	\$0
77	HEALTHY FAMILIES - SED	\$5,000	\$5,000	\$0
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPA'	\$0	-\$4,412,000	\$4,412,000
79	IMD ANCILLARY SERVICES	\$0	-\$4,000,000	\$4,000,000
80	CHART REVIEW	-\$1,138,000	-\$1,138,000	\$0
81	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$74,280,000	-\$104,157,000	\$29,877,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
MENTAL HEALTH				
198	LATE CLAIMS FOR SMHS	\$3,783,000	\$3,783,000	\$0
	MENTAL HEALTH SUBTOTAL	\$352,728,000	\$314,439,000	\$38,289,000
WAIVER--MH/UCD & BTR				
82	MH/UCD & BTR—DSH PAYMENT	\$184,358,000	\$122,268,000	\$62,090,000
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	\$786,080,000	\$393,040,000	\$393,040,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	\$656,305,000	\$328,152,500	\$328,152,500
85	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$326,815,000	\$326,815,000	\$0
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	\$280,704,000	\$140,352,000	\$140,352,000
87	BTR—SAFETY NET CARE POOL	\$19,667,000	\$19,667,000	\$0
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	\$187,327,000	\$93,663,500	\$93,663,500
89	BTR - LIHP - MCE	\$162,795,000	\$162,795,000	\$0
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$126,379,000	\$126,379,000	\$0
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COS'	\$87,171,000	\$87,171,000	\$0
92	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$25,948,970	\$12,974,480	\$12,974,480
93	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$23,509,000	\$23,509,000	\$0
94	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$3,458,000	\$149,939,000	-\$146,481,000
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$10,204,000	\$5,102,000	\$5,102,000
96	MH/UCD—SAFETY NET CARE POOL	\$8,186,000	\$8,186,000	\$0
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$4,712,000	\$2,356,000	\$2,356,000
98	MH/UCD—STABILIZATION FUNDING	\$2,650,000	\$0	\$2,650,000
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HI	\$2,164,000	\$2,164,000	\$0
101	MH/UCD & BTR—BCCTP	\$0	\$327,000	-\$327,000
102	MH/UCD & BTR—DPH INTERIM RATE	\$0	\$414,987,500	-\$414,987,500
103	MH/UCD & BTR—MIA-LTC	\$0	\$393,000	-\$393,000
104	MH/UCD & BTR—CCS AND GHPP	\$17,900,000	\$17,900,000	\$0
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MED	\$800,000,000	\$400,000,000	\$400,000,000
206	GLOBAL PAYMENT PROGRAM	\$2,603,064,000	\$1,301,532,000	\$1,301,532,000
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRA	\$0	\$37,500,000	-\$37,500,000
209	WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE	\$75,000,000	\$37,500,000	\$37,500,000
	WAIVER--MH/UCD & BTR SUBTOTAL	\$6,394,396,970	\$4,214,672,980	\$2,179,723,980
MANAGED CARE				
108	CCI-MANAGED CARE PAYMENTS	\$4,267,130,250	\$2,133,565,130	\$2,133,565,130
109	CCI-TRANSFER OF IHSS COSTS TO CDSS	\$2,307,539,000	\$0	\$2,307,539,000
111	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$1,744,753,000	\$1,180,569,480	\$564,183,520
112	MANAGED CARE RATE RANGE IGTS	\$637,364,000	\$342,910,000	\$294,454,000
113	MANAGED CARE PUBLIC HOSPITAL IGTS	\$518,150,000	\$259,075,000	\$259,075,000
115	HQAF RATE RANGE INCREASES	\$190,077,000	\$97,079,000	\$92,998,000
118	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEI	\$60,200,000	\$54,180,000	\$6,020,000
119	INLAND EMPIRE HEALTH PLAN SETTLEMENT	\$36,700,000	\$18,350,000	\$18,350,000
121	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$0	\$2,000,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
MANAGED CARE				
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION	\$183,000	\$91,500	\$91,500
124	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTME	\$0	\$0	\$0
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0
127	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	\$0	\$0	\$0
130	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0
131	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	-\$5,687,000	-\$2,843,500	-\$2,843,500
132	CCI-SAVINGS AND DEFERRAL	-\$555,578,150	-\$277,789,080	-\$277,789,080
133	RETRO MC RATE ADJUSTMENTS	-\$1,094,480,000	-\$1,311,420,500	\$216,940,500
	MANAGED CARE SUBTOTAL	\$8,108,351,100	\$2,493,767,030	\$5,614,584,070
PROVIDER RATES				
134	MEDICARE PART B PREMIUM INCREASE	\$152,212,000	\$66,935,500	\$85,276,500
135	DENTAL RETROACTIVE RATE CHANGES	\$252,417,000	\$148,666,200	\$103,750,800
136	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$237,348,680	\$118,674,340	\$118,674,340
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	\$88,137,000	\$44,068,500	\$44,068,500
138	LTC RATE ADJUSTMENT	\$45,805,590	\$22,902,800	\$22,902,800
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$47,658,980	\$23,829,490	\$23,829,490
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$19,700,000	\$9,850,000	\$9,850,000
141	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$10,758,790	\$6,626,350	\$4,132,440
142	HOSPICE RATE INCREASES	\$3,268,360	\$1,634,180	\$1,634,180
144	LONG TERM CARE QUALITY ASSURANCE FUND EXP	-\$31,649,000	\$0	-\$31,649,000
145	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$3,088,280	-\$1,544,140	-\$1,544,140
146	NON-AB 1629 LTC RATE FREEZE	-\$4,532,300	-\$2,266,150	-\$2,266,150
147	LABORATORY RATE METHODOLOGY CHANGE	-\$20,265,790	-\$10,132,900	-\$10,132,900
148	10% PROVIDER PAYMENT REDUCTION	-\$22,239,430	-\$11,119,720	-\$11,119,720
149	REDUCTION TO RADIOLOGY RATES	-\$44,549,850	-\$22,274,930	-\$22,274,930
	PROVIDER RATES SUBTOTAL	\$730,981,730	\$395,849,530	\$335,132,210
SUPPLEMENTAL PMNTS.				
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$8,613,826,000	\$5,128,013,000	\$3,485,813,000
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$288,962,000	\$288,962,000	\$0
152	HOSPITAL QAF - HOSPITAL PAYMENTS	\$264,597,000	\$101,896,000	\$162,701,000
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	\$210,610,000	\$210,610,000	\$0
154	NDPH IGT SUPPLEMENTAL PAYMENTS	\$136,685,000	\$89,597,000	\$47,088,000
155	CERTIFICATION PAYMENTS FOR DP-NFS	\$111,321,000	\$111,321,000	\$0
156	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL P	\$105,372,460	\$53,540,600	\$51,831,860
157	FFP FOR LOCAL TRAUMA CENTERS	\$101,793,000	\$50,896,500	\$50,896,500
158	CAPITAL PROJECT DEBT REIMBURSEMENT	\$100,941,000	\$60,488,500	\$40,452,500
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$61,611,000	\$61,611,000	\$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	\$10,000,000	\$5,000,000	\$5,000,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
SUPPLEMENTAL PMNTS.				
161	IGT PAYMENTS FOR HOSPITAL SERVICES	\$8,333,000	\$4,167,000	\$4,166,000
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	\$8,000,000	\$4,000,000	\$4,000,000
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEN	\$6,063,000	\$6,063,000	\$0
200	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$57,224,000	\$0	\$57,224,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$10,085,338,460	\$6,176,165,600	\$3,909,172,860
OTHER				
170	ARRA HITECH - PROVIDER PAYMENTS	\$182,108,000	\$182,108,000	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- C	\$155,709,000	\$155,709,000	\$0
173	CCI IHSS RECONCILIATION	\$60,000,000	\$60,000,000	\$0
174	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	\$50,929,000	\$25,464,500	\$25,464,500
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDC	\$18,496,000	\$13,151,000	\$5,345,000
179	INDIAN HEALTH SERVICES	\$5,545,000	\$24,027,500	-\$18,482,500
180	WPCS WORKERS' COMPENSATION	\$4,764,000	\$2,382,000	\$2,382,000
181	OVERTIME FOR WPCS PROVIDERS	\$4,231,000	\$2,115,500	\$2,115,500
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$2,939,000	\$2,057,500	\$881,500
186	CDDS DENTAL SERVICES	\$902,000	\$0	\$902,000
187	AUDIT SETTLEMENTS	\$854,000	\$0	\$854,000
188	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	\$325,000	\$162,500	\$162,500
189	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,595,366,800	-\$1,595,366,800
190	FUNDING ADJUST.—OTLICP	\$0	\$100,237,360	-\$100,237,360
191	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0
192	CLPP FUND	\$0	\$0	\$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0
195	IHSS REDUCTION IN SERVICE HOURS	-\$2,558,000	-\$2,558,000	\$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	-\$17,449,000	\$0	-\$17,449,000
210	FFP REPAYMENT FOR CDDS COSTS	\$0	-\$42,537,000	\$42,537,000
	OTHER SUBTOTAL	\$466,795,000	\$2,117,686,660	-\$1,650,891,660
	GRAND TOTAL	\$26,855,623,770	\$17,403,905,450	\$9,451,718,320

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

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

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
PROFESSIONAL	\$6,883,700,130	\$4,447,616,000	\$2,436,084,140
PHYSICIANS	\$930,353,720	\$600,413,910	\$329,939,810
OTHER MEDICAL	\$3,752,830,580	\$2,429,081,030	\$1,323,749,550
CO. & COMM. OUTPATIENT	\$2,200,515,830	\$1,418,121,050	\$782,394,780
PHARMACY	\$1,001,911,480	\$689,414,150	\$312,497,330
HOSPITAL INPATIENT	\$13,532,437,430	\$8,687,518,520	\$4,844,918,900
COUNTY INPATIENT	\$3,644,862,690	\$2,454,278,690	\$1,190,584,000
COMMUNITY INPATIENT	\$9,887,574,740	\$6,233,239,830	\$3,654,334,900
LONG TERM CARE	\$3,064,107,350	\$1,614,825,770	\$1,449,281,580
NURSING FACILITIES	\$2,676,430,470	\$1,414,437,860	\$1,261,992,610
ICF-DD	\$387,676,880	\$200,387,910	\$187,288,970
OTHER SERVICES	\$1,032,519,500	\$652,642,850	\$379,876,660
MEDICAL TRANSPORTATION	\$169,747,550	\$119,850,650	\$49,896,900
OTHER SERVICES	\$620,806,700	\$409,899,840	\$210,906,860
HOME HEALTH	\$241,965,240	\$122,892,350	\$119,072,900
TOTAL FEE-FOR-SERVICE	\$25,514,675,890	\$16,092,017,280	\$9,422,658,610
MANAGED CARE	\$47,187,755,440	\$30,668,786,100	\$16,518,969,330
TWO PLAN MODEL	\$29,590,851,670	\$18,875,007,670	\$10,715,844,000
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,452,796,350	\$7,174,553,280	\$3,278,243,060
GEOGRAPHIC MANAGED CARE	\$5,012,550,600	\$3,222,418,690	\$1,790,131,910
PHP & OTHER MANAG. CARE	\$661,697,720	\$358,554,010	\$303,143,720
REGIONAL MODEL	\$1,469,859,100	\$1,038,252,460	\$431,606,640
DENTAL	\$1,256,258,310	\$799,567,470	\$456,690,840
MENTAL HEALTH	\$2,302,672,340	\$2,155,115,610	\$147,556,730
AUDITS/ LAWSUITS	-\$30,038,000	\$1,663,000	-\$31,701,000
EPSDT SCREENS	\$47,172,920	\$25,264,160	\$21,908,760
MEDICARE PAYMENTS	\$4,464,007,000	\$1,285,622,500	\$3,178,384,500
STATE HOSP./DEVELOPMENTAL CNTRS.	\$206,129,000	\$163,592,000	\$42,537,000
MISC. SERVICES	\$7,112,717,700	\$6,369,227,010	\$743,490,690
RECOVERIES	-\$306,727,000	-\$146,274,000	-\$160,453,000
DRUG MEDI-CAL	\$163,283,000	\$145,893,500	\$17,389,500
GRAND TOTAL MEDI-CAL	\$87,917,906,600	\$57,560,474,640	\$30,357,431,970

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

SERVICE CATEGORY	2015-16 APPROPRIATION	NOV. 2015 EST. FOR 2015-16	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	\$5,805,658,110	\$6,883,700,130	\$1,078,042,030	18.57
PHYSICIANS	\$939,157,020	\$930,353,720	-\$8,803,300	-0.94
OTHER MEDICAL	\$2,991,639,220	\$3,752,830,580	\$761,191,360	25.44
CO. & COMM. OUTPATIENT	\$1,874,861,870	\$2,200,515,830	\$325,653,960	17.37
PHARMACY	\$266,920,620	\$1,001,911,480	\$734,990,860	275.36
HOSPITAL INPATIENT	\$11,829,970,610	\$13,532,437,430	\$1,702,466,810	14.39
COUNTY INPATIENT	\$2,504,750,370	\$3,644,862,690	\$1,140,112,320	45.52
COMMUNITY INPATIENT	\$9,325,220,240	\$9,887,574,740	\$562,354,490	6.03
LONG TERM CARE	\$1,426,338,830	\$3,064,107,350	\$1,637,768,520	114.82
NURSING FACILITIES	\$1,295,142,780	\$2,676,430,470	\$1,381,287,690	106.65
ICF-DD	\$131,196,050	\$387,676,880	\$256,480,830	195.49
OTHER SERVICES	\$786,335,220	\$1,032,519,500	\$246,184,280	31.31
MEDICAL TRANSPORTATION	\$159,661,110	\$169,747,550	\$10,086,450	6.32
OTHER SERVICES	\$517,264,190	\$620,806,700	\$103,542,510	20.02
HOME HEALTH	\$109,409,930	\$241,965,240	\$132,555,320	121.15
TOTAL FEE-FOR-SERVICE	\$20,115,223,390	\$25,514,675,890	\$5,399,452,500	26.84
MANAGED CARE	\$50,386,927,650	\$47,187,755,440	-\$3,199,172,210	-6.35
TWO PLAN MODEL	\$32,295,871,790	\$29,590,851,670	-\$2,705,020,120	-8.38
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,565,610,520	\$10,452,796,350	-\$112,814,180	-1.07
GEOGRAPHIC MANAGED CARE	\$5,696,227,170	\$5,012,550,600	-\$683,676,570	-12.00
PHP & OTHER MANAG. CARE	\$605,093,390	\$661,697,720	\$56,604,330	9.35
REGIONAL MODEL	\$1,224,124,780	\$1,469,859,100	\$245,734,330	20.07
DENTAL	\$1,228,477,560	\$1,256,258,310	\$27,780,740	2.26
MENTAL HEALTH	\$2,734,654,380	\$2,302,672,340	-\$431,982,030	-15.80
AUDITS/ LAWSUITS	\$6,547,500	-\$30,038,000	-\$36,585,500	-558.77
EPSDT SCREENS	\$55,403,810	\$47,172,920	-\$8,230,890	-14.86
MEDICARE PAYMENTS	\$4,259,230,170	\$4,464,007,000	\$204,776,830	4.81
STATE HOSP./DEVELOPMENTAL CNTRS.	\$206,883,020	\$206,129,000	-\$754,020	-0.36
MISC. SERVICES	\$7,800,707,000	\$7,112,717,700	-\$687,989,300	-8.82
RECOVERIES	-\$277,857,640	-\$306,727,000	-\$28,869,360	10.39
DRUG MEDI-CAL	\$154,981,860	\$163,283,000	\$8,301,140	5.36
GRAND TOTAL MEDI-CAL	\$86,671,178,700	\$87,917,906,600	\$1,246,727,900	1.44
STATE FUNDS	\$31,104,105,180	\$30,357,431,970	-\$746,673,220	-2.40

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
1	FAMILY PACT PROGRAM	\$540,109,000	\$135,377,800	\$460,031,000	\$113,948,100	-\$80,078,000	-\$21,429,700
2	MEDI-CAL ADULT INMATE PROGRAMS	\$59,918,000	\$0	\$148,598,000	\$0	\$88,680,000	\$0
3	BREAST AND CERVICAL CANCER TREATMENT	\$109,731,000	\$51,506,600	\$101,577,000	\$48,657,250	-\$8,154,000	-\$2,849,350
5	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATE	\$56,404,000	\$0	\$46,958,000	\$0	-\$9,446,000	\$0
6	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%	\$29,630,000	\$14,815,000	\$30,024,000	\$15,012,000	\$394,000	\$197,000
7	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION	\$40,000,000	\$40,000,000	\$26,193,000	\$20,420,000	-\$13,807,000	-\$19,580,000
9	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	\$6,424,000	\$2,248,250	\$6,424,000	\$1,140,190	\$0	-\$1,108,060
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$1,469,000	\$514,000	\$2,383,000	\$423,040	\$914,000	-\$90,960
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	-\$80,419,200	\$0	-\$201,893,790	\$0	-\$121,474,590
13	NEW QUALIFIED IMMIGRANTS	\$0	\$178,884,000	\$0	\$388,613,000	\$0	\$209,729,000
14	SCHIP FUNDING FOR PRENATAL CARE	\$0	-\$87,287,200	\$0	-\$110,502,990	\$0	-\$23,215,790
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	-\$38,895,000	\$0	-\$43,872,980	\$0	-\$4,977,980
16	INCARCERATION VERIFICATION PROGRAM	-\$1,939,000	-\$969,500	-\$7,711,000	-\$1,267,500	-\$5,772,000	-\$298,000
17	PARIS-VETERANS	-\$10,309,950	-\$5,154,980	-\$10,895,720	-\$5,447,860	-\$585,770	-\$292,880
18	TLICP PREMIUMS	-\$74,115,000	-\$25,940,250	-\$72,911,000	-\$12,941,760	\$1,204,000	\$12,998,490
--	FEDERAL IMMIGRATION REFORM	\$20,883,000	\$16,779,000	\$0	\$0	-\$20,883,000	-\$16,779,000
	ELIGIBILITY SUBTOTAL	\$778,204,050	\$201,458,520	\$730,670,280	\$212,286,700	-\$47,533,770	\$10,828,180
AFFORDABLE CARE ACT							
19	COMMUNITY FIRST CHOICE OPTION	\$1,399,733,000	\$0	\$1,399,733,000	\$0	\$0	\$0
20	ACA OPTIONAL EXPANSION	\$13,773,270,000	\$8,553,000	\$793,495,000	\$563,000	-\$12,979,775,000	-\$7,990,000
21	HEALTH INSURER FEE	\$257,898,000	\$90,264,500	\$258,130,000	\$83,352,790	\$232,000	-\$6,911,710
22	ACA MANDATORY EXPANSION	\$2,772,048,000	\$1,293,434,100	\$85,609,000	\$36,379,010	-\$2,686,439,000	-\$1,257,055,090
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$5,716,000	\$0	\$5,716,000	\$0	\$0	\$0
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	-\$57,454,000	\$0	-\$24,295,000	\$0	\$33,159,000

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>AFFORDABLE CARE ACT</u>							
25	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$0	\$0	\$0	\$349,000	\$0	\$349,000
26	ACA MAGI SAVINGS	\$0	-\$36,129,000	\$0	\$0	\$0	\$36,129,000
27	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$647,227,000	\$131,419,750	\$0	-\$134,502,500	-\$647,227,000	-\$265,922,250
30	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$2,890	-\$1,440	-\$1,891,000	-\$945,500	-\$1,888,110	-\$944,060
31	ACA REDETERMINATIONS	-\$796,842,000	-\$333,361,000	-\$796,842,000	-\$333,361,000	\$0	\$0
32	MANAGED CARE DRUG REBATES	-\$450,000,000	-\$145,914,000	-\$387,000,000	-\$130,036,950	\$63,000,000	\$15,877,050
--	ACA DELAY OF REDETERMINATIONS	\$43,470,000	\$17,836,300	\$0	\$0	-\$43,470,000	-\$17,836,300
--	ACA EXPANSION-ADDITIONAL CHIP FUNDING	\$77,777,000	-\$381,127,000	\$0	\$0	-\$77,777,000	\$381,127,000
--	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	\$83,370,000	\$0	\$0	\$0	-\$83,370,000	\$0
--	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	\$256,614,000	\$93,034,000	\$0	\$0	-\$256,614,000	-\$93,034,000
--	ACA EXPRESS LANE ENROLLMENT	\$1,052,416,000	\$22,798,500	\$0	\$0	-\$1,052,416,000	-\$22,798,500
--	ACCELERATED ENROLLMENT	\$557,000	\$278,500	\$0	\$0	-\$557,000	-\$278,500
	AFFORDABLE CARE ACT SUBTOTAL	\$19,123,251,110	\$703,632,210	\$1,356,950,000	-\$502,497,150	-\$17,766,301,110	-\$1,206,129,360
<u>BENEFITS</u>							
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$273,184,000	\$0	\$273,219,000	\$0	\$35,000	\$0
34	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$135,735,000	\$0	\$131,198,000	\$0	-\$4,537,000	\$0
35	BEHAVIORAL HEALTH TREATMENT	\$228,717,000	\$114,358,500	\$104,304,000	\$47,101,100	-\$124,413,000	-\$67,257,400
36	CCS DEMONSTRATION PROJECT PILOTS	\$41,388,000	\$20,694,000	\$41,388,000	\$20,694,000	\$0	\$0
37	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$40,464,000	\$20,232,000	\$0	\$0
38	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$21,252,000	\$9,988,500	\$21,252,000	\$9,255,260	\$0	-\$733,240
39	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$32,253,000	\$2,731,000	\$20,537,000	\$2,186,000	-\$11,716,000	-\$545,000
40	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR	\$18,236,000	\$8,898,550	\$9,118,000	\$4,323,020	-\$9,118,000	-\$4,575,530
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,272,000	\$29,000	\$5,126,000	\$22,000	-\$146,000	-\$7,000
42	CCT FUND TRANSFER TO CDSS AND CDDS	\$4,909,000	\$0	\$3,803,000	\$0	-\$1,106,000	\$0

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>BENEFITS</u>							
43	ALLIED DENTAL PROFESSIONALS ENROLLMENT	\$1,647,000	\$761,850	\$1,153,000	\$576,500	-\$494,000	-\$185,350
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$760,000	\$380,000	\$697,000	\$333,400	-\$63,000	-\$46,600
45	CHDP PROGRAM DENTAL REFERRAL	\$808,000	\$404,000	\$606,000	\$300,720	-\$202,000	-\$103,280
46	BENEFICIARY OUTREACH AND EDUCATION PROGRAM	\$0	\$0	\$216,000	\$66,660	\$216,000	\$66,660
47	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$296,000	\$0	\$156,000	\$0	-\$140,000	\$0
48	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$138,000	\$0	\$143,000	\$0	\$5,000	\$0
49	WOMEN'S HEALTH SERVICES	-\$9,688,020	-\$1,914,340	\$25,000	\$5,200	\$9,713,020	\$1,919,540
50	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINC	-\$2,293,000	-\$1,146,500	-\$1,642,000	-\$784,880	\$651,000	\$361,620
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$16,764,000	-\$8,382,000	-\$12,414,000	-\$6,207,000	\$4,350,000	\$2,175,000
203	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	\$0	\$0	-\$96,000	-\$48,000	-\$96,000	-\$48,000
--	VOLUNTARY INPATIENT DETOXIFICATION	\$31,911,000	\$10,754,500	\$0	\$0	-\$31,911,000	-\$10,754,500
	BENEFITS SUBTOTAL	\$808,224,980	\$177,789,060	\$639,253,000	\$98,055,980	-\$168,971,980	-\$79,733,080
<u>PHARMACY</u>							
52	ORKAMBI BENEFIT	\$0	\$0	\$18,077,490	\$8,588,020	\$18,077,490	\$8,588,020
53	ADAP RYAN WHITE MEDS DATA MATCH	\$0	\$0	\$2,400,000	\$1,200,000	\$2,400,000	\$1,200,000
54	HEPATITIS C REVISED CLINICAL GUIDELINES	\$13,400,000	\$6,700,000	\$2,400,000	\$1,200,000	-\$11,000,000	-\$5,500,000
55	NON FFP DRUGS	\$0	\$244,000	\$0	\$221,500	\$0	-\$22,500
56	BCCTP DRUG REBATES	-\$18,000,000	-\$6,300,000	-\$16,000,000	-\$5,600,000	\$2,000,000	\$700,000
57	MEDICAL SUPPLY REBATES	-\$31,000,000	-\$15,500,000	-\$29,518,000	-\$12,692,500	\$1,482,000	\$2,807,500
58	LITIGATION SETTLEMENTS	\$0	\$0	-\$36,262,000	-\$36,262,000	-\$36,262,000	-\$36,262,000
59	FAMILY PACT DRUG REBATES	-\$62,779,000	-\$7,875,100	-\$54,527,000	-\$6,839,900	\$8,252,000	\$1,035,200
60	STATE SUPPLEMENTAL DRUG REBATES	-\$147,563,000	-\$63,203,500	-\$185,506,000	-\$74,556,900	-\$37,943,000	-\$11,353,400
61	AGED AND DISPUTED DRUG REBATES	-\$200,000,000	-\$99,992,000	-\$300,000,000	-\$149,988,000	-\$100,000,000	-\$49,996,000
62	FEDERAL DRUG REBATE PROGRAM	-\$1,649,234,000	-\$587,551,800	-\$2,056,458,000	-\$776,288,700	-\$407,224,000	-\$188,736,900

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
PHARMACY							
--	RESTORATION OF ENTERAL NUTRITION BENEFIT	\$28,892,000	\$14,446,000	\$0	\$0	-\$28,892,000	-\$14,446,000
	PHARMACY SUBTOTAL	-\$2,066,284,000	-\$759,032,400	-\$2,655,393,510	-\$1,051,018,480	-\$589,109,510	-\$291,986,080
DRUG MEDI-CAL							
65	RESIDENTIAL TREATMENT SERVICES EXPANSION	\$0	\$0	\$14,561,000	\$5,096,500	\$14,561,000	\$5,096,500
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$0	\$3,036,000	\$0	\$0	\$0
--	ANNUAL RATE ADJUSTMENT	\$5,399,000	\$794,000	\$0	\$0	-\$5,399,000	-\$794,000
--	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$28,380,000	\$0	\$0	\$0	\$28,380,000	\$0
	DRUG MEDI-CAL SUBTOTAL	-\$19,945,000	\$794,000	\$17,597,000	\$5,096,500	\$37,542,000	\$4,302,500
MENTAL HEALTH							
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	\$407,834,000	\$0	\$232,291,000	\$0	-\$175,543,000	\$0
73	ELIMINATION OF STATE MAXIMUM RATES	\$78,309,000	\$0	\$78,309,000	\$0	\$0	\$0
74	TRANSITION OF HFP - SMH SERVICES	\$42,520,000	\$0	\$53,804,000	\$0	\$11,284,000	\$0
75	KATIE A. V. DIANA BONTA	\$36,192,000	\$0	\$35,954,000	\$0	-\$238,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$23,964,000	\$0	\$24,000,000	\$0	\$36,000	\$0
77	HEALTHY FAMILIES - SED	\$5,000	\$0	\$5,000	\$0	\$0	\$0
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	\$0	\$3,432,000	\$0	\$4,412,000	\$0	\$980,000
79	IMD ANCILLARY SERVICES	\$0	\$4,000,000	\$0	\$4,000,000	\$0	\$0
80	CHART REVIEW	-\$646,000	\$0	-\$1,138,000	\$0	-\$492,000	\$0
81	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$74,280,000	\$29,877,000	-\$74,280,000	\$29,877,000	\$0	\$0
198	LATE CLAIMS FOR SMHS	\$3,783,000	\$0	\$3,783,000	\$0	\$0	\$0
	MENTAL HEALTH SUBTOTAL	\$517,681,000	\$37,309,000	\$352,728,000	\$38,289,000	-\$164,953,000	\$980,000
WAIVER--MH/UCD & BTR							
82	MH/UCD & BTR—DSH PAYMENT	\$1,710,164,000	\$497,983,500	\$184,358,000	\$62,090,000	-\$1,525,806,000	-\$435,893,500

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
WAIVER--MH/UCD & BTR							
83	BTR—DPH DELIVERY SYSTEM REFORM INCENTIVE PC	\$1,393,468,000	\$696,734,000	\$786,080,000	\$393,040,000	-\$607,388,000	-\$303,694,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT	\$655,933,000	\$327,966,500	\$656,305,000	\$328,152,500	\$372,000	\$186,000
85	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$326,815,000	\$0	\$326,815,000	\$0	\$0	\$0
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL F	\$258,309,000	\$129,154,500	\$280,704,000	\$140,352,000	\$22,395,000	\$11,197,500
87	BTR—SAFETY NET CARE POOL	\$226,167,000	\$0	\$19,667,000	\$0	-\$206,500,000	\$0
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	\$295,327,000	\$143,744,000	\$187,327,000	\$93,663,500	-\$108,000,000	-\$50,080,500
89	BTR - LIHP - MCE	\$1,306,712,000	\$409,479,000	\$162,795,000	\$0	-\$1,143,917,000	-\$409,479,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$7,906,000	\$0	\$126,379,000	\$0	\$118,473,000	\$0
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	\$72,800,000	\$0	\$87,171,000	\$0	\$14,371,000	\$0
92	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$24,412,590	\$12,206,290	\$26,066,260	\$13,033,130	\$1,653,680	\$826,840
93	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$23,509,000	\$0	\$23,509,000	\$0	\$0	\$0
94	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$18,191,000	-\$128,618,000	\$3,458,000	-\$146,481,000	-\$14,733,000	-\$17,863,000
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$0	\$0	\$10,204,000	\$5,102,000	\$10,204,000	\$5,102,000
96	MH/UCD—SAFETY NET CARE POOL	\$8,186,000	\$0	\$8,186,000	\$0	\$0	\$0
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$4,713,000	\$2,356,500	\$4,712,000	\$2,356,000	-\$1,000	-\$500
98	MH/UCD—STABILIZATION FUNDING	\$2,650,000	\$2,650,000	\$2,650,000	\$2,650,000	\$0	\$0
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	\$1,601,000	\$0	\$2,164,000	\$0	\$563,000	\$0
101	MH/UCD & BTR—BCCTP	\$0	-\$378,000	\$0	-\$327,000	\$0	\$51,000
102	MH/UCD & BTR—DPH INTERIM RATE	\$0	-\$400,862,000	\$0	-\$414,987,500	\$0	-\$14,125,500
103	MH/UCD & BTR—MIA-LTC	\$0	\$832,000	\$0	-\$393,000	\$0	-\$1,225,000
104	MH/UCD & BTR—CCS AND GHPP	-\$21,660,000	\$0	\$17,900,000	\$0	\$39,560,000	\$0
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-C	\$0	\$0	\$800,000,000	\$400,000,000	\$800,000,000	\$400,000,000
206	GLOBAL PAYMENT PROGRAM	\$0	\$0	\$2,603,064,000	\$1,301,532,000	\$2,603,064,000	\$1,301,532,000
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$0	\$0	-\$37,500,000	\$0	-\$37,500,000
209	WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE	\$0	\$0	\$75,000,000	\$37,500,000	\$75,000,000	\$37,500,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
WAIVER--MH/UCD & BTR							
	WAIVER--MH/UCD & BTR SUBTOTAL	\$6,315,203,590	\$1,693,248,290	\$6,394,514,260	\$2,179,782,630	\$79,310,680	\$486,534,340
MANAGED CARE							
108	CCI-MANAGED CARE PAYMENTS	\$11,095,458,000	\$5,547,729,000	\$9,889,062,000	\$4,944,531,000	-\$1,206,396,000	-\$603,198,000
109	CCI-TRANSFER OF IHSS COSTS TO CDSS	\$2,840,320,000	\$2,840,320,000	\$2,307,539,000	\$2,307,539,000	-\$532,781,000	-\$532,781,000
111	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$1,062,016,000	\$371,706,000	\$1,744,753,000	\$564,183,520	\$682,737,000	\$192,477,520
112	MANAGED CARE RATE RANGE IGTS	\$902,617,000	\$423,033,000	\$637,364,000	\$294,454,000	-\$265,253,000	-\$128,579,000
113	MANAGED CARE PUBLIC HOSPITAL IGTS	\$510,340,000	\$255,170,000	\$518,150,000	\$259,075,000	\$7,810,000	\$3,905,000
115	HQAF RATE RANGE INCREASES	\$65,077,000	\$30,500,000	\$190,077,000	\$92,998,000	\$125,000,000	\$62,498,000
118	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEED	\$60,183,000	\$6,018,300	\$60,200,000	\$6,020,000	\$17,000	\$1,700
119	INLAND EMPIRE HEALTH PLAN SETTLEMENT	\$0	\$0	\$36,700,000	\$18,350,000	\$36,700,000	\$18,350,000
121	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	\$0	\$0	\$183,000	\$91,500	\$183,000	\$91,500
124	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0	\$0	\$0	\$0
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN	\$0	\$0	\$0	\$0	\$0	\$0
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0	\$0	\$0	\$0
127	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0	\$0	\$0	\$0
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	\$0	\$0	\$0	\$0	\$0
130	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0	\$0	\$0	\$0
131	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	\$0	\$0	-\$5,687,000	-\$2,843,500	-\$5,687,000	-\$2,843,500
132	CCI-SAVINGS AND DEFERRAL	-\$8,082,617,000	-\$4,041,308,500	-\$6,783,616,000	-\$3,391,808,000	\$1,299,001,000	\$649,500,500
133	RETRO MC RATE ADJUSTMENTS	\$0	\$0	-\$1,094,480,000	\$216,940,500	-\$1,094,480,000	\$216,940,500
--	BLOOD FACTOR CARVE OUT	\$52,671,000	\$26,335,500	\$0	\$0	-\$52,671,000	-\$26,335,500
--	CAPITATED RATE ADJUSTMENT FOR FY 2015-16	\$0	\$0	\$0	\$0	\$0	\$0
--	FFS COSTS FOR MANAGED CARE ENROLLEES	\$0	\$0	\$0	\$0	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
MANAGED CARE							
--	MANAGED CARE EXPANSION TO RURAL COUNTIES	\$1,302,000	\$651,000	\$0	\$0	-\$1,302,000	-\$651,000
	MANAGED CARE SUBTOTAL	\$8,509,367,000	\$5,462,154,300	\$7,502,245,000	\$5,311,531,020	-\$1,007,122,000	-\$150,623,280
PROVIDER RATES							
134	MEDICARE PART B PREMIUM INCREASE	\$0	\$0	\$152,212,000	\$85,276,500	\$152,212,000	\$85,276,500
135	DENTAL RETROACTIVE RATE CHANGES	\$0	\$0	\$252,417,000	\$103,750,800	\$252,417,000	\$103,750,800
136	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$265,131,680	\$132,565,840	\$238,517,410	\$119,258,710	-\$26,614,270	-\$13,307,130
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	\$90,191,000	\$45,095,500	\$88,137,000	\$44,068,500	-\$2,054,000	-\$1,027,000
138	LTC RATE ADJUSTMENT	\$62,176,530	\$31,088,270	\$45,805,590	\$22,902,800	-\$16,370,940	-\$8,185,470
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$97,496,990	\$48,748,500	\$83,218,060	\$41,609,030	-\$14,278,930	-\$7,139,470
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$22,918,000	\$11,459,000	\$19,700,000	\$9,850,000	-\$3,218,000	-\$1,609,000
141	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$19,358,570	\$9,679,280	\$24,074,260	\$9,246,890	\$4,715,690	-\$432,390
142	HOSPICE RATE INCREASES	\$13,051,790	\$6,525,890	\$3,539,480	\$1,769,740	-\$9,512,300	-\$4,756,150
144	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	\$0	\$0	-\$31,649,000	-\$31,649,000	-\$31,649,000	-\$31,649,000
145	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$14,529,000	-\$7,264,500	-\$13,824,000	-\$6,912,000	\$705,000	\$352,500
146	NON-AB 1629 LTC RATE FREEZE	-\$23,361,000	-\$11,680,500	-\$4,592,000	-\$2,296,000	\$18,769,000	\$9,384,500
147	LABORATORY RATE METHODOLOGY CHANGE	-\$47,625,940	-\$23,812,970	-\$20,265,790	-\$10,132,900	\$27,360,150	\$13,680,080
148	10% PROVIDER PAYMENT REDUCTION	-\$228,177,000	-\$114,088,500	-\$184,559,620	-\$92,279,810	\$43,617,380	\$21,808,690
149	REDUCTION TO RADIOLOGY RATES	-\$41,734,390	-\$20,867,200	-\$44,549,850	-\$22,274,930	-\$2,815,460	-\$1,407,730
--	AB 1629 ADD-ONS	\$17,716,990	\$8,858,490	\$0	\$0	-\$17,716,990	-\$8,858,490
--	ELIMINATION OF DENTAL PROVIDER PAYMENT REDUC	\$60,044,000	\$30,022,000	\$0	\$0	-\$60,044,000	-\$30,022,000
--	GENETIC DISEASE SCREENING PROGRAM FEE INCRE/	\$7,257,540	\$3,628,770	\$0	\$0	-\$7,257,540	-\$3,628,770
	PROVIDER RATES SUBTOTAL	\$299,915,750	\$149,957,870	\$608,180,550	\$272,188,330	\$308,264,800	\$122,230,460
SUPPLEMENTAL PMNTS.							
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$8,620,326,000	\$3,704,505,000	\$8,613,826,000	\$3,485,813,000	-\$6,500,000	-\$218,692,000

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
SUPPLEMENTAL PMNTS.							
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$183,170,000	\$0	\$288,962,000	\$0	\$105,792,000	\$0
152	HOSPITAL QAF - HOSPITAL PAYMENTS	\$304,964,000	\$203,143,000	\$264,597,000	\$162,701,000	-\$40,367,000	-\$40,442,000
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	\$189,150,000	\$0	\$210,610,000	\$0	\$21,460,000	\$0
154	NDPH IGT SUPPLEMENTAL PAYMENTS	\$120,513,000	\$60,256,500	\$136,685,000	\$47,088,000	\$16,172,000	-\$13,168,500
155	CERTIFICATION PAYMENTS FOR DP-NFS	\$46,924,000	\$0	\$111,321,000	\$0	\$64,397,000	\$0
156	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAY	\$131,038,050	\$65,519,030	\$105,372,460	\$51,831,860	-\$25,665,600	-\$13,687,170
157	FFP FOR LOCAL TRAUMA CENTERS	\$78,700,000	\$39,350,000	\$101,793,000	\$50,896,500	\$23,093,000	\$11,546,500
158	CAPITAL PROJECT DEBT REIMBURSEMENT	\$97,315,000	\$38,753,500	\$100,941,000	\$40,452,500	\$3,626,000	\$1,699,000
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$62,986,000	\$0	\$61,611,000	\$0	-\$1,375,000	\$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$5,000,000	\$0	\$0
161	IGT PAYMENTS FOR HOSPITAL SERVICES	\$10,400,000	\$5,200,000	\$8,333,000	\$4,166,000	-\$2,067,000	-\$1,034,000
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$0	\$0
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENT:	\$3,600,000	\$0	\$6,063,000	\$0	\$2,463,000	\$0
200	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$0	\$0	\$57,224,000	\$57,224,000	\$57,224,000	\$57,224,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$9,867,086,050	\$4,125,727,030	\$10,085,338,460	\$3,909,172,860	\$218,252,400	-\$216,554,170
OTHER							
170	ARRA HITECH - PROVIDER PAYMENTS	\$156,676,000	\$0	\$182,108,000	\$0	\$25,432,000	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CD	\$139,734,000	\$0	\$155,709,000	\$0	\$15,975,000	\$0
173	CCI IHSS RECONCILIATION	\$0	\$0	\$60,000,000	\$0	\$60,000,000	\$0
174	NONCONTRACT HOSP INPATIENT COST SETTLEMENT:	\$28,083,000	\$14,041,500	\$50,929,000	\$25,464,500	\$22,846,000	\$11,423,000
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$15,665,000	\$7,430,000	\$18,496,000	\$5,345,000	\$2,831,000	-\$2,085,000
179	INDIAN HEALTH SERVICES	\$2,317,000	-\$10,616,500	\$5,545,000	-\$18,482,500	\$3,228,000	-\$7,866,000
180	WPCS WORKERS' COMPENSATION	\$4,596,000	\$2,298,000	\$4,764,000	\$2,382,000	\$168,000	\$84,000
181	OVERTIME FOR WPCS PROVIDERS	\$3,000,000	\$1,500,000	\$4,231,000	\$2,115,500	\$1,231,000	\$615,500

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$0	\$0	\$2,939,000	\$881,500	\$2,939,000	\$881,500
186	CDDS DENTAL SERVICES	\$1,248,000	\$1,248,000	\$902,000	\$902,000	-\$346,000	-\$346,000
187	AUDIT SETTLEMENTS	\$854,000	\$854,000	\$854,000	\$854,000	\$0	\$0
188	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	\$325,000	\$162,500	\$325,000	\$162,500	\$0	\$0
189	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$0	\$0	-\$1,595,366,800	\$0	-\$1,595,366,800
190	FUNDING ADJUST.—OTLICP	\$0	\$0	\$0	-\$100,237,360	\$0	-\$100,237,360
191	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0	\$0	\$0	\$0
192	CLPP FUND	\$0	\$0	\$0	\$0	\$0	\$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0	\$0	\$0	\$0
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
195	IHSS REDUCTION IN SERVICE HOURS	\$0	\$0	-\$2,558,000	\$0	-\$2,558,000	\$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	-\$18,000,000	-\$18,000,000	-\$17,449,000	-\$17,449,000	\$551,000	\$551,000
210	FFP REPAYMENT FOR CDDS COSTS	\$0	\$0	\$0	\$42,537,000	\$0	\$42,537,000
	OTHER SUBTOTAL	\$334,498,000	-\$1,082,500	\$466,795,000	-\$1,650,891,660	\$132,297,000	-\$1,649,809,160
	GRAND TOTAL	\$44,467,202,530	\$11,791,955,390	\$25,498,878,040	\$8,821,995,730	-\$18,968,324,490	-\$2,969,959,650

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

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

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$11,950,480	\$131,711,300	\$83,476,510	\$52,224,450	\$2,104,620	\$47,538,030
OTHER MEDICAL	\$64,688,420	\$673,014,010	\$376,339,750	\$326,168,620	\$7,250,060	\$44,548,440
CO. & COMM. OUTPATIENT	\$5,879,160	\$113,722,720	\$139,923,040	\$31,558,520	\$960,590	\$44,587,530
PHARMACY	\$2,802,730	\$272,281,810	\$330,666,460	\$57,173,050	\$1,898,870	\$26,269,640
COUNTY INPATIENT	\$5,905,840	\$450,215,330	\$48,579,420	\$37,873,000	\$2,397,500	\$102,703,990
COMMUNITY INPATIENT	\$55,401,880	\$1,040,721,630	\$522,973,710	\$286,356,680	\$18,537,730	\$381,679,720
NURSING FACILITIES	\$201,061,590	\$84,123,270	\$486,236,920	\$3,610,810	\$1,060,731,910	\$3,036,230
ICF-DD	\$1,199,070	\$1,662,290	\$177,979,370	\$369,740	\$30,192,610	\$0
MEDICAL TRANSPORTATION	\$6,754,400	\$14,811,140	\$30,763,810	\$4,168,170	\$3,330,460	\$4,625,830
OTHER SERVICES	\$45,845,770	\$19,578,610	\$223,189,530	\$42,541,440	\$43,850,990	\$1,823,380
HOME HEALTH	\$1,083,630	\$1,920,000	\$142,661,730	\$5,254,940	\$55,720	\$529,220
FFS SUBTOTAL	\$402,572,970	\$2,803,762,120	\$2,562,790,240	\$847,299,410	\$1,171,311,060	\$657,342,010
DENTAL	\$38,542,760	\$397,142,620	\$88,706,030	\$138,884,600	\$3,872,880	\$0
MENTAL HEALTH	\$5,694,660	\$121,767,500	\$751,699,940	\$553,292,030	\$714,460	\$0
TWO PLAN MODEL	\$1,960,834,590	\$9,718,923,360	\$5,869,057,990	\$1,273,868,330	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$558,837,550	\$3,709,806,420	\$1,406,759,740	\$320,587,030	\$628,127,110	\$0
GEOGRAPHIC MANAGED CARE	\$309,999,530	\$1,639,322,270	\$1,037,988,230	\$222,218,960	\$0	\$0
PHP & OTHER MANAG. CARE	\$157,193,510	\$37,168,440	\$91,436,460	\$17,127,330	\$6,779,320	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$9,158,670	\$0	\$0
MEDICARE PAYMENTS	\$1,474,059,780	\$0	\$1,400,205,980	\$2,160,340	\$143,062,490	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$10,774,380	\$0	\$25,238,880	\$35,344,790	\$1,070,530	\$0
MISC. SERVICES	\$360,873,120	\$29,950,000	\$3,607,542,430	\$692,810	\$0	\$0
DRUG MEDI-CAL	\$5,483,290	\$38,173,880	\$12,844,750	\$17,988,210	\$546,920	\$0
REGIONAL MODEL	\$4,377,490	\$640,674,230	\$299,334,270	\$78,404,690	\$0	\$0
NON-FFS SUBTOTAL	\$4,886,670,660	\$16,332,928,730	\$14,590,814,690	\$2,669,727,790	\$784,173,720	\$0
TOTAL DOLLARS (1)	\$5,289,243,620	\$19,136,690,840	\$17,153,604,930	\$3,517,027,210	\$1,955,484,770	\$657,342,010
ELIGIBLES ***	436,800	3,329,800	1,023,200	1,432,900	43,400	22,000
ANNUAL \$/ELIGIBLE	\$12,109	\$5,747	\$16,765	\$2,454	\$45,057	\$29,879
AVG. MO. \$/ELIGIBLE	\$1,009	\$479	\$1,397	\$205	\$3,755	\$2,490

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

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

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$2,742,730	\$17,307,170	\$19,905,960	\$12,307,670	\$196,158,700	\$24,430,450
OTHER MEDICAL	\$5,312,080	\$150,148,350	\$98,516,570	\$94,280,090	\$866,273,630	\$111,779,120
CO. & COMM. OUTPATIENT	\$994,530	\$24,697,100	\$14,972,280	\$19,568,650	\$128,563,160	\$12,531,160
PHARMACY	\$3,992,620	\$28,518,650	\$8,975,950	\$26,704,060	\$102,077,700	\$24,635,380
COUNTY INPATIENT	\$18,859,850	\$2,904,360	\$57,372,010	\$95,770,670	\$251,145,150	\$18,750,410
COMMUNITY INPATIENT	\$22,901,230	\$88,636,190	\$123,878,300	\$92,768,800	\$1,035,351,300	\$120,736,890
NURSING FACILITIES	\$250,912,720	\$274,360	\$207,570,640	\$54,491,000	\$18,777,360	\$5,426,650
ICF-DD	\$160,468,310	\$24,220	\$994,350	\$8,791,850	\$375,230	\$1,264,010
MEDICAL TRANSPORTATION	\$1,442,570	\$532,330	\$10,633,230	\$12,739,850	\$11,609,000	\$1,823,210
OTHER SERVICES	\$8,823,460	-\$10,695,880	\$49,983,560	\$45,211,450	\$98,410,410	\$9,585,220
HOME HEALTH	\$11,860	\$4,665,910	\$848,650	\$53,550,880	\$9,658,800	\$12,371,130
FFS SUBTOTAL	\$476,461,970	\$307,012,750	\$593,651,480	\$516,184,970	\$2,718,400,450	\$343,333,630
DENTAL	\$1,209,310	\$52,458,250	\$32,080,450	\$15,632,800	\$241,519,120	\$24,865,400
MENTAL HEALTH	\$2,311,480	\$70,718,270	\$6,177,970	\$79,688,460	\$366,061,760	\$65,436,120
TWO PLAN MODEL	\$0	\$761,112,620	\$1,562,889,050	\$643,373,860	\$2,551,799,620	\$35,070,780
COUNTY ORGANIZED HEALTH SYSTEMS	\$210,774,470	\$362,291,560	\$533,921,040	\$315,000,210	\$945,037,070	\$31,164,430
GEOGRAPHIC MANAGED CARE	\$0	\$166,733,860	\$222,623,920	\$117,175,590	\$409,280,450	\$5,269,880
PHP & OTHER MANAG. CARE	\$217,400	\$11,599,440	\$131,520,090	\$15,409,110	\$46,365,420	\$2,574,180
EPSDT SCREENS	\$0	\$6,420,760	\$0	\$0	\$24,908,590	\$1,406,920
MEDICARE PAYMENTS	\$37,175,820	\$0	\$894,925,010	\$434,579,220	\$77,838,350	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$328,070	\$0	\$10,443,840	\$4,491,790	\$95,795,250	\$5,525,320
MISC. SERVICES	\$0	-\$72,911,000	\$306,365,810	\$647,546,720	\$1,754,340	\$12,819,410
DRUG MEDI-CAL	\$167,050	\$11,392,130	\$5,204,070	\$2,286,050	\$48,922,080	\$2,645,050
REGIONAL MODEL	\$0	\$55,874,480	\$19,284,280	\$21,597,540	\$188,012,330	\$1,093,000
NON-FFS SUBTOTAL	\$252,183,590	\$1,425,690,380	\$3,725,435,540	\$2,296,781,350	\$4,997,294,390	\$187,870,490
TOTAL DOLLARS (1)	\$728,645,570	\$1,732,703,120	\$4,319,087,020	\$2,812,966,330	\$7,715,694,840	\$531,204,130
ELIGIBLES ***	13,300	1,018,400	431,100	187,300	3,883,600	224,000
ANNUAL \$/ELIGIBLE	\$54,785	\$1,701	\$10,019	\$15,019	\$1,987	\$2,371
AVG. MO. \$/ELIGIBLE	\$4,565	\$142	\$835	\$1,252	\$166	\$198

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

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

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$162,580	\$164,660	\$4,636,080	\$121,957,510	\$10,927,140	\$5,830,440
OTHER MEDICAL	\$347,990	\$636,220	\$5,815,970	\$230,646,150	\$105,560,910	\$47,324,240
CO. & COMM. OUTPATIENT	\$68,820	\$68,060	\$3,811,100	\$24,314,550	\$8,600,040	\$6,529,170
PHARMACY	\$631,070	\$120,660	\$2,390,860	\$6,535,600	\$5,918,340	\$7,540,330
COUNTY INPATIENT	\$322,590	\$6,380	\$11,402,760	\$96,433,540	\$1,850,380	\$1,808,550
COMMUNITY INPATIENT	\$829,710	\$349,620	\$29,173,610	\$621,970,480	\$58,025,260	\$26,644,700
NURSING FACILITIES	\$18,999,340	\$340	\$3,244,800	\$2,324,070	\$1,340,650	\$477,780
ICF-DD	\$741,090	\$0	\$233,090	\$0	\$0	\$64,580
MEDICAL TRANSPORTATION	\$120,970	\$4,490	\$726,430	\$2,055,330	\$544,610	\$200,670
OTHER SERVICES	\$688,140	\$17,810	\$342,200	\$13,972,810	\$8,000,230	\$10,017,640
HOME HEALTH	\$90	\$80	\$4,300	\$1,968,420	\$2,558,810	\$1,467,260
FFS SUBTOTAL	\$22,912,380	\$1,368,320	\$61,781,200	\$1,122,178,470	\$203,326,350	\$107,905,370
DENTAL	\$82,410	\$148,510	\$18,059,390	\$8,939,590	\$10,475,090	\$14,036,840
MENTAL HEALTH	\$21,010	\$69,300	\$152,040	\$760,180	\$5,601,560	\$18,738,700
TWO PLAN MODEL	\$123,130	\$786,940	\$0	\$220,085,810	\$398,431,850	\$225,411,800
COUNTY ORGANIZED HEALTH SYSTEMS	\$179,590	\$186,760	\$1,936,300	\$93,782,440	\$178,259,770	\$102,271,880
GEOGRAPHIC MANAGED CARE	\$24,090	\$166,850	\$0	\$37,375,050	\$75,833,230	\$51,652,890
PHP & OTHER MANAG. CARE	\$7,510	\$0	\$0	\$3,665,490	\$6,123,050	\$3,456,520
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$3,373,570	\$1,904,410
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$17,270	\$0	\$1,179,060	\$8,416,250	\$0	\$7,503,580
MISC. SERVICES	\$4,171,400	\$0	\$0	\$65,040	\$61,160	\$106,440
DRUG MEDI-CAL	\$8,170	\$16,820	\$0	\$4,202,240	\$6,625,900	\$3,740,390
REGIONAL MODEL	\$1,080	\$5,480	\$0	\$13,279,660	\$34,586,850	\$16,980,770
NON-FFS SUBTOTAL	\$4,635,660	\$1,380,660	\$21,326,790	\$390,571,750	\$719,372,020	\$445,804,230
TOTAL DOLLARS (1)	\$27,548,050	\$2,748,980	\$83,107,990	\$1,512,750,220	\$922,698,370	\$553,709,600
ELIGIBLES ***	700	1,300	47,800	341,200	535,300	304,200
ANNUAL \$/ELIGIBLE	\$39,354	\$2,115	\$1,739	\$4,434	\$1,724	\$1,820
AVG. MO. \$/ELIGIBLE	\$3,280	\$176	\$145	\$369	\$144	\$152

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

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

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$745,536,470
OTHER MEDICAL	\$3,208,650,610
CO. & COMM. OUTPATIENT	\$581,350,170
PHARMACY	\$909,133,790
COUNTY INPATIENT	\$1,204,301,740
COMMUNITY INPATIENT	\$4,526,937,440
NURSING FACILITIES	\$2,402,640,430
ICF-DD	\$384,359,800
MEDICAL TRANSPORTATION	\$106,886,510
OTHER SERVICES	\$611,186,770
HOME HEALTH	\$238,611,420
FFS SUBTOTAL	\$14,919,595,160
DENTAL	\$1,086,656,050
MENTAL HEALTH	\$2,048,905,450
TWO PLAN MODEL	\$25,221,769,740
COUNTY ORGANIZED HEALTH SYSTEMS	\$9,398,923,350
GEOGRAPHIC MANAGED CARE	\$4,295,664,820
PHP & OTHER MANAG. CARE	\$530,643,270
EPSDT SCREENS	\$47,172,920
MEDICARE PAYMENTS	\$4,464,007,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$206,129,000
MISC. SERVICES	\$4,899,037,700
DRUG MEDI-CAL	\$160,247,000
REGIONAL MODEL	\$1,373,506,150
NON-FFS SUBTOTAL	\$53,732,662,440
TOTAL DOLLARS (1)	\$68,652,257,600
ELIGIBLES ***	13,276,300
ANNUAL \$/ELIGIBLE	\$5,171
AVG. MO. \$/ELIGIBLE	\$431

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

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

EXCLUDED POLICY CHANGES: 71

1	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
26	ACA MAGI SAVINGS
49	WOMEN'S HEALTH SERVICES
55	NON FFP DRUGS
59	FAMILY PACT DRUG REBATES
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
82	MH/UCD & BTR—DSH PAYMENT
83	BTR—DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYME
87	BTR—SAFETY NET CARE POOL
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
89	BTR - LIHP - MCE
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
94	BTR—DESIGNATED STATE HEALTH PROGRAMS
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
96	MH/UCD—SAFETY NET CARE POOL
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
98	MH/UCD—STABILIZATION FUNDING
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PF
100	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
101	MH/UCD & BTR—BCCTP

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

EXCLUDED POLICY CHANGES: 71

103	MH/UCD & BTR—MIA-LTC
104	MH/UCD & BTR—CCS AND GHPP
109	CCI-TRANSFER OF IHSS COSTS TO CDSS
124	EXTEND GROSS PREMIUM TAX
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE
127	GENERAL FUND REIMBURSEMENTS FROM DPHS
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
130	MCO TAX MANAGED CARE PLANS
135	DENTAL RETROACTIVE RATE CHANGES
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
144	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITUF
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
152	HOSPITAL QAF - HOSPITAL PAYMENTS
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
154	NDPH IGT SUPPLEMENTAL PAYMENTS
155	CERTIFICATION PAYMENTS FOR DP-NFS
157	FFP FOR LOCAL TRAUMA CENTERS
158	CAPITAL PROJECT DEBT REIMBURSEMENT
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	IGT PAYMENTS FOR HOSPITAL SERVICES
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
170	ARRA HITECH - PROVIDER PAYMENTS
175	MEDI-CAL TCM PROGRAM
186	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS
191	CIGARETTE AND TOBACCO SURTAX FUNDS
192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS

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

EXCLUDED POLICY CHANGES: 71

194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
200	DP-NF CAPITAL PROJECT DEBT REPAYMENT
202	PALLIATIVE CARE SERVICES IMPLEMENTATION
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
206	GLOBAL PAYMENT PROGRAM
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM
208	WAIVER 2020 WHOLE PERSON CARE PILOTS

MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2016-17

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
I. BASE ESTIMATES			
A. B/Y FFS BASE	\$16,860,021,610	\$8,430,010,810	\$8,430,010,810
B. B/Y BASE POLICY CHANGES	\$42,278,796,010	\$29,211,010,890	\$13,067,785,110
C. BASE ADJUSTMENTS	-\$153,558,000	-\$194,491,900	\$40,933,900
D. ADJUSTED BASE	<u>\$58,985,259,620</u>	<u>\$37,446,529,800</u>	<u>\$21,538,729,820</u>
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	\$911,967,570	\$581,614,500	\$330,353,070
B. AFFORDABLE CARE ACT	\$2,423,391,500	\$2,723,949,780	-\$300,558,280
C. BENEFITS	\$772,235,000	\$628,760,330	\$143,474,670
D. PHARMACY	-\$2,623,608,960	-\$1,604,483,280	-\$1,019,125,680
E. DRUG MEDI-CAL	\$95,063,000	\$62,200,300	\$32,862,700
F. MENTAL HEALTH	\$238,086,000	\$231,638,000	\$6,448,000
G. WAIVER--MH/UCD & BTR	\$6,151,434,840	\$3,572,278,870	\$2,579,155,970
H. MANAGED CARE	\$4,457,494,850	-\$420,704,190	\$4,878,199,050
I. PROVIDER RATES	\$906,554,750	\$434,665,600	\$471,889,160
J. SUPPLEMENTAL PMNTS.	\$8,158,767,000	\$5,121,082,670	\$3,037,684,330
K. OTHER	\$4,693,000	\$1,726,755,870	-\$1,722,062,870
L. TOTAL CHANGE	<u>\$21,496,078,560</u>	<u>\$13,057,758,450</u>	<u>\$8,438,320,110</u>
III. TOTAL MEDI-CAL ESTIMATE	<u><u>\$80,481,338,180</u></u>	<u><u>\$50,504,288,250</u></u>	<u><u>\$29,977,049,930</u></u>

**SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<u>ELIGIBILITY</u>				
1	FAMILY PACT PROGRAM	\$460,116,000	\$346,146,600	\$113,969,400
2	MEDI-CAL ADULT INMATE PROGRAMS	\$189,301,000	\$189,301,000	\$0
3	BREAST AND CERVICAL CANCER TREATMENT	\$107,444,000	\$57,036,850	\$50,407,150
5	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	\$62,482,000	\$62,482,000	\$0
6	PREGNANT WOMEN FULL SCOPE EXPANSION 60-13i	\$0	\$0	\$0
7	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSI	\$177,251,000	\$34,436,000	\$142,815,000
9	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	\$3,170,170	\$2,789,690	\$380,480
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$1,496,000	\$1,316,480	\$179,520
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	\$221,321,880	-\$221,321,880
13	NEW QUALIFIED IMMIGRANTS	\$0	-\$383,543,000	\$383,543,000
14	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$115,403,200	-\$115,403,200
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$10,928,120	-\$10,928,120
16	INCARCERATION VERIFICATION PROGRAM	-\$8,864,180	-\$7,258,190	-\$1,605,990
17	PARIS-VETERANS	-\$5,344,410	-\$2,672,210	-\$2,672,210
18	TLICP PREMIUMS	-\$75,084,000	-\$66,073,920	-\$9,010,080
	ELIGIBILITY SUBTOTAL	\$911,967,570	\$581,614,500	\$330,353,070
<u>AFFORDABLE CARE ACT</u>				
19	COMMUNITY FIRST CHOICE OPTION	\$1,743,700,000	\$1,743,700,000	\$0
20	ACA OPTIONAL EXPANSION	\$1,198,736,000	\$1,169,330,800	\$29,405,200
21	HEALTH INSURER FEE	\$140,580,000	\$94,810,070	\$45,769,930
22	ACA MANDATORY EXPANSION	\$161,458,000	\$95,039,800	\$66,418,200
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$8,904,000	-\$8,904,000
26	ACA MAGI SAVINGS	\$0	\$0	\$0
27	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$0	\$131,140,000	-\$131,140,000
29	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	-\$83,925,000	-\$52,161,000	-\$31,764,000
30	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$1,547,000	-\$773,500	-\$773,500
31	ACA REDETERMINATIONS	-\$199,210,500	-\$115,870,250	-\$83,340,250
32	MANAGED CARE DRUG REBATES	-\$536,400,000	-\$350,170,140	-\$186,229,860
	AFFORDABLE CARE ACT SUBTOTAL	\$2,423,391,500	\$2,723,949,780	-\$300,558,280
<u>BENEFITS</u>				
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$286,516,000	\$286,516,000	\$0
34	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$138,135,000	\$138,135,000	\$0
35	BEHAVIORAL HEALTH TREATMENT	\$206,236,000	\$115,711,200	\$90,524,800
36	CCS DEMONSTRATION PROJECT PILOTS	\$41,388,000	\$20,694,000	\$20,694,000
37	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$20,232,000
38	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$21,252,000	\$12,241,000	\$9,011,000
39	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$32,282,000	\$27,979,000	\$4,303,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2016-17

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<u>BENEFITS</u>				
40	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FO	\$18,236,000	\$9,589,960	\$8,646,040
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,298,000	\$5,277,000	\$21,000
42	CCT FUND TRANSFER TO CDSS AND CDDS	\$4,090,000	\$4,090,000	\$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$972,000	\$511,080	\$460,920
45	CHDP PROGRAM DENTAL REFERRAL	\$808,000	\$407,040	\$400,960
46	BENEFICIARY OUTREACH AND EDUCATION PROGRA	\$860,000	\$589,410	\$270,590
47	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$115,000	\$115,000	\$0
48	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$139,000	\$139,000	\$0
49	WOMEN'S HEALTH SERVICES	\$339,000	\$262,800	\$76,200
50	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVI	-\$4,512,000	-\$2,372,660	-\$2,139,340
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$22,518,000	-\$11,259,000	-\$11,259,000
199	END OF LIFE SERVICES	\$2,330,000	\$0	\$2,330,000
203	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICE:	-\$195,000	-\$97,500	-\$97,500
	BENEFITS SUBTOTAL	\$772,235,000	\$628,760,330	\$143,474,670
<u>PHARMACY</u>				
52	ORKAMBI BENEFIT	\$56,762,000	\$29,868,000	\$26,894,000
53	ADAP RYAN WHITE MEDS DATA MATCH	\$627,000	\$313,500	\$313,500
54	HEPATITIS C REVISED CLINICAL GUIDELINES	\$2,189,040	\$1,094,520	\$1,094,520
55	NON FFP DRUGS	\$0	-\$19,500	\$19,500
56	BCCTP DRUG REBATES	-\$16,000,000	-\$10,400,000	-\$5,600,000
57	MEDICAL SUPPLY REBATES	-\$30,923,000	-\$24,166,300	-\$6,756,700
59	FAMILY PACT DRUG REBATES	-\$54,989,000	-\$48,091,300	-\$6,897,700
60	STATE SUPPLEMENTAL DRUG REBATES	-\$233,749,000	-\$136,093,000	-\$97,656,000
61	AGED AND DISPUTED DRUG REBATES	-\$300,000,000	-\$150,012,000	-\$149,988,000
62	FEDERAL DRUG REBATE PROGRAM	-\$2,047,526,000	-\$1,266,977,200	-\$780,548,800
	PHARMACY SUBTOTAL	-\$2,623,608,960	-\$1,604,483,280	-\$1,019,125,680
<u>DRUG MEDI-CAL</u>				
65	RESIDENTIAL TREATMENT SERVICES EXPANSION	\$90,892,000	\$58,398,300	\$32,493,700
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$3,036,000	\$0
69	ANNUAL RATE ADJUSTMENT	\$1,135,000	\$766,000	\$369,000
	DRUG MEDI-CAL SUBTOTAL	\$95,063,000	\$62,200,300	\$32,862,700
<u>MENTAL HEALTH</u>				
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	\$175,544,000	\$175,544,000	\$0
75	KATIE A. V. DIANA BONTA	\$35,364,000	\$35,364,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$25,500,000	\$25,500,000	\$0
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPA	\$0	-\$270,000	\$270,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2016-17

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<u>MENTAL HEALTH</u>				
79	IMD ANCILLARY SERVICES	\$0	-\$4,000,000	\$4,000,000
80	CHART REVIEW	-\$913,000	-\$913,000	\$0
81	INTERIM AND FINAL COST SETTLEMENTS - SMHS	\$0	\$0	\$0
198	LATE CLAIMS FOR SMHS	\$2,175,000	\$205,000	\$1,970,000
211	MHP COSTS FOR CHILDREN AND YOUTH IN FOSTER	\$416,000	\$208,000	\$208,000
	MENTAL HEALTH SUBTOTAL	\$238,086,000	\$231,638,000	\$6,448,000
<u>WAIVER--MH/UCD & BTR</u>				
82	MH/UCD & BTR—DSH PAYMENT	\$34,000,000	\$17,000,000	\$17,000,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEN	\$571,258,000	\$285,629,000	\$285,629,000
85	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	-\$218,972,000	-\$218,972,000	\$0
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	\$258,202,000	\$129,101,000	\$129,101,000
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	\$70,492,000	\$35,246,000	\$35,246,000
89	BTR - LIHP - MCE	\$141,648,000	\$141,648,000	\$0
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	-\$12,363,000	-\$12,363,000	\$0
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COS	\$80,844,000	\$80,844,000	\$0
92	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$78,470,840	\$39,235,420	\$39,235,420
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$3,800,000	\$1,900,000	\$1,900,000
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HI	\$1,471,000	\$1,471,000	\$0
100	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	-\$12,022,000	\$12,022,000
102	MH/UCD & BTR—DPH INTERIM RATE	\$0	\$437,269,450	-\$437,269,450
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MED	\$1,600,000,000	\$800,000,000	\$800,000,000
206	GLOBAL PAYMENT PROGRAM	\$2,492,584,000	\$1,246,292,000	\$1,246,292,000
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRA	\$0	\$75,000,000	-\$75,000,000
208	WAIVER 2020 WHOLE PERSON CARE PILOTS	\$900,000,000	\$450,000,000	\$450,000,000
209	WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE	\$150,000,000	\$75,000,000	\$75,000,000
	WAIVER--MH/UCD & BTR SUBTOTAL	\$6,151,434,840	\$3,572,278,870	\$2,579,155,970
<u>MANAGED CARE</u>				
108	CCI-MANAGED CARE PAYMENTS	\$4,575,652,110	\$2,287,826,060	\$2,287,826,060
109	CCI-TRANSFER OF IHSS COSTS TO CDSS	\$2,477,372,000	\$0	\$2,477,372,000
112	MANAGED CARE RATE RANGE IGTS	\$871,975,000	\$470,874,000	\$401,101,000
113	MANAGED CARE PUBLIC HOSPITAL IGTS	\$531,316,000	\$265,658,000	\$265,658,000
115	HQAF RATE RANGE INCREASES	\$148,000,000	\$74,000,000	\$74,000,000
118	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEI	\$207,000,000	\$186,300,000	\$20,700,000
121	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$0	\$2,000,000
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0
127	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	\$0	\$0	\$0

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

**SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<u>MANAGED CARE</u>				
130	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0
132	CCI-SAVINGS AND DEFERRAL	-\$1,182,240,260	-\$591,120,130	-\$591,120,130
133	RETRO MC RATE ADJUSTMENTS	-\$3,510,424,000	-\$3,291,743,620	-\$218,680,380
202	PALLIATIVE CARE SERVICES IMPLEMENTATION	\$9,364,000	\$4,682,000	\$4,682,000
204	CAPITATED RATE ADJUSTMENT FOR FY 2016-17	\$327,480,000	\$172,819,500	\$154,660,500
	MANAGED CARE SUBTOTAL	\$4,457,494,850	-\$420,704,200	\$4,878,199,040
<u>PROVIDER RATES</u>				
134	MEDICARE PART B PREMIUM INCREASE	\$356,916,000	\$156,953,500	\$199,962,500
136	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$215,262,300	\$107,631,150	\$107,631,150
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	\$88,137,000	\$44,068,500	\$44,068,500
138	LTC RATE ADJUSTMENT	\$106,573,880	\$53,286,940	\$53,286,940
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$241,843,320	\$120,921,660	\$120,921,660
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$13,000,000	\$6,500,000	\$6,500,000
141	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$24,959,040	\$15,372,240	\$9,586,800
142	HOSPICE RATE INCREASES	\$8,261,790	\$4,130,900	\$4,130,900
143	GDSP NEWBORN SCREENING PROGRAM FEE INCRE	\$1,940,860	\$970,430	\$970,430
144	LONG TERM CARE QUALITY ASSURANCE FUND EXP	\$0	\$0	\$0
145	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$12,351,550	-\$6,175,770	-\$6,175,770
146	NON-AB 1629 LTC RATE FREEZE	-\$20,828,580	-\$10,414,290	-\$10,414,290
147	LABORATORY RATE METHODOLOGY CHANGE	-\$30,711,260	-\$15,355,630	-\$15,355,630
148	10% PROVIDER PAYMENT REDUCTION	-\$34,370,040	-\$17,185,020	-\$17,185,020
149	REDUCTION TO RADIOLOGY RATES	-\$52,078,000	-\$26,039,000	-\$26,039,000
	PROVIDER RATES SUBTOTAL	\$906,554,760	\$434,665,600	\$471,889,150
<u>SUPPLEMENTAL PMNTS.</u>				
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$7,150,333,000	\$4,318,351,000	\$2,831,982,000
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$234,312,000	\$234,312,000	\$0
152	HOSPITAL QAF - HOSPITAL PAYMENTS	\$25,661,000	\$0	\$25,661,000
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	\$202,400,000	\$202,400,000	\$0
154	NDPH IGT SUPPLEMENTAL PAYMENTS	\$100,498,000	\$53,811,000	\$46,687,000
155	CERTIFICATION PAYMENTS FOR DP-NFS	\$103,366,000	\$103,366,000	\$0
156	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL P	\$107,000,000	\$68,003,670	\$38,996,330
157	FFP FOR LOCAL TRAUMA CENTERS	\$80,103,000	\$40,051,500	\$40,051,500
158	CAPITAL PROJECT DEBT REIMBURSEMENT	\$102,317,000	\$61,176,500	\$41,140,500
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$22,782,000	\$22,782,000	\$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	\$10,000,000	\$5,000,000	\$5,000,000
161	IGT PAYMENTS FOR HOSPITAL SERVICES	\$8,333,000	\$4,167,000	\$4,166,000
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	\$8,000,000	\$4,000,000	\$4,000,000

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**SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2016-17**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<u>SUPPLEMENTAL PMNTS.</u>				
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEN	\$3,662,000	\$3,662,000	\$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$8,158,767,000	\$5,121,082,670	\$3,037,684,330
<u>OTHER</u>				
170	ARRA HITECH - PROVIDER PAYMENTS	\$127,681,000	\$127,681,000	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- C	\$59,690,000	\$59,690,000	\$0
174	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	\$50,929,000	\$25,464,500	\$25,464,500
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDC	\$10,738,000	\$5,902,000	\$4,836,000
179	INDIAN HEALTH SERVICES	\$25,289,000	\$41,629,600	-\$16,340,600
180	WPCS WORKERS' COMPENSATION	\$2,625,000	\$1,312,500	\$1,312,500
181	OVERTIME FOR WPCS PROVIDERS	\$5,391,000	\$2,695,500	\$2,695,500
186	CDDS DENTAL SERVICES	\$902,000	\$0	\$902,000
187	AUDIT SETTLEMENTS	\$854,000	\$0	\$854,000
188	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	\$449,000	\$224,500	\$224,500
189	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,605,590,850	-\$1,605,590,850
190	FUNDING ADJUST.—OTLICP	\$0	\$122,771,420	-\$122,771,420
191	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0
192	CLPP FUND	\$0	\$0	\$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0
195	IHSS REDUCTION IN SERVICE HOURS	-\$262,406,000	-\$262,406,000	\$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	-\$17,449,000	\$0	-\$17,449,000
210	FFP REPAYMENT FOR CDDS COSTS	\$0	-\$3,800,000	\$3,800,000
	OTHER SUBTOTAL	\$4,693,000	\$1,726,755,870	-\$1,722,062,870
	GRAND TOTAL	\$21,496,078,560	\$13,057,758,450	\$8,438,320,110

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

Last Refresh Date: 12/23/2015

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**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2016-17**

<u>SERVICE CATEGORY</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
PROFESSIONAL	\$6,483,662,290	\$4,197,237,780	\$2,286,424,510
PHYSICIANS	\$910,104,230	\$583,466,760	\$326,637,470
OTHER MEDICAL	\$3,774,835,940	\$2,439,176,240	\$1,335,659,700
CO. & COMM. OUTPATIENT	\$1,798,722,120	\$1,174,594,780	\$624,127,340
PHARMACY	\$1,012,331,800	\$749,277,470	\$263,054,340
HOSPITAL INPATIENT	\$11,810,369,670	\$7,554,666,480	\$4,255,703,190
COUNTY INPATIENT	\$3,051,601,710	\$1,964,859,800	\$1,086,741,910
COMMUNITY INPATIENT	\$8,758,767,960	\$5,589,806,680	\$3,168,961,280
LONG TERM CARE	\$2,871,966,080	\$1,512,701,390	\$1,359,264,690
NURSING FACILITIES	\$2,504,856,630	\$1,327,123,890	\$1,177,732,740
ICF-DD	\$367,109,450	\$185,577,500	\$181,531,950
OTHER SERVICES	\$686,095,800	\$335,357,070	\$350,738,730
MEDICAL TRANSPORTATION	\$119,243,490	\$75,176,750	\$44,066,740
OTHER SERVICES	\$342,900,040	\$146,842,870	\$196,057,160
HOME HEALTH	\$223,952,270	\$113,337,450	\$110,614,820
TOTAL FEE-FOR-SERVICE	\$22,864,425,640	\$14,349,240,190	\$8,515,185,450
MANAGED CARE	\$41,700,087,680	\$25,095,672,650	\$16,604,415,030
TWO PLAN MODEL	\$25,893,999,950	\$15,242,777,690	\$10,651,222,250
COUNTY ORGANIZED HEALTH SYS	\$9,224,056,290	\$5,821,530,390	\$3,402,525,900
GEOGRAPHIC MANAGED CARE	\$4,636,292,360	\$2,828,496,500	\$1,807,795,860
PHP & OTHER MANAG. CARE	\$657,945,210	\$347,960,810	\$309,984,400
REGIONAL MODEL	\$1,287,793,870	\$854,907,260	\$432,886,620
DENTAL	\$1,267,208,980	\$804,544,960	\$462,664,010
MENTAL HEALTH	\$2,249,655,710	\$2,120,027,790	\$129,627,920
AUDITS/ LAWSUITS	\$4,719,000	\$932,500	\$3,786,500
EPSDT SCREENS	\$56,507,000	\$30,164,080	\$26,342,920
MEDICARE PAYMENTS	\$4,932,148,000	\$1,400,824,000	\$3,531,324,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$207,330,000	\$203,530,000	\$3,800,000
MISC. SERVICES	\$7,247,211,170	\$6,442,070,070	\$805,141,100
RECOVERIES	-\$289,203,000	-\$137,917,000	-\$151,286,000
DRUG MEDI-CAL	\$241,248,000	\$195,199,000	\$46,049,000
GRAND TOTAL MEDI-CAL	\$80,481,338,180	\$50,504,288,250	\$29,977,049,930

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

<u>SERVICE CATEGORY</u>	<u>NOV. 2015 EST. FOR 2015-16</u>	<u>NOV. 2015 EST. FOR 2016-17</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$6,883,700,130	\$6,483,662,290	-\$400,037,840	-5.81
PHYSICIANS	\$930,353,720	\$910,104,230	-\$20,249,490	-2.18
OTHER MEDICAL	\$3,752,830,580	\$3,774,835,940	\$22,005,360	0.59
CO. & COMM. OUTPATIENT	\$2,200,515,830	\$1,798,722,120	-\$401,793,710	-18.26
PHARMACY	\$1,001,911,480	\$1,012,331,800	\$10,420,330	1.04
HOSPITAL INPATIENT	\$13,532,437,430	\$11,810,369,670	-\$1,722,067,760	-12.73
COUNTY INPATIENT	\$3,644,862,690	\$3,051,601,710	-\$593,260,980	-16.28
COMMUNITY INPATIENT	\$9,887,574,740	\$8,758,767,960	-\$1,128,806,780	-11.42
LONG TERM CARE	\$3,064,107,350	\$2,871,966,080	-\$192,141,280	-6.27
NURSING FACILITIES	\$2,676,430,470	\$2,504,856,630	-\$171,573,840	-6.41
ICF-DD	\$387,676,880	\$367,109,450	-\$20,567,430	-5.31
OTHER SERVICES	\$1,032,519,500	\$686,095,800	-\$346,423,700	-33.55
MEDICAL TRANSPORTATION	\$169,747,550	\$119,243,490	-\$50,504,060	-29.75
OTHER SERVICES	\$620,806,700	\$342,900,040	-\$277,906,670	-44.77
HOME HEALTH	\$241,965,240	\$223,952,270	-\$18,012,970	-7.44
TOTAL FEE-FOR-SERVICE	\$25,514,675,890	\$22,864,425,640	-\$2,650,250,250	-10.39
MANAGED CARE	\$47,187,755,440	\$41,700,087,680	-\$5,487,667,750	-11.63
TWO PLAN MODEL	\$29,590,851,670	\$25,893,999,950	-\$3,696,851,730	-12.49
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,452,796,350	\$9,224,056,290	-\$1,228,740,050	-11.76
GEOGRAPHIC MANAGED CARE	\$5,012,550,600	\$4,636,292,360	-\$376,258,240	-7.51
PHP & OTHER MANAG. CARE	\$661,697,720	\$657,945,210	-\$3,752,510	-0.57
REGIONAL MODEL	\$1,469,859,100	\$1,287,793,870	-\$182,065,230	-12.39
DENTAL	\$1,256,258,310	\$1,267,208,980	\$10,950,670	0.87
MENTAL HEALTH	\$2,302,672,340	\$2,249,655,710	-\$53,016,630	-2.30
AUDITS/ LAWSUITS	-\$30,038,000	\$4,719,000	\$34,757,000	-115.71
EPSDT SCREENS	\$47,172,920	\$56,507,000	\$9,334,080	19.79
MEDICARE PAYMENTS	\$4,464,007,000	\$4,932,148,000	\$468,141,000	10.49
STATE HOSP./DEVELOPMENTAL CNTRS.	\$206,129,000	\$207,330,000	\$1,201,000	0.58
MISC. SERVICES	\$7,112,717,700	\$7,247,211,170	\$134,493,470	1.89
RECOVERIES	-\$306,727,000	-\$289,203,000	\$17,524,000	-5.71
DRUG MEDI-CAL	\$163,283,000	\$241,248,000	\$77,965,000	47.75
GRAND TOTAL MEDI-CAL	\$87,917,906,600	\$80,481,338,180	-\$7,436,568,420	-8.46
STATE FUNDS	\$30,357,431,970	\$29,977,049,930	-\$380,382,040	-1.25

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
1	FAMILY PACT PROGRAM	\$460,031,000	\$113,948,100	\$460,116,000	\$113,969,400	\$85,000	\$21,300
2	MEDI-CAL ADULT INMATE PROGRAMS	\$148,598,000	\$0	\$189,301,000	\$0	\$40,703,000	\$0
3	BREAST AND CERVICAL CANCER TREATMENT	\$101,577,000	\$48,657,250	\$107,444,000	\$50,407,150	\$5,867,000	\$1,749,900
5	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	\$46,958,000	\$0	\$62,482,000	\$0	\$15,524,000	\$0
6	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%	\$30,024,000	\$15,012,000	\$0	\$0	-\$30,024,000	-\$15,012,000
7	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION	\$26,193,000	\$20,420,000	\$177,251,000	\$142,815,000	\$151,058,000	\$122,395,000
9	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	\$6,424,000	\$1,140,190	\$6,735,000	\$808,320	\$311,000	-\$331,870
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$2,383,000	\$423,040	\$1,496,000	\$179,520	-\$887,000	-\$243,520
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	-\$201,893,790	\$0	-\$221,321,880	\$0	-\$19,428,090
13	NEW QUALIFIED IMMIGRANTS	\$0	\$388,613,000	\$0	\$383,543,000	\$0	-\$5,070,000
14	SCHIP FUNDING FOR PRENATAL CARE	\$0	-\$110,502,990	\$0	-\$115,403,200	\$0	-\$4,900,210
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	-\$43,872,980	\$0	-\$10,928,120	\$0	\$32,944,860
16	INCARCERATION VERIFICATION PROGRAM	-\$7,711,000	-\$1,267,500	-\$12,047,000	-\$2,182,650	-\$4,336,000	-\$915,150
17	PARIS-VETERANS	-\$10,895,720	-\$5,447,860	-\$16,474,760	-\$8,237,380	-\$5,579,030	-\$2,789,520
18	TLICP PREMIUMS	-\$72,911,000	-\$12,941,760	-\$75,084,000	-\$9,010,080	-\$2,173,000	\$3,931,680
	ELIGIBILITY SUBTOTAL	\$730,670,280	\$212,286,700	\$901,219,240	\$324,639,080	\$170,548,970	\$112,352,380
AFFORDABLE CARE ACT							
19	COMMUNITY FIRST CHOICE OPTION	\$1,399,733,000	\$0	\$1,743,700,000	\$0	\$343,967,000	\$0
20	ACA OPTIONAL EXPANSION	\$793,495,000	\$563,000	\$1,198,736,000	\$29,405,200	\$405,241,000	\$28,842,200
21	HEALTH INSURER FEE	\$258,130,000	\$83,352,790	\$140,580,000	\$45,769,930	-\$117,550,000	-\$37,582,860
22	ACA MANDATORY EXPANSION	\$85,609,000	\$36,379,010	\$161,458,000	\$66,418,200	\$75,849,000	\$30,039,190
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$5,716,000	\$0	\$0	\$0	-\$5,716,000	\$0
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	-\$24,295,000	\$0	-\$8,904,000	\$0	\$15,391,000
25	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$0	\$349,000	\$0	\$0	\$0	-\$349,000
26	ACA MAGI SAVINGS	\$0	\$0	\$0	\$0	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>AFFORDABLE CARE ACT</u>							
27	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$0	-\$134,502,500	\$0	-\$131,140,000	\$0	\$3,362,500
29	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	\$0	\$0	-\$83,925,000	-\$31,764,000	-\$83,925,000	-\$31,764,000
30	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$1,891,000	-\$945,500	-\$1,547,000	-\$773,500	\$344,000	\$172,000
31	ACA REDETERMINATIONS	-\$796,842,000	-\$333,361,000	-\$796,842,000	-\$333,361,000	\$0	\$0
32	MANAGED CARE DRUG REBATES	-\$387,000,000	-\$130,036,950	-\$536,400,000	-\$186,229,860	-\$149,400,000	-\$56,192,910
	AFFORDABLE CARE ACT SUBTOTAL	\$1,356,950,000	-\$502,497,150	\$1,825,760,000	-\$550,579,030	\$468,810,000	-\$48,081,880
<u>BENEFITS</u>							
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$273,219,000	\$0	\$286,516,000	\$0	\$13,297,000	\$0
34	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$131,198,000	\$0	\$138,135,000	\$0	\$6,937,000	\$0
35	BEHAVIORAL HEALTH TREATMENT	\$104,304,000	\$47,101,100	\$206,236,000	\$90,524,800	\$101,932,000	\$43,423,700
36	CCS DEMONSTRATION PROJECT PILOTS	\$41,388,000	\$20,694,000	\$41,388,000	\$20,694,000	\$0	\$0
37	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$40,464,000	\$20,232,000	\$0	\$0
38	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$21,252,000	\$9,255,260	\$21,252,000	\$9,011,000	\$0	-\$244,260
39	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$20,537,000	\$2,186,000	\$32,282,000	\$4,303,000	\$11,745,000	\$2,117,000
40	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR	\$9,118,000	\$4,323,020	\$18,236,000	\$8,646,040	\$9,118,000	\$4,323,020
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,126,000	\$22,000	\$5,298,000	\$21,000	\$172,000	-\$1,000
42	CCT FUND TRANSFER TO CDSS AND CDDS	\$3,803,000	\$0	\$4,090,000	\$0	\$287,000	\$0
43	ALLIED DENTAL PROFESSIONALS ENROLLMENT	\$1,153,000	\$576,500	\$0	\$0	-\$1,153,000	-\$576,500
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$697,000	\$333,400	\$972,000	\$460,920	\$275,000	\$127,520
45	CHDP PROGRAM DENTAL REFERRAL	\$606,000	\$300,720	\$808,000	\$400,960	\$202,000	\$100,240
46	BENEFICIARY OUTREACH AND EDUCATION PROGRAM	\$216,000	\$66,660	\$860,000	\$270,590	\$644,000	\$203,930
47	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$156,000	\$0	\$115,000	\$0	-\$41,000	\$0
48	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$143,000	\$0	\$139,000	\$0	-\$4,000	\$0
49	WOMEN'S HEALTH SERVICES	\$25,000	\$5,200	\$339,000	\$76,200	\$314,000	\$71,000
50	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINC	-\$1,642,000	-\$784,880	-\$4,512,000	-\$2,139,340	-\$2,870,000	-\$1,354,460

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>BENEFITS</u>							
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$12,414,000	-\$6,207,000	-\$22,518,000	-\$11,259,000	-\$10,104,000	-\$5,052,000
199	END OF LIFE SERVICES	\$0	\$0	\$2,330,000	\$2,330,000	\$2,330,000	\$2,330,000
203	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES	-\$96,000	-\$48,000	-\$195,000	-\$97,500	-\$99,000	-\$49,500
	BENEFITS SUBTOTAL	\$639,253,000	\$98,055,980	\$772,235,000	\$143,474,670	\$132,982,000	\$45,418,690
<u>PHARMACY</u>							
52	ORKAMBI BENEFIT	\$18,077,490	\$8,588,020	\$56,762,000	\$26,894,000	\$38,684,510	\$18,305,980
53	ADAP RYAN WHITE MEDS DATA MATCH	\$2,400,000	\$1,200,000	\$627,000	\$313,500	-\$1,773,000	-\$886,500
54	HEPATITIS C REVISED CLINICAL GUIDELINES	\$2,400,000	\$1,200,000	\$2,400,000	\$1,200,000	\$0	\$0
55	NON FFP DRUGS	\$0	\$221,500	\$0	\$19,500	\$0	-\$202,000
56	BCCTP DRUG REBATES	-\$16,000,000	-\$5,600,000	-\$16,000,000	-\$5,600,000	\$0	\$0
57	MEDICAL SUPPLY REBATES	-\$29,518,000	-\$12,692,500	-\$30,923,000	-\$6,756,700	-\$1,405,000	\$5,935,800
58	LITIGATION SETTLEMENTS	-\$36,262,000	-\$36,262,000	\$0	\$0	\$36,262,000	\$36,262,000
59	FAMILY PACT DRUG REBATES	-\$54,527,000	-\$6,839,900	-\$54,989,000	-\$6,897,700	-\$462,000	-\$57,800
60	STATE SUPPLEMENTAL DRUG REBATES	-\$185,506,000	-\$74,556,900	-\$233,749,000	-\$97,656,000	-\$48,243,000	-\$23,099,100
61	AGED AND DISPUTED DRUG REBATES	-\$300,000,000	-\$149,988,000	-\$300,000,000	-\$149,988,000	\$0	\$0
62	FEDERAL DRUG REBATE PROGRAM	-\$2,056,458,000	-\$776,288,700	-\$2,047,526,000	-\$780,548,800	\$8,932,000	-\$4,260,100
	PHARMACY SUBTOTAL	-\$2,655,393,510	-\$1,051,018,480	-\$2,623,398,000	-\$1,019,020,200	\$31,995,510	\$31,998,280
<u>DRUG MEDI-CAL</u>							
65	RESIDENTIAL TREATMENT SERVICES EXPANSION	\$14,561,000	\$5,096,500	\$90,892,000	\$32,493,700	\$76,331,000	\$27,397,200
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$0	\$3,036,000	\$0	\$0	\$0
69	ANNUAL RATE ADJUSTMENT	\$0	\$0	\$1,135,000	\$369,000	\$1,135,000	\$369,000
	DRUG MEDI-CAL SUBTOTAL	\$17,597,000	\$5,096,500	\$95,063,000	\$32,862,700	\$77,466,000	\$27,766,200
<u>MENTAL HEALTH</u>							
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	\$232,291,000	\$0	\$175,544,000	\$0	-\$56,747,000	\$0
73	ELIMINATION OF STATE MAXIMUM RATES	\$78,309,000	\$0	\$0	\$0	-\$78,309,000	\$0

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
MENTAL HEALTH							
74	TRANSITION OF HFP - SMH SERVICES	\$53,804,000	\$0	\$0	\$0	-\$53,804,000	\$0
75	KATIE A. V. DIANA BONTA	\$35,954,000	\$0	\$35,364,000	\$0	-\$590,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$24,000,000	\$0	\$25,500,000	\$0	\$1,500,000	\$0
77	HEALTHY FAMILIES - SED	\$5,000	\$0	\$0	\$0	-\$5,000	\$0
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	\$0	\$4,412,000	\$0	\$270,000	\$0	-\$4,142,000
79	IMD ANCILLARY SERVICES	\$0	\$4,000,000	\$0	\$4,000,000	\$0	\$0
80	CHART REVIEW	-\$1,138,000	\$0	-\$913,000	\$0	\$225,000	\$0
81	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$74,280,000	\$29,877,000	\$0	\$0	\$74,280,000	-\$29,877,000
198	LATE CLAIMS FOR SMHS	\$3,783,000	\$0	\$2,175,000	\$1,970,000	-\$1,608,000	\$1,970,000
211	MHP COSTS FOR CHILDREN AND YOUTH IN FOSTER C	\$0	\$0	\$416,000	\$208,000	\$416,000	\$208,000
MENTAL HEALTH SUBTOTAL		\$352,728,000	\$38,289,000	\$238,086,000	\$6,448,000	-\$114,642,000	-\$31,841,000
WAIVER--MH/UCD & BTR							
82	MH/UCD & BTR--DSH PAYMENT	\$184,358,000	\$62,090,000	\$34,000,000	\$17,000,000	-\$150,358,000	-\$45,090,000
83	BTR--DPH DELIVERY SYSTEM REFORM INCENTIVE PC	\$786,080,000	\$393,040,000	\$0	\$0	-\$786,080,000	-\$393,040,000
84	MH/UCD & BTR--PRIVATE HOSPITAL DSH REPLACEME	\$656,305,000	\$328,152,500	\$571,258,000	\$285,629,000	-\$85,047,000	-\$42,523,500
85	MH/UCD & BTR--DPH INTERIM & FINAL RECONS	\$326,815,000	\$0	-\$218,972,000	\$0	-\$545,787,000	\$0
86	MH/UCD & BTR--PRIVATE HOSPITAL SUPPLEMENTAL F	\$280,704,000	\$140,352,000	\$258,202,000	\$129,101,000	-\$22,502,000	-\$11,251,000
87	BTR--SAFETY NET CARE POOL	\$19,667,000	\$0	\$0	\$0	-\$19,667,000	\$0
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	\$187,327,000	\$93,663,500	\$70,492,000	\$35,246,000	-\$116,835,000	-\$58,417,500
89	BTR - LIHP - MCE	\$162,795,000	\$0	\$141,648,000	\$0	-\$21,147,000	\$0
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$126,379,000	\$0	-\$12,363,000	\$0	-\$138,742,000	\$0
91	MH/UCD & BTR--DPH PHYSICIAN & NON-PHYS. COST	\$87,171,000	\$0	\$80,844,000	\$0	-\$6,327,000	\$0
92	MH/UCD & BTR--DPH INTERIM RATE GROWTH	\$26,066,260	\$13,033,130	\$78,635,980	\$39,317,990	\$52,569,710	\$26,284,860
93	MH/UCD--HEALTH CARE COVERAGE INITIATIVE	\$23,509,000	\$0	\$0	\$0	-\$23,509,000	\$0
94	BTR--DESIGNATED STATE HEALTH PROGRAMS	\$3,458,000	-\$146,481,000	\$0	\$0	-\$3,458,000	\$146,481,000

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>WAIVER--MH/UCD & BTR</u>							
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$10,204,000	\$5,102,000	\$0	\$0	-\$10,204,000	-\$5,102,000
96	MH/UCD—SAFETY NET CARE POOL	\$8,186,000	\$0	\$0	\$0	-\$8,186,000	\$0
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$4,712,000	\$2,356,000	\$3,800,000	\$1,900,000	-\$912,000	-\$456,000
98	MH/UCD—STABILIZATION FUNDING	\$2,650,000	\$2,650,000	\$0	\$0	-\$2,650,000	-\$2,650,000
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	\$2,164,000	\$0	\$1,471,000	\$0	-\$693,000	\$0
100	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	\$0	\$0	\$12,022,000	\$0	\$12,022,000
101	MH/UCD & BTR—BCCTP	\$0	-\$327,000	\$0	\$0	\$0	\$327,000
102	MH/UCD & BTR—DPH INTERIM RATE	\$0	-\$414,987,500	\$0	-\$437,269,450	\$0	-\$22,281,950
103	MH/UCD & BTR—MIA-LTC	\$0	-\$393,000	\$0	\$0	\$0	\$393,000
104	MH/UCD & BTR—CCS AND GHPP	\$17,900,000	\$0	\$0	\$0	-\$17,900,000	\$0
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-C	\$800,000,000	\$400,000,000	\$1,600,000,000	\$800,000,000	\$800,000,000	\$400,000,000
206	GLOBAL PAYMENT PROGRAM	\$2,603,064,000	\$1,301,532,000	\$2,492,584,000	\$1,246,292,000	-\$110,480,000	-\$55,240,000
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	-\$37,500,000	\$0	-\$75,000,000	\$0	-\$37,500,000
208	WAIVER 2020 WHOLE PERSON CARE PILOTS	\$0	\$0	\$900,000,000	\$450,000,000	\$900,000,000	\$450,000,000
209	WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE	\$75,000,000	\$37,500,000	\$150,000,000	\$75,000,000	\$75,000,000	\$37,500,000
	WAIVER--MH/UCD & BTR SUBTOTAL	\$6,394,514,260	\$2,179,782,630	\$6,151,599,980	\$2,579,238,540	-\$242,914,290	\$399,455,910
<u>MANAGED CARE</u>							
108	CCI-MANAGED CARE PAYMENTS	\$9,889,062,000	\$4,944,531,000	\$10,319,468,000	\$5,159,734,000	\$430,406,000	\$215,203,000
109	CCI-TRANSFER OF IHSS COSTS TO CDSS	\$2,307,539,000	\$2,307,539,000	\$2,477,372,000	\$2,477,372,000	\$169,833,000	\$169,833,000
111	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$1,744,753,000	\$564,183,520	\$0	\$0	-\$1,744,753,000	-\$564,183,520
112	MANAGED CARE RATE RANGE IGTS	\$637,364,000	\$294,454,000	\$871,975,000	\$401,101,000	\$234,611,000	\$106,647,000
113	MANAGED CARE PUBLIC HOSPITAL IGTS	\$518,150,000	\$259,075,000	\$531,316,000	\$265,658,000	\$13,166,000	\$6,583,000
115	HQAF RATE RANGE INCREASES	\$190,077,000	\$92,998,000	\$148,000,000	\$74,000,000	-\$42,077,000	-\$18,998,000
118	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEED	\$60,200,000	\$6,020,000	\$207,000,000	\$20,700,000	\$146,800,000	\$14,680,000
119	INLAND EMPIRE HEALTH PLAN SETTLEMENT	\$36,700,000	\$18,350,000	\$0	\$0	-\$36,700,000	-\$18,350,000

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
MANAGED CARE							
121	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	\$183,000	\$91,500	\$0	\$0	-\$183,000	-\$91,500
124	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0	\$0	\$0	\$0
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN'	\$0	\$0	\$0	\$0	\$0	\$0
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0	\$0	\$0	\$0
127	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0	\$0	\$0	\$0
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	\$0	\$0	\$0	\$0	\$0
130	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0	\$0	\$0	\$0
131	FORMER AGNEWS' BENEFICIARIES RECOUPMENT	-\$5,687,000	-\$2,843,500	\$0	\$0	\$5,687,000	\$2,843,500
132	CCI-SAVINGS AND DEFERRAL	-\$6,783,616,000	-\$3,391,808,000	-\$7,716,973,000	-\$3,858,486,500	-\$933,357,000	-\$466,678,500
133	RETRO MC RATE ADJUSTMENTS	-\$1,094,480,000	\$216,940,500	-\$3,510,424,000	-\$218,680,380	-\$2,415,944,000	-\$435,620,880
202	PALLIATIVE CARE SERVICES IMPLEMENTATION	\$0	\$0	\$9,364,000	\$4,682,000	\$9,364,000	\$4,682,000
204	CAPITATED RATE ADJUSTMENT FOR FY 2016-17	\$0	\$0	\$327,480,000	\$154,660,500	\$327,480,000	\$154,660,500
	MANAGED CARE SUBTOTAL	\$7,502,245,000	\$5,311,531,020	\$3,666,578,000	\$4,482,740,620	-\$3,835,667,000	-\$828,790,400
PROVIDER RATES							
134	MEDICARE PART B PREMIUM INCREASE	\$152,212,000	\$85,276,500	\$356,916,000	\$199,962,500	\$204,704,000	\$114,686,000
135	DENTAL RETROACTIVE RATE CHANGES	\$252,417,000	\$103,750,800	\$0	\$0	-\$252,417,000	-\$103,750,800
136	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$238,517,410	\$119,258,710	\$216,474,550	\$108,237,280	-\$22,042,860	-\$11,021,430
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	\$88,137,000	\$44,068,500	\$88,137,000	\$44,068,500	\$0	\$0
138	LTC RATE ADJUSTMENT	\$45,805,590	\$22,902,800	\$106,573,880	\$53,286,940	\$60,768,290	\$30,384,150
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$83,218,060	\$41,609,030	\$241,843,320	\$120,921,660	\$158,625,260	\$79,312,630
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$19,700,000	\$9,850,000	\$13,000,000	\$6,500,000	-\$6,700,000	-\$3,350,000
141	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$24,074,260	\$9,246,890	\$24,959,040	\$9,586,800	\$884,780	\$339,910
142	HOSPICE RATE INCREASES	\$3,539,480	\$1,769,740	\$8,261,790	\$4,130,900	\$4,722,310	\$2,361,150
143	GDSP NEWBORN SCREENING PROGRAM FEE INCREAS	\$0	\$0	\$1,940,860	\$970,430	\$1,940,860	\$970,430

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>PROVIDER RATES</u>							
144	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	-\$31,649,000	-\$31,649,000	\$0	\$0	\$31,649,000	\$31,649,000
145	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$13,824,000	-\$6,912,000	-\$23,087,000	-\$11,543,500	-\$9,263,000	-\$4,631,500
146	NON-AB 1629 LTC RATE FREEZE	-\$4,592,000	-\$2,296,000	-\$20,839,000	-\$10,419,500	-\$16,247,000	-\$8,123,500
147	LABORATORY RATE METHODOLOGY CHANGE	-\$20,265,790	-\$10,132,900	-\$30,711,260	-\$15,355,630	-\$10,445,470	-\$5,222,730
148	10% PROVIDER PAYMENT REDUCTION	-\$184,559,620	-\$92,279,810	-\$196,963,000	-\$98,481,500	-\$12,403,380	-\$6,201,690
149	REDUCTION TO RADIOLOGY RATES	-\$44,549,850	-\$22,274,930	-\$52,078,000	-\$26,039,000	-\$7,528,150	-\$3,764,070
	PROVIDER RATES SUBTOTAL	\$608,180,550	\$272,188,330	\$734,428,180	\$385,825,870	\$126,247,630	\$113,637,530
<u>SUPPLEMENTAL PMNTS.</u>							
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$8,613,826,000	\$3,485,813,000	\$7,150,333,000	\$2,831,982,000	-\$1,463,493,000	-\$653,831,000
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$288,962,000	\$0	\$234,312,000	\$0	-\$54,650,000	\$0
152	HOSPITAL QAF - HOSPITAL PAYMENTS	\$264,597,000	\$162,701,000	\$25,661,000	\$25,661,000	-\$238,936,000	-\$137,040,000
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	\$210,610,000	\$0	\$202,400,000	\$0	-\$8,210,000	\$0
154	NDPH IGT SUPPLEMENTAL PAYMENTS	\$136,685,000	\$47,088,000	\$100,498,000	\$46,687,000	-\$36,187,000	-\$401,000
155	CERTIFICATION PAYMENTS FOR DP-NFS	\$111,321,000	\$0	\$103,366,000	\$0	-\$7,955,000	\$0
156	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAY	\$105,372,460	\$51,831,860	\$107,000,000	\$38,996,330	\$1,627,540	-\$12,835,530
157	FFP FOR LOCAL TRAUMA CENTERS	\$101,793,000	\$50,896,500	\$80,103,000	\$40,051,500	-\$21,690,000	-\$10,845,000
158	CAPITAL PROJECT DEBT REIMBURSEMENT	\$100,941,000	\$40,452,500	\$102,317,000	\$41,140,500	\$1,376,000	\$688,000
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$61,611,000	\$0	\$22,782,000	\$0	-\$38,829,000	\$0
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$5,000,000	\$0	\$0
161	IGT PAYMENTS FOR HOSPITAL SERVICES	\$8,333,000	\$4,166,000	\$8,333,000	\$4,166,000	\$0	\$0
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$0	\$0
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENT:	\$6,063,000	\$0	\$3,662,000	\$0	-\$2,401,000	\$0
200	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$57,224,000	\$57,224,000	\$0	\$0	-\$57,224,000	-\$57,224,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$10,085,338,460	\$3,909,172,860	\$8,158,767,000	\$3,037,684,330	-\$1,926,571,460	-\$871,488,530
<u>OTHER</u>							

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER							
170	ARRA HITECH - PROVIDER PAYMENTS	\$182,108,000	\$0	\$127,681,000	\$0	-\$54,427,000	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDI	\$155,709,000	\$0	\$59,690,000	\$0	-\$96,019,000	\$0
173	CCI IHSS RECONCILIATION	\$60,000,000	\$0	\$0	\$0	-\$60,000,000	\$0
174	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	\$50,929,000	\$25,464,500	\$50,929,000	\$25,464,500	\$0	\$0
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$18,496,000	\$5,345,000	\$10,738,000	\$4,836,000	-\$7,758,000	-\$509,000
179	INDIAN HEALTH SERVICES	\$5,545,000	-\$18,482,500	\$25,289,000	-\$16,340,600	\$19,744,000	\$2,141,900
180	WPCS WORKERS' COMPENSATION	\$4,764,000	\$2,382,000	\$2,625,000	\$1,312,500	-\$2,139,000	-\$1,069,500
181	OVERTIME FOR WPCS PROVIDERS	\$4,231,000	\$2,115,500	\$5,391,000	\$2,695,500	\$1,160,000	\$580,000
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$2,939,000	\$881,500	\$0	\$0	-\$2,939,000	-\$881,500
186	CDDS DENTAL SERVICES	\$902,000	\$902,000	\$902,000	\$902,000	\$0	\$0
187	AUDIT SETTLEMENTS	\$854,000	\$854,000	\$854,000	\$854,000	\$0	\$0
188	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	\$325,000	\$162,500	\$449,000	\$224,500	\$124,000	\$62,000
189	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	-\$1,595,366,800	\$0	-\$1,605,590,850	\$0	-\$10,224,050
190	FUNDING ADJUST.—OTLICP	\$0	-\$100,237,360	\$0	-\$122,771,420	\$0	-\$22,534,060
191	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0	\$0	\$0	\$0
192	CLPP FUND	\$0	\$0	\$0	\$0	\$0	\$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0	\$0	\$0	\$0
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
195	IHSS REDUCTION IN SERVICE HOURS	-\$2,558,000	\$0	-\$262,406,000	\$0	-\$259,848,000	\$0
196	COUNTY SHARE OF OTLICP-CCS COSTS	-\$17,449,000	-\$17,449,000	-\$17,449,000	-\$17,449,000	\$0	\$0
210	FFP REPAYMENT FOR CDDS COSTS	\$0	\$42,537,000	\$0	\$3,800,000	\$0	-\$38,737,000
	OTHER SUBTOTAL	\$466,795,000	-\$1,650,891,660	\$4,693,000	-\$1,722,062,870	-\$462,102,000	-\$71,171,210
	GRAND TOTAL	\$25,498,878,040	\$8,821,995,730	\$19,925,031,400	\$7,701,251,710	-\$5,573,846,640	-\$1,120,744,020

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

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$8,314,530	\$132,743,520	\$61,122,690	\$51,523,040	\$1,638,740	\$46,505,970
OTHER MEDICAL	\$58,081,630	\$681,276,490	\$338,253,220	\$323,669,600	\$6,680,530	\$44,066,530
CO. & COMM. OUTPATIENT	\$4,606,000	\$114,762,280	\$115,983,690	\$30,643,180	\$835,760	\$43,121,890
PHARMACY	\$1,932,320	\$349,785,390	\$233,604,610	\$66,745,020	\$1,449,960	\$27,170,140
COUNTY INPATIENT	\$1,860,670	\$385,883,280	\$17,608,920	\$20,158,400	\$940,510	\$101,684,040
COMMUNITY INPATIENT	\$34,021,970	\$1,051,638,550	\$394,947,020	\$272,063,580	\$15,853,380	\$373,686,030
NURSING FACILITIES	\$168,057,620	\$94,316,950	\$402,343,570	\$3,566,240	\$1,068,782,340	\$3,178,760
ICF-DD	\$1,150,860	\$1,749,710	\$165,475,210	\$416,530	\$29,113,830	\$0
MEDICAL TRANSPORTATION	\$5,369,890	\$15,093,410	\$24,550,870	\$3,851,460	\$2,766,970	\$4,535,050
OTHER SERVICES	\$9,852,800	\$19,970,700	\$47,875,300	\$45,204,060	\$41,940,960	\$1,829,780
HOME HEALTH	\$961,620	\$1,966,730	\$130,040,100	\$5,185,950	\$48,260	\$515,120
FFS SUBTOTAL	\$294,209,920	\$2,849,187,010	\$1,931,805,210	\$823,027,050	\$1,170,051,250	\$646,293,330
DENTAL	\$44,986,240	\$460,939,860	\$103,535,700	\$161,164,070	\$4,521,390	\$0
MENTAL HEALTH	\$5,601,590	\$119,974,330	\$774,708,050	\$569,316,480	\$702,780	\$0
TWO PLAN MODEL	\$1,865,005,200	\$6,785,920,770	\$5,693,135,640	\$1,148,232,310	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$476,297,860	\$2,743,708,400	\$1,314,210,140	\$285,094,680	\$628,544,630	\$0
GEOGRAPHIC MANAGED CARE	\$316,441,650	\$1,339,843,220	\$1,013,464,270	\$204,601,070	\$0	\$0
PHP & OTHER MANAG. CARE	\$180,032,560	\$38,919,660	\$104,053,770	\$18,040,820	\$7,811,840	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$10,899,080	\$0	\$0
MEDICARE PAYMENTS	\$1,630,060,790	\$0	\$1,548,034,980	\$2,432,550	\$157,949,400	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$10,893,760	\$0	\$25,552,960	\$35,261,120	\$1,065,320	\$0
MISC. SERVICES	\$508,783,430	\$69,794,000	\$3,722,359,560	\$579,380	\$0	\$0
DRUG MEDI-CAL	\$8,429,220	\$58,434,130	\$19,724,040	\$27,218,880	\$827,560	\$0
REGIONAL MODEL	\$4,887,860	\$499,238,900	\$294,874,080	\$68,115,610	\$0	\$0
NON-FFS SUBTOTAL	\$5,051,420,170	\$12,116,773,270	\$14,613,653,180	\$2,530,956,060	\$801,422,930	\$0
TOTAL DOLLARS (1)	\$5,345,630,090	\$14,965,960,280	\$16,545,458,390	\$3,353,983,110	\$1,971,474,180	\$646,293,330
ELIGIBLES ***	443,800	3,392,000	1,041,000	1,436,500	43,400	22,000
ANNUAL \$/ELIGIBLE	\$12,045	\$4,412	\$15,894	\$2,335	\$45,426	\$29,377
AVG. MO. \$/ELIGIBLE	\$1,004	\$368	\$1,324	\$195	\$3,785	\$2,448

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$2,044,140	\$17,662,000	\$16,269,400	\$9,664,670	\$198,100,800	\$22,150,120
OTHER MEDICAL	\$4,937,790	\$157,183,580	\$88,847,540	\$84,673,610	\$880,563,230	\$110,062,770
CO. & COMM. OUTPATIENT	\$850,620	\$24,778,670	\$12,982,240	\$16,661,390	\$129,635,970	\$11,166,570
PHARMACY	\$2,948,590	\$33,856,290	\$6,945,490	\$20,247,250	\$121,886,950	\$27,827,790
COUNTY INPATIENT	\$8,780,190	\$3,094,480	\$26,831,970	\$41,429,970	\$140,148,290	\$14,005,660
COMMUNITY INPATIENT	\$18,638,120	\$91,318,970	\$108,612,450	\$74,578,520	\$1,005,702,200	\$123,948,540
NURSING FACILITIES	\$248,332,320	\$202,010	\$180,537,850	\$49,541,280	\$18,888,040	\$4,982,560
ICF-DD	\$155,056,250	\$22,740	\$950,410	\$7,390,320	\$366,960	\$1,295,410
MEDICAL TRANSPORTATION	\$1,179,870	\$563,360	\$8,986,510	\$11,934,790	\$11,194,870	\$1,682,030
OTHER SERVICES	\$7,944,220	-\$9,087,560	\$13,466,650	\$7,131,370	\$105,744,930	\$9,315,890
HOME HEALTH	\$6,670	\$4,542,220	\$738,740	\$49,469,280	\$9,589,450	\$12,578,950
FFS SUBTOTAL	\$450,718,770	\$324,136,760	\$465,169,250	\$372,722,460	\$2,621,821,680	\$339,016,300
DENTAL	\$1,411,810	\$60,873,450	\$37,443,590	\$18,246,250	\$284,153,730	\$28,854,240
MENTAL HEALTH	\$2,273,710	\$18,059,880	\$6,077,000	\$81,996,400	\$382,384,130	\$69,877,610
TWO PLAN MODEL	\$0	\$716,004,410	\$1,514,575,230	\$627,002,690	\$2,338,003,540	\$30,649,580
COUNTY ORGANIZED HEALTH SYSTEMS	\$209,896,640	\$328,782,140	\$493,852,470	\$303,349,060	\$849,985,740	\$27,498,330
GEOGRAPHIC MANAGED CARE	\$0	\$156,087,210	\$226,792,290	\$116,205,690	\$382,543,770	\$4,842,780
PHP & OTHER MANAG. CARE	\$249,550	\$12,579,890	\$153,132,690	\$17,568,940	\$49,820,210	\$2,679,530
EPSDT SCREENS	\$0	\$7,866,590	\$0	\$0	\$29,773,270	\$1,654,520
MEDICARE PAYMENTS	\$41,081,070	\$0	\$989,535,050	\$480,557,410	\$82,496,760	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$326,470	\$0	\$10,832,390	\$4,654,030	\$95,945,110	\$5,429,700
MISC. SERVICES	\$0	-\$75,084,000	\$431,935,330	\$668,399,830	\$1,467,120	\$11,788,320
DRUG MEDI-CAL	\$252,740	\$11,789,890	\$8,098,700	\$3,592,980	\$73,602,670	\$4,003,180
REGIONAL MODEL	\$0	\$49,137,030	\$20,378,460	\$21,186,110	\$165,782,770	\$947,120
NON-FFS SUBTOTAL	\$255,491,980	\$1,286,096,480	\$3,892,653,210	\$2,342,759,380	\$4,735,958,810	\$188,224,900
TOTAL DOLLARS (1)	\$706,210,760	\$1,610,233,240	\$4,357,822,460	\$2,715,481,840	\$7,357,780,490	\$527,241,210
ELIGIBLES ***	13,300	1,060,300	449,000	194,800	3,908,700	221,200
ANNUAL \$/ELIGIBLE	\$53,099	\$1,519	\$9,706	\$13,940	\$1,882	\$2,384
AVG. MO. \$/ELIGIBLE	\$4,425	\$127	\$809	\$1,162	\$157	\$199

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$113,570	\$168,410	\$4,186,680	\$117,088,760	\$11,737,880	\$6,175,660
OTHER MEDICAL	\$345,490	\$626,150	\$5,280,070	\$228,141,090	\$107,964,510	\$49,377,780
CO. & COMM. OUTPATIENT	\$61,660	\$67,330	\$3,597,970	\$23,456,980	\$8,858,810	\$6,823,470
PHARMACY	\$675,710	\$124,110	\$2,493,450	\$7,265,030	\$8,492,630	\$10,916,020
COUNTY INPATIENT	\$147,130	\$4,370	\$4,723,730	\$55,953,220	\$1,084,790	\$1,041,180
COMMUNITY INPATIENT	\$799,080	\$352,000	\$23,138,650	\$608,054,960	\$58,224,080	\$28,196,150
NURSING FACILITIES	\$19,109,310	\$370	\$3,186,590	\$2,325,020	\$1,334,490	\$487,750
ICF-DD	\$746,760	\$0	\$237,270	\$0	\$0	\$61,830
MEDICAL TRANSPORTATION	\$105,370	\$4,690	\$748,780	\$2,057,960	\$594,380	\$215,420
OTHER SERVICES	\$659,520	\$15,190	\$307,360	\$13,895,080	\$8,152,190	\$11,017,100
HOME HEALTH	\$20	\$90	\$4,020	\$1,776,790	\$2,453,720	\$1,489,370
FFS SUBTOTAL	\$22,763,650	\$1,362,710	\$47,904,560	\$1,060,014,900	\$208,897,480	\$115,801,740
DENTAL	\$96,200	\$173,370	\$20,952,370	\$10,118,610	\$12,324,230	\$16,511,880
MENTAL HEALTH	\$20,670	\$71,270	\$149,310	\$746,570	\$6,073,900	\$20,319,940
TWO PLAN MODEL	\$110,670	\$756,740	\$0	\$217,523,850	\$368,958,450	\$208,431,510
COUNTY ORGANIZED HEALTH SYSTEMS	\$155,200	\$173,350	\$1,738,150	\$91,030,400	\$163,073,260	\$93,329,640
GEOGRAPHIC MANAGED CARE	\$22,670	\$158,900	\$0	\$37,438,450	\$71,773,520	\$48,924,830
PHP & OTHER MANAG. CARE	\$7,900	\$0	\$0	\$3,910,600	\$6,565,870	\$3,726,150
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$4,027,770	\$2,285,770
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$14,730	\$0	\$1,175,780	\$8,525,020	\$0	\$7,653,620
MISC. SERVICES	\$3,723,090	\$0	\$0	\$67,010	\$40,910	\$71,190
DRUG MEDI-CAL	\$12,340	\$25,450	\$0	\$6,433,040	\$10,058,780	\$5,708,390
REGIONAL MODEL	\$980	\$5,280	\$0	\$12,240,200	\$30,811,860	\$15,100,130
NON-FFS SUBTOTAL	\$4,164,460	\$1,364,350	\$24,015,610	\$388,033,750	\$673,708,550	\$422,063,070
TOTAL DOLLARS (1)	\$26,928,100	\$2,727,050	\$71,920,170	\$1,448,048,650	\$882,606,020	\$537,864,810
ELIGIBLES ***	600	1,300	47,900	347,300	543,500	311,800
ANNUAL \$/ELIGIBLE	\$44,880	\$2,098	\$1,501	\$4,169	\$1,624	\$1,725
AVG. MO. \$/ELIGIBLE	\$3,740	\$175	\$125	\$347	\$135	\$144

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$707,210,580
OTHER MEDICAL	\$3,170,031,630
CO. & COMM. OUTPATIENT	\$548,894,480
PHARMACY	\$924,366,760
COUNTY INPATIENT	\$825,380,830
COMMUNITY INPATIENT	\$4,283,774,250
NURSING FACILITIES	\$2,269,173,080
ICF-DD	\$364,034,090
MEDICAL TRANSPORTATION	\$95,435,670
OTHER SERVICES	\$335,235,540
HOME HEALTH	\$221,367,120
FFS SUBTOTAL	\$13,744,904,030
DENTAL	\$1,266,306,980
MENTAL HEALTH	\$2,058,353,630
TWO PLAN MODEL	\$21,514,310,610
COUNTY ORGANIZED HEALTH SYSTEMS	\$8,010,720,100
GEOGRAPHIC MANAGED CARE	\$3,919,140,320
PHP & OTHER MANAG. CARE	\$599,099,980
EPSDT SCREENS	\$56,507,000
MEDICARE PAYMENTS	\$4,932,148,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$207,330,000
MISC. SERVICES	\$5,343,925,170
DRUG MEDI-CAL	\$238,212,000
REGIONAL MODEL	\$1,182,706,380
NON-FFS SUBTOTAL	\$49,328,760,140
TOTAL DOLLARS (1)	\$63,073,664,170
ELIGIBLES ***	13,478,400
ANNUAL \$/ELIGIBLE	\$4,680
AVG. MO. \$/ELIGIBLE	\$390

(1) Does not include Audits & Lawsuits and Recoveries.

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

EXCLUDED POLICY CHANGES: 71

1	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
26	ACA MAGI SAVINGS
49	WOMEN'S HEALTH SERVICES
55	NON FFP DRUGS
59	FAMILY PACT DRUG REBATES
68	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
87	BTR—SAFETY NET CARE POOL
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
89	BTR - LIHP - MCE
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
94	BTR—DESIGNATED STATE HEALTH PROGRAMS
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
96	MH/UCD—SAFETY NET CARE POOL
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
98	MH/UCD—STABILIZATION FUNDING
99	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
100	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

EXCLUDED POLICY CHANGES: 71

101	MH/UCD & BTR—BCCTP
103	MH/UCD & BTR—MIA-LTC
104	MH/UCD & BTR—CCS AND GHPP
109	CCI-TRANSFER OF IHSS COSTS TO CDSS
124	EXTEND GROSS PREMIUM TAX
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE
127	GENERAL FUND REIMBURSEMENTS FROM DPHS
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
130	MCO TAX MANAGED CARE PLANS
135	DENTAL RETROACTIVE RATE CHANGES
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
144	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
152	HOSPITAL QAF - HOSPITAL PAYMENTS
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
154	NDPH IGT SUPPLEMENTAL PAYMENTS
155	CERTIFICATION PAYMENTS FOR DP-NFS
157	FFP FOR LOCAL TRAUMA CENTERS
158	CAPITAL PROJECT DEBT REIMBURSEMENT
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	IGT PAYMENTS FOR HOSPITAL SERVICES
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
170	ARRA HITECH - PROVIDER PAYMENTS
175	MEDI-CAL TCM PROGRAM
186	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS
191	CIGARETTE AND TOBACCO SURTAX FUNDS

FISCAL YEAR 2016-17 COST PER ELIGIBLE BASED ON NOVEMBER 2015 ESTIMATE

EXCLUDED POLICY CHANGES: 71

192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
200	DP-NF CAPITAL PROJECT DEBT REPAYMENT
202	PALLIATIVE CARE SERVICES IMPLEMENTATION
205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
206	GLOBAL PAYMENT PROGRAM
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM
208	WAIVER 2020 WHOLE PERSON CARE PILOTS

**Estimated Average Monthly Certified Eligibles
November 2015 Estimate
Fiscal Years 2014-2015, 2015-2016 & 2016-2017**

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

	2014-2015	2015-2016	2016-2017	14-15 To 15-16 % Change	15-16 To 16-17 % Change
Public Assistance	2,936,700	2,892,900	2,921,300	-1.49%	0.98%
Seniors	430,500	436,800	443,800	1.46%	1.60%
Persons with Disabilities ^{6/}	1,020,200	1,023,200	1,041,000	0.29%	1.74%
Families	1,486,000	1,432,900	1,436,500	-3.57%	0.25%
Long Term	57,900	56,700	56,700	-2.07%	0.00%
Seniors	44,000	43,400	43,400	-1.36%	0.00%
Persons with Disabilities ^{6/}	13,900	13,300	13,300	-4.32%	0.00%
Medically Needy ^{1/}	4,443,900	4,489,100	4,539,600	1.02%	1.12%
Seniors	380,600	423,400	441,300	11.25%	4.23%
Persons with Disabilities ^{6/}	180,800	182,100	189,600	0.72%	4.12%
Families ^{2/}	3,882,500	3,883,600	3,908,700	0.03%	0.65%
Medically Indigent	254,100	224,700	221,800	-11.57%	-1.29%
Children	253,200	224,000	221,200	-11.53%	-1.25%
Adults	900	700	600	-22.22%	-14.29%
Other	4,595,900	5,612,900	5,739,000	22.13%	2.25%
Refugees	1,700	1,300	1,300	-23.53%	0.00%
Undocumented Persons ^{3/}	51,700	47,800	47,900	-7.54%	0.21%
185% Poverty ^{4/}	290,400	341,200	347,300	17.49%	1.79%
133% Poverty	370,000	535,300	543,500	44.68%	1.53%
100% Poverty	269,000	304,200	311,800	13.09%	2.50%
250% Poverty	973,800	1,018,400	1,060,300	4.58%	4.11%
ACA Optional Expansion	2,603,200	3,329,800	3,392,000	27.91%	1.87%
Hospital PE	23,600	22,000	22,000	-6.78%	0.00%
QMB	12,500	12,900	12,900	3.20%	0.00%
GRAND TOTAL ^{5/}	12,288,500	13,276,300	13,478,400	8.04%	1.52%

Note: Graphs of eligibles represent base projections only and do not reflect estimated impact of policy changes.

***** See CL Page B reflecting impact of Policy Changes.**

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

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

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

	2014-2015	2015-2016	2016-2017
Total Undoc. Persons	885,100	902,400	902,400

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

	2014-2015	2015-2016	2016-2017
Presumptive Eligibility	21,900	21,500	21,500

⁵ The following Medi-Cal special program eligibles (average monthly during FY 2013-4 shown in parenthesis) are not included above: BCCTP (12,923), Tuberculosis (622), Dialysis (168), TPN (1). Family PACT eligibles are also not included above.

⁶ With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

November 2015 Medi-Cal Estimate
Caseload Changes Identified in Policy Changes
(Portion not in the base estimate)

<u>Policy Change</u>	<u>Budget Aid Category</u>	<u>Average Monthly Eligibles</u>		
		<u>2014-15</u>	<u>2015-16</u>	<u>2016-17</u>
PC 2 Medi-Cal Adult Inmate Programs	LT-OAS	10	10	10
	MN-OAS	70	22	22
	MN-ATD	14	4	4
	MI-C	5	1	1
	POV 185	32	29	29
	Newly	0	515	515
	Total	131	582	582
PC 4 Medi-Cal Access Program Mothers 213-322%	Pov 185	0	3,534	3,085
	Total	0	3,534	3,085
PC 5 Medi-Cal Inpt Hosp Costs - Juvenile Inmates	MI-C	505	505	505
	Total	505	505	505
PC 7 Undocumented Children Full Scope Expansion	PA-ATD	0	44	2,163
	PA-AFDC	0	61	2,985
	MN-ATD	0	8	394
	MN-AFDC	0	167	8,153
	MI-C	0	9	453
	MI-A	0	0	0
	POV 250	0	43	2,154
	POV 185	0	13	661
	POV 133	0	23	1,103
	POV 100	0	13	626
	OBRA	0	2	100
	Total	0	383	18,791
PC 8 Medi-Cal Access Program Infants 266-322%	MI-C	0	3,349	2,594
	Total	0	3,349	2,594
PC 9 Medi-Cal Access Program 30 Week Change	POV 185	0	75	75
	Total	0	75	75
PC 11 Federal Immigration Reform	PA-ATD	0	0	425
	PA-AFDC	0	0	595
	MN-ATD	0	0	76
	MN-AFDC	0	0	1,617
	MI-C	0	0	91
	MI-A	0	0	0
	POV 250	0	0	332
	POV 185	0	0	104
	POV 133	0	0	175
	POV 100	0	0	99
	OBRA	0	0	20
	Total	0	0	3,532
PC 16 Incarceration Verification Program	MN-AFDC	0	(43)	(43)
	PA-ATD	0	(1)	(1)
	PA-AFDC	0	(4)	(4)
	MI-C	0	(5)	(5)
	POV 100	0	(7)	(7)
Total	0	(61)	(61)	

November 2015 Medi-Cal Estimate
Caseload Changes Identified in Policy Changes
(Portion not in the base estimate)

<u>Policy Change</u>	<u>Budget Aid Category</u>	<u>Average Monthly Eligibles</u>		
		<u>2014-15</u>	<u>2015-16</u>	<u>2016-17</u>
PC 17 PARIS-Veterans	LTC-OAS	0	(5)	(5)
	MN-OAS	0	(6)	(6)
	MN-ATD	0	(5)	(5)
	MN-AFDC	0	(7)	(7)
	PA-OAS	0	0	0
	PA-ATD	0	(0)	(0)
	PA-AFDC	0	(3)	(3)
	MI-A	0	(3)	(3)
	Total	0	(29)	(29)
PC 20 ACA Optional Expansion	Newly	0	153,348	259,472
	Total	0	153,348	259,472
PC 22 ACA Mandatory Expansion	MN-OAS	0	8,809	14,904
	POV 250	0	14,035	23,747
	POV 185	0	2,764	4,678
	POV 133	0	7,452	12,609
	POV 100	0	6,264	10,599
	Total	0	39,324	66,538
PC 29 ACA Expansion-New Qualified Immigrants	Newly	0	0	(42,374)
	Total	0	0	(42,374)
PC 31 ACA Redeterminations	PA-OAS	0	(98)	(113)
	PA-ATD	0	(234)	(269)
	PA-AFDC	0	(342)	(394)
	LT-OAS	0	(160)	(184)
	LT-ATD	0	(51)	(58)
	POV 250	0	(357)	(411)
	MN-OAS	0	(81)	(94)
	MN-ATD	0	(41)	(47)
	MN-AFDC	0	(14,255)	(16,423)
	MI-C	0	(51)	(58)
	Newly	0	(1,397)	(1,610)
	POV 185	0	(59)	(68)
	POV 133	0	(52)	(60)
	POV 100	0	(88)	(101)
	Total	0	(17,266)	(19,892)
Total By Aid Category Group				
	PA Aged	0	(98)	(113)
	PA Disabled	0	(191)	2,317
	PA AFDC (Famili	0	(287)	3,179
	LT Aged	10	(154)	(178)
	LT Disabled	0	(51)	(58)
	MN Aged	70	8,742	14,826
	MN Disabled	14	(33)	422
	MN AFDC (Famili	0	(14,139)	(6,704)
	MI Adult	0	0	0
	MI Children	510	3,809	3,581
	250% Poverty	0	13,721	25,822
	185% Poverty	0	6,356	8,562
	133% Poverty	32	7,422	13,826
	100% Poverty	0	6,182	11,215
	Newly	0	152,466	216,003
	OBRA	0	2	119
	Total	636	183,747	292,820

Comparison of Average Monthly Certified Eligibles
November 2015 Estimate
Fiscal Year 2015-16

(With Estimated Impact of Eligibility Policy Changes)

	Appropriation 2015-2016	Adjusted Appropriation ³ 2015-2016	November 2015 2015-2016	% Change	Adjusted % Change
Public Assistance	2,984,900	2,984,100	2,892,900	-3.08%	-3.06%
Seniors	436,300	436,300	436,800	0.11%	0.11%
Persons with Disabilities ²	1,039,000	1,038,700	1,023,200	-1.52%	-1.49%
Families	1,509,600	1,509,100	1,432,900	-5.08%	-5.05%
Long Term	57,000	57,000	56,700	-0.53%	-0.53%
Seniors	43,300	43,300	43,400	0.23%	0.23%
Persons with Disabilities ²	13,700	13,700	13,300	-2.92%	-2.92%
Medically Needy¹	4,379,500	4,378,200	4,489,100	2.50%	2.53%
Seniors	370,400	370,400	423,400	14.31%	14.31%
Persons with Disabilities ²	186,400	186,300	182,100	-2.31%	-2.25%
Families	3,822,700	3,821,500	3,883,600	1.59%	1.63%
Medically Indigent	2,751,600	228,000	224,700	-91.83%	-1.45%
Children	227,500	227,100	224,000	-1.54%	-1.37%
Adults	2,524,100	900	700	-99.97%	-22.22%
Other	2,257,800	4,783,600	5,612,900	148.60%	17.34%
Refugees	1,600	1,600	1,300	-18.75%	-18.75%
Undocumented Persons	208,800	208,800	47,800	-77.11%	-77.11%
185% Poverty	305,900	310,300	341,200	11.54%	9.96%
133% Poverty	248,400	248,300	535,300	115.50%	115.59%
100% Poverty	432,200	432,100	304,200	-29.62%	-29.60%
250% Poverty	1,046,500	1,046,200	1,018,400	-2.69%	-2.66%
ACA Optional Expansion		2,485,500	3,329,800	n/a	33.97%
Hospital PE		36,400	22,000	n/a	-39.56%
QMB	14,400	14,400	12,900	-10.42%	-10.42%
GRAND TOTAL	12,430,800	12,430,900	13,276,300	6.80%	6.80%

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

² With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

³ The Appropriation caseload adjusted to reflect the new Aid Categories of ACA Optional Expansion and Hospital PE.

The Grand Total difference of 100, is due to rounding.

Estimated Average Monthly Certified Eligibles
November 2015 Estimate
Fiscal Years 2014-2015, 2015-2016 & 2016-2017

Managed Care					
<i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	2014-2015	2015-2016	2016-2017	14-15 To 15-16 % Change	15-16 To 16-17 % Change
Public Assistance	2,323,260	2,439,890	2,478,560	5.02%	1.58%
Seniors	224,880	322,140	331,000	43.25%	2.75%
Persons with Disabilities ⁴	767,290	850,190	876,250	10.80%	3.07%
Families	1,331,090	1,267,560	1,271,310	-4.77%	0.30%
Long Term	21,770	29,560	29,540	35.78%	-0.07%
Seniors	16,460	22,710	22,690	37.97%	-0.09%
Persons with Disabilities ⁴	5,310	6,850	6,850	29.00%	0.00%
Medically Needy ¹	3,118,090	3,129,580	3,158,010	0.37%	0.91%
Seniors	206,730	272,750	287,110	31.94%	5.26%
Persons with Disabilities ⁴	103,560	118,370	123,430	14.30%	4.27%
Families ²	2,807,800	2,738,460	2,747,470	-2.47%	0.33%
Medically Indigent	61,920	51,410	50,450	-16.97%	-1.87%
Children	61,610	51,190	50,230	-16.91%	-1.88%
Adults	310	220	220	-29.03%	0.00%
Other	3,443,830	4,370,820	4,469,640	26.92%	2.26%
Refugees	990	800	800	-19.19%	0.00%
Undocumented Persons	1,110	950	1,070	-14.41%	12.63%
185% Poverty	115,340	153,140	156,200	32.77%	2.00%
133% Poverty	312,440	456,830	461,800	46.21%	1.09%
100% Poverty	231,280	263,550	267,520	13.95%	1.51%
250% Poverty	859,470	904,500	936,730	5.24%	3.56%
ACA Optional Expansion	1,923,200	2,591,050	2,645,520	34.73%	2.10%
GRAND TOTAL ³	8,968,870	10,021,260	10,186,200	11.73%	1.65%
Percent of Statewide	72.99%	75.48%	75.57%		

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

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

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

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

⁴ With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

Estimated Average Monthly Certified Eligibles
November 2015 Estimate
Fiscal Years 2014-2015, 2015-2016 & 2016-2017

Fee-For-Service					
<i>(With Estimated Impact of Eligibility Policy Changes)^{***}</i>					
	2014-2015	2015-2016	2016-2017	14-15 To 15-16 % Change	15-16 To 16-17 % Change
Public Assistance	613,440	453,010	442,740	-26.15%	-2.27%
Seniors	205,620	114,660	112,800	-44.24%	-1.62%
Persons with Disabilities ³	252,910	173,010	164,750	-31.59%	-4.77%
Families	154,910	165,340	165,190	6.73%	-0.09%
Long Term	36,130	27,140	27,160	-24.88%	0.07%
Seniors	27,540	20,690	20,710	-24.87%	0.10%
Persons with Disabilities ³	8,590	6,450	6,450	-24.91%	0.00%
Medically Needy¹	1,325,810	1,359,520	1,381,590	2.54%	1.62%
Seniors	173,870	150,650	154,190	-13.35%	2.35%
Persons with Disabilities ³	77,240	63,730	66,170	-17.49%	3.83%
Families ²	1,074,700	1,145,140	1,161,230	6.55%	1.41%
Medically Indigent	192,180	173,290	171,350	-9.83%	-1.12%
Children	191,590	172,810	170,970	-9.80%	-1.06%
Adults	590	480	380	-18.64%	-20.83%
Other	1,152,070	1,242,080	1,269,360	7.81%	2.20%
Refugees	710	500	500	-29.58%	0.00%
Undocumented Persons	50,590	46,850	46,830	-7.39%	-0.04%
185% Poverty	175,060	188,060	191,100	7.43%	1.62%
133% Poverty	57,560	78,470	81,700	36.33%	4.12%
100% Poverty	37,720	40,650	44,280	7.77%	8.93%
250% Poverty	114,330	113,900	123,570	-0.38%	8.49%
ACA Optional Expansion	680,000	738,750	746,480	8.64%	1.05%
Hospital PE	23,600	22,000	22,000	-6.78%	0.00%
QMB	12,500	12,900	12,900	3.20%	0.00%
GRAND TOTAL	3,319,630	3,255,040	3,292,200	-1.95%	1.14%
Percent of Statewide	27.01%	24.52%	24.43%		

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

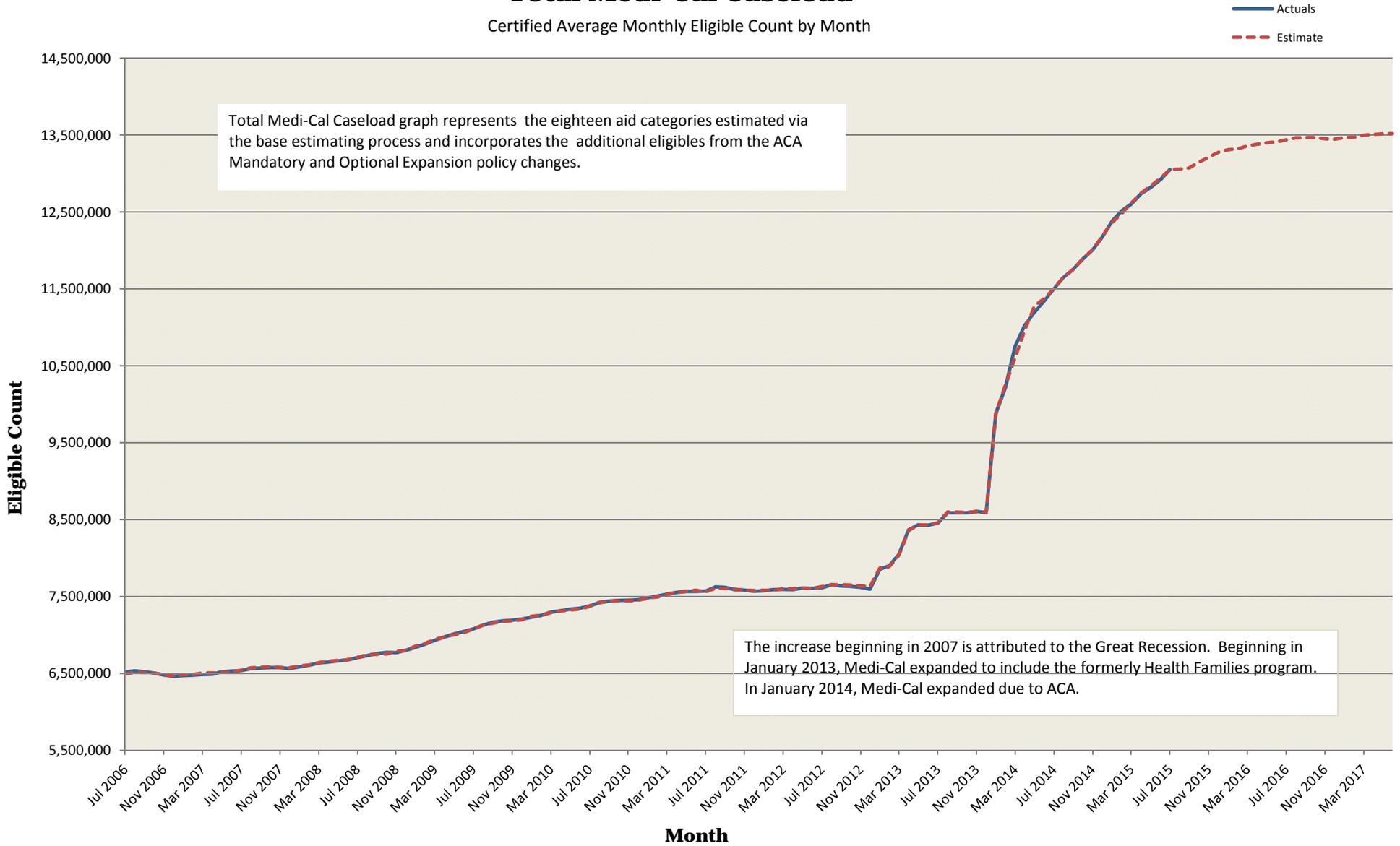
¹ Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

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

³ With the May 2015 Medi-Cal Estimate, the Blind and Disabled programs have been combined for estimating purposes.

Total Medi-Cal Caseload

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate

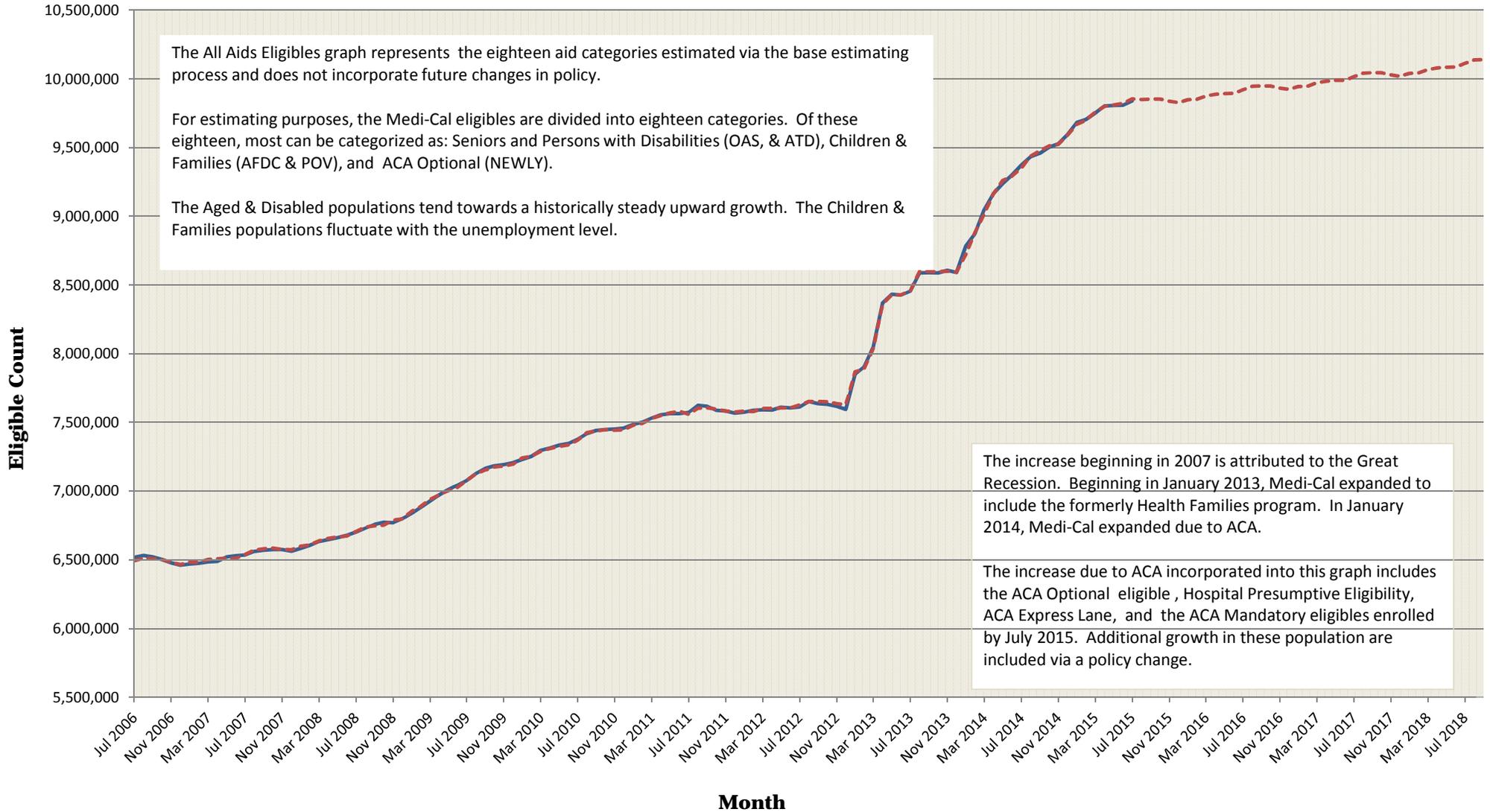
The All Aids Eligibles graph represents the eighteen aid categories estimated via the base estimating process and does not incorporate future changes in policy.

For estimating purposes, the Medi-Cal eligibles are divided into eighteen categories. Of these eighteen, most can be categorized as: Seniors and Persons with Disabilities (OAS, & ATD), Children & Families (AFDC & POV), and ACA Optional (NEWLY).

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

The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Health Families program. In January 2014, Medi-Cal expanded due to ACA.

The increase due to ACA incorporated into this graph includes the ACA Optional eligible, Hospital Presumptive Eligibility, ACA Express Lane, and the ACA Mandatory eligibles enrolled by July 2015. Additional growth in these population are included via a policy change.



Statewide Expanded Eligible for Aid Category: Families and Children

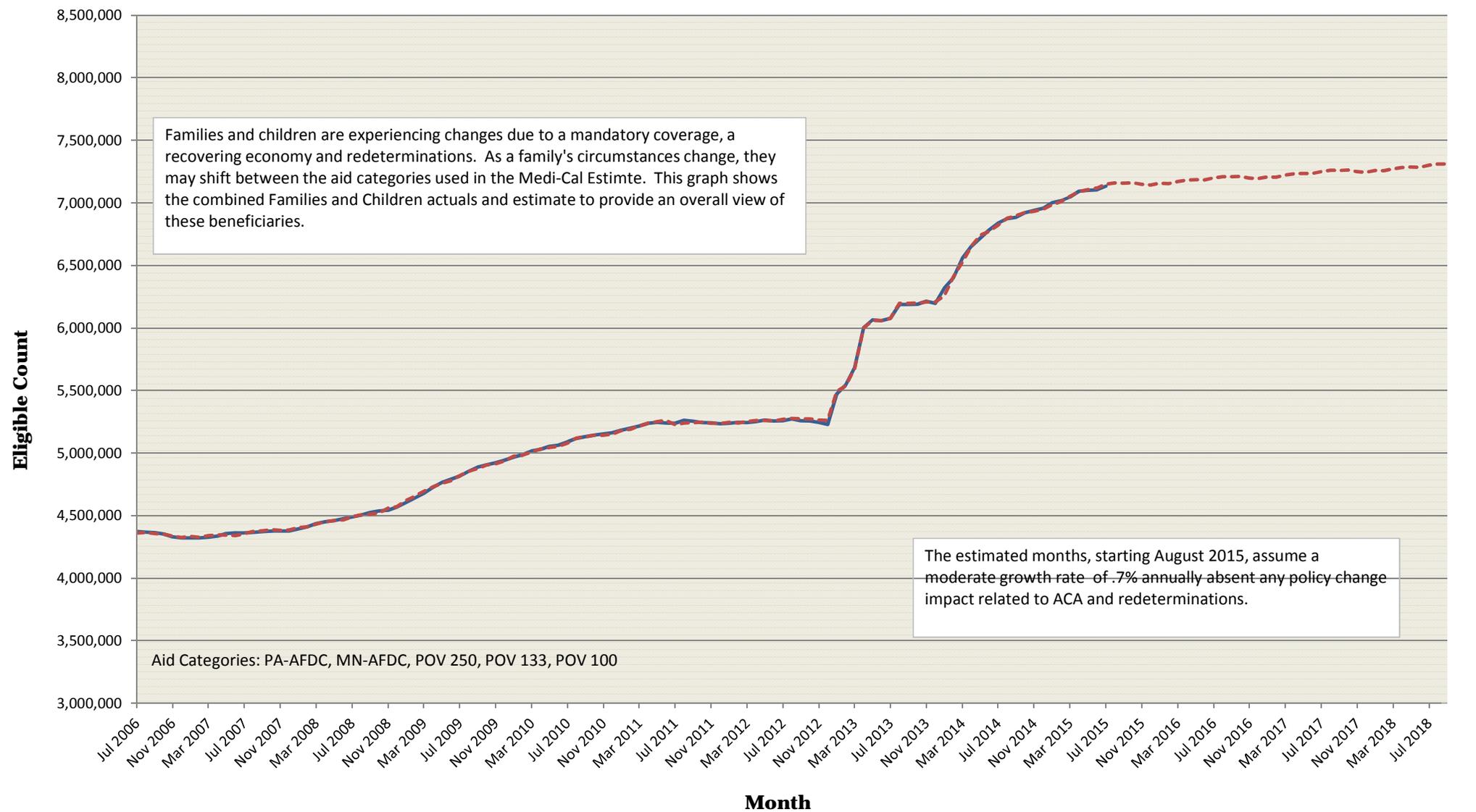
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate

Families and children are experiencing changes due to a mandatory coverage, a recovering economy and redeterminations. As a family's circumstances change, they may shift between the aid categories used in the Medi-Cal Estimate. This graph shows the combined Families and Children actuals and estimate to provide an overall view of these beneficiaries.

The estimated months, starting August 2015, assume a moderate growth rate of .7% annually absent any policy change impact related to ACA and redeterminations.

Aid Categories: PA-AFDC, MN-AFDC, POV 250, POV 133, POV 100



Statewide Expanded Eligible for Aid Category: Seniors and Persons with Disabilities

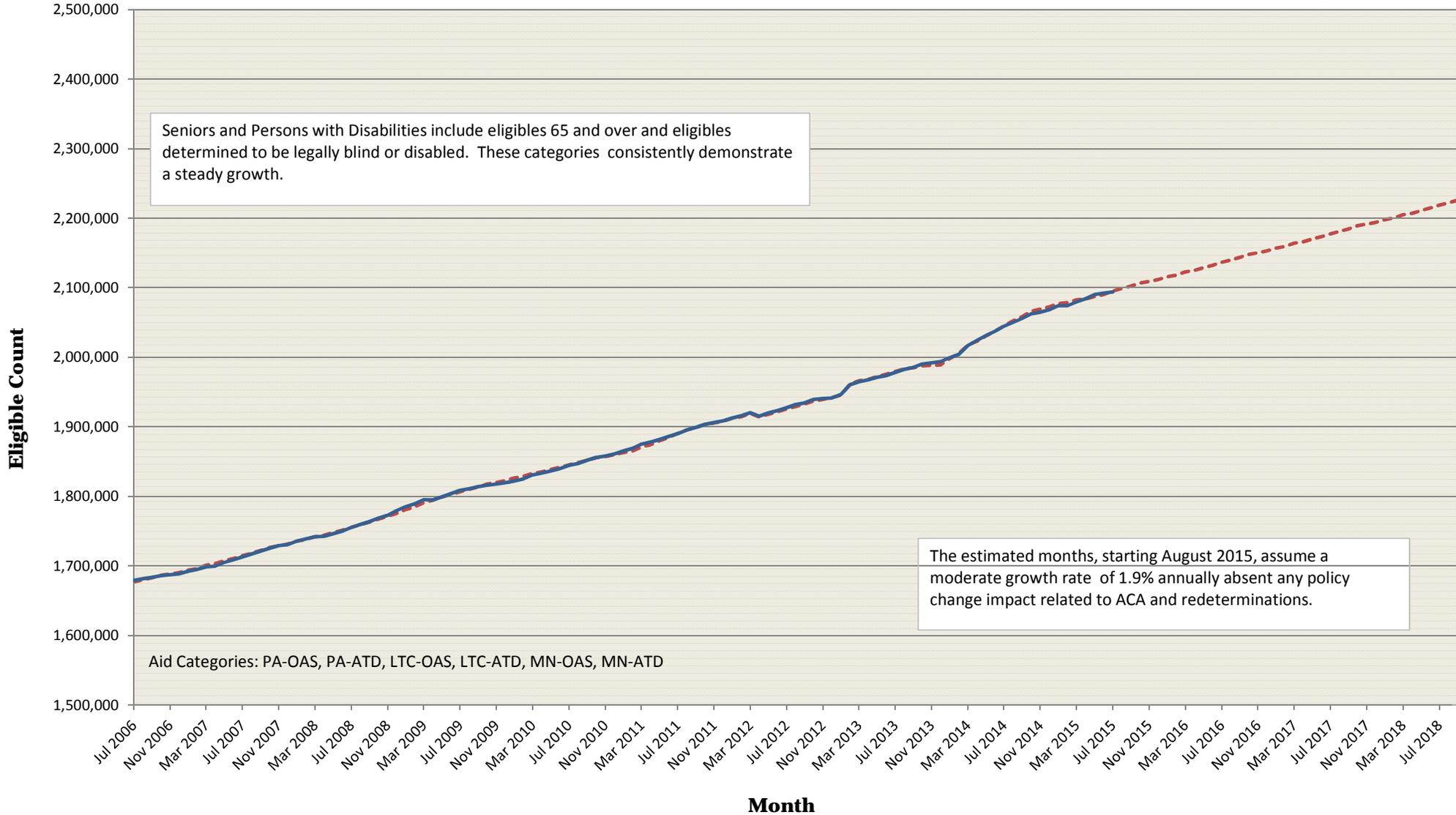
Certified Average Monthly Eligible Count by Month

— Actuals
- - - Estimate

Seniors and Persons with Disabilities include eligibles 65 and over and eligibles determined to be legally blind or disabled. These categories consistently demonstrate a steady growth.

The estimated months, starting August 2015, assume a moderate growth rate of 1.9% annually absent any policy change impact related to ACA and redeterminations.

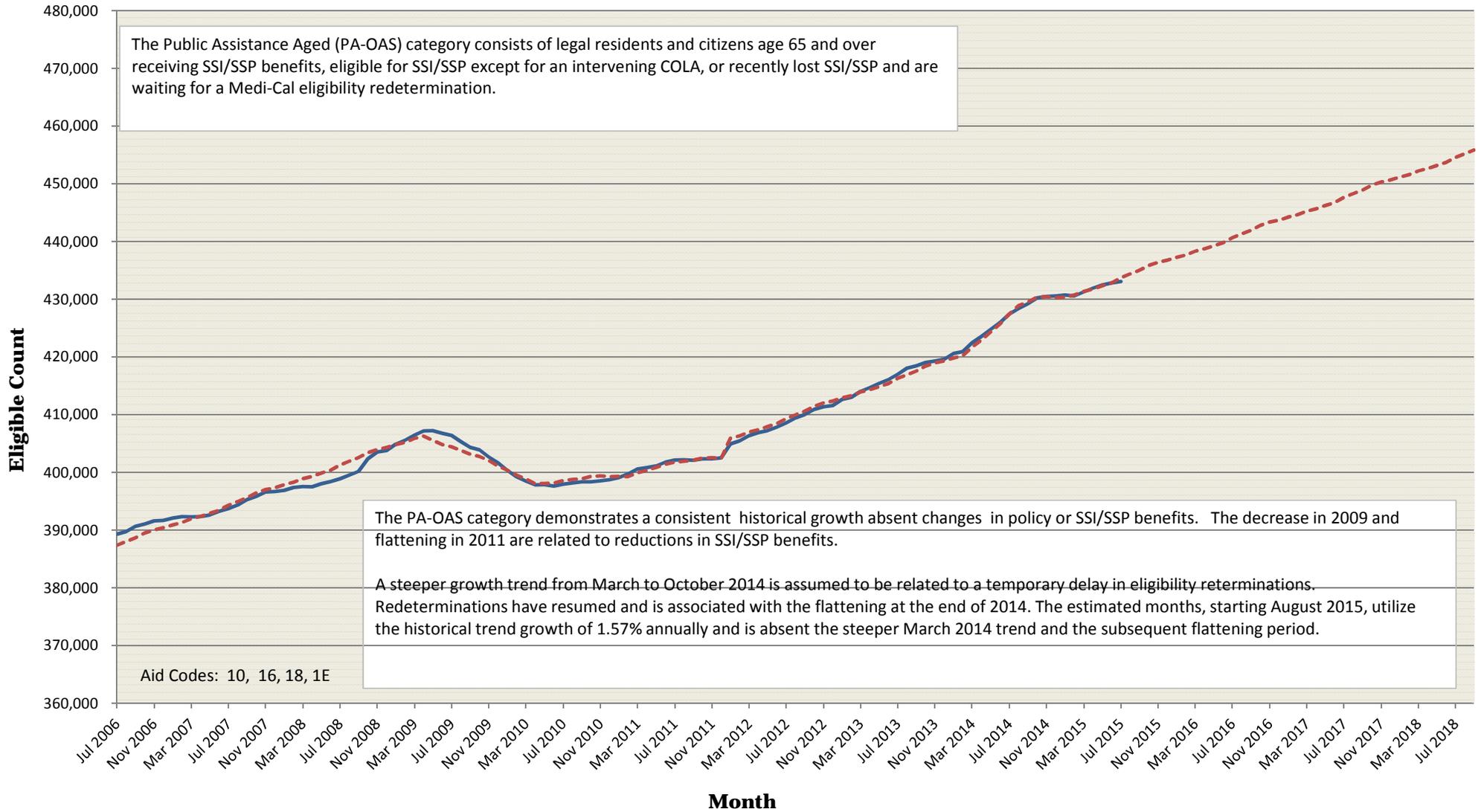
Aid Categories: PA-OAS, PA-ATD, LTC-OAS, LTC-ATD, MN-OAS, MN-ATD



Statewide Expanded Eligible: Public Assistance Seniors (PA-OAS)

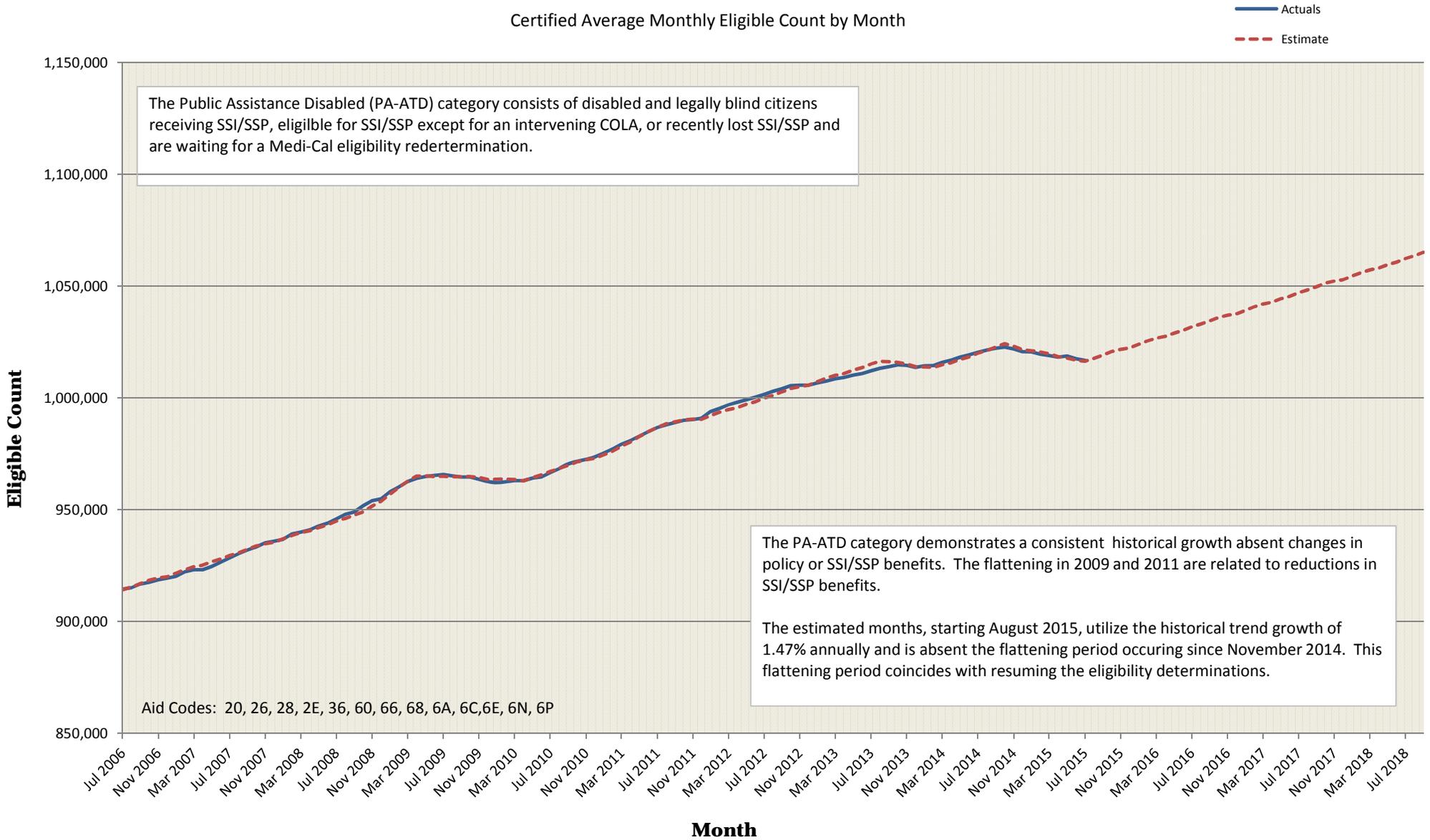
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate



Statewide Expanded Eligible: Public Assistance Persons with Disabilities (PA-ATD)

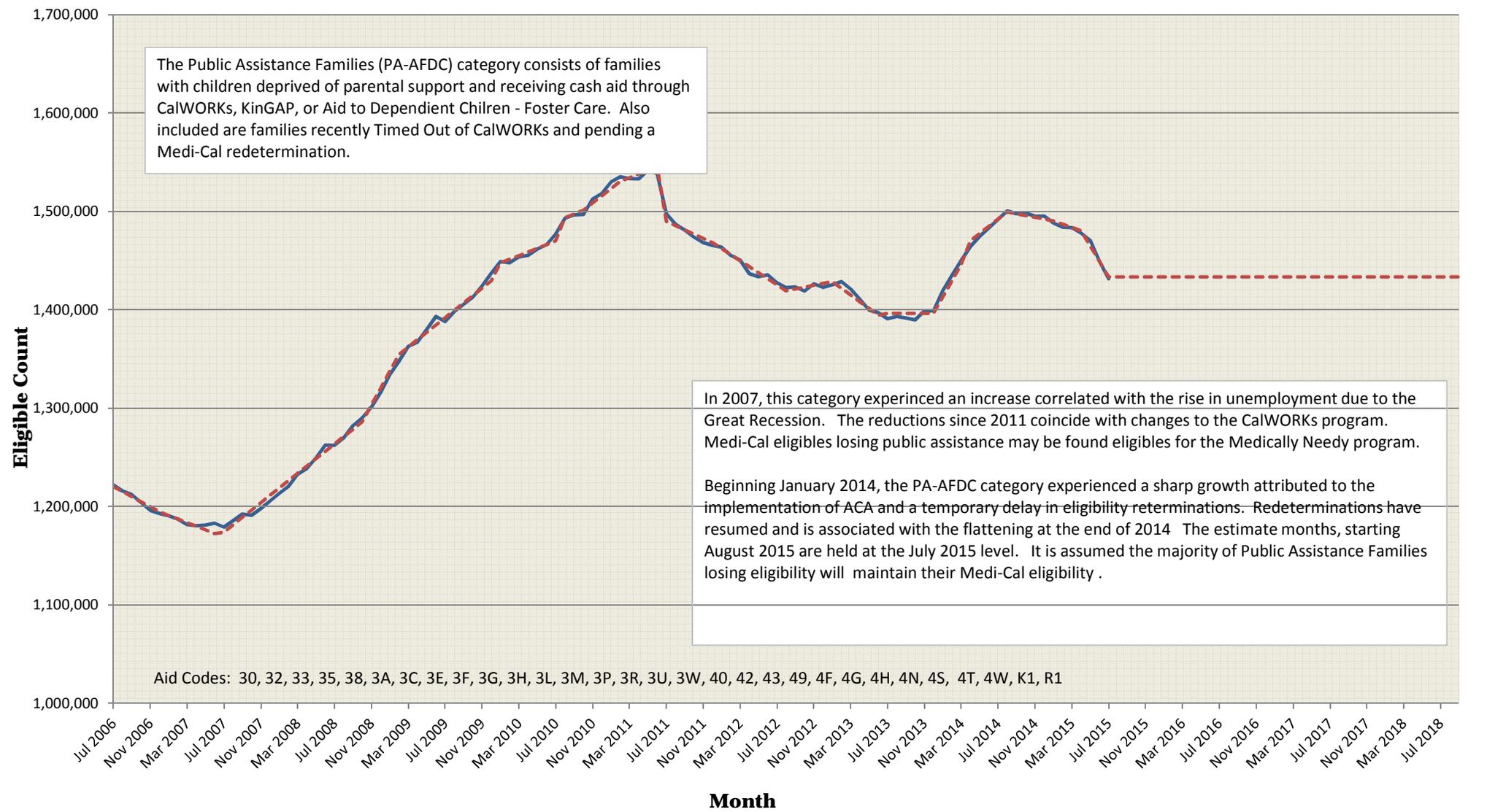
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Public Assistance Families (PA-AFDC)

Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate



Statewide Expanded Eligible: Long Term Seniors (LT-OAS)

Certified Average Monthly Eligible Count by Month

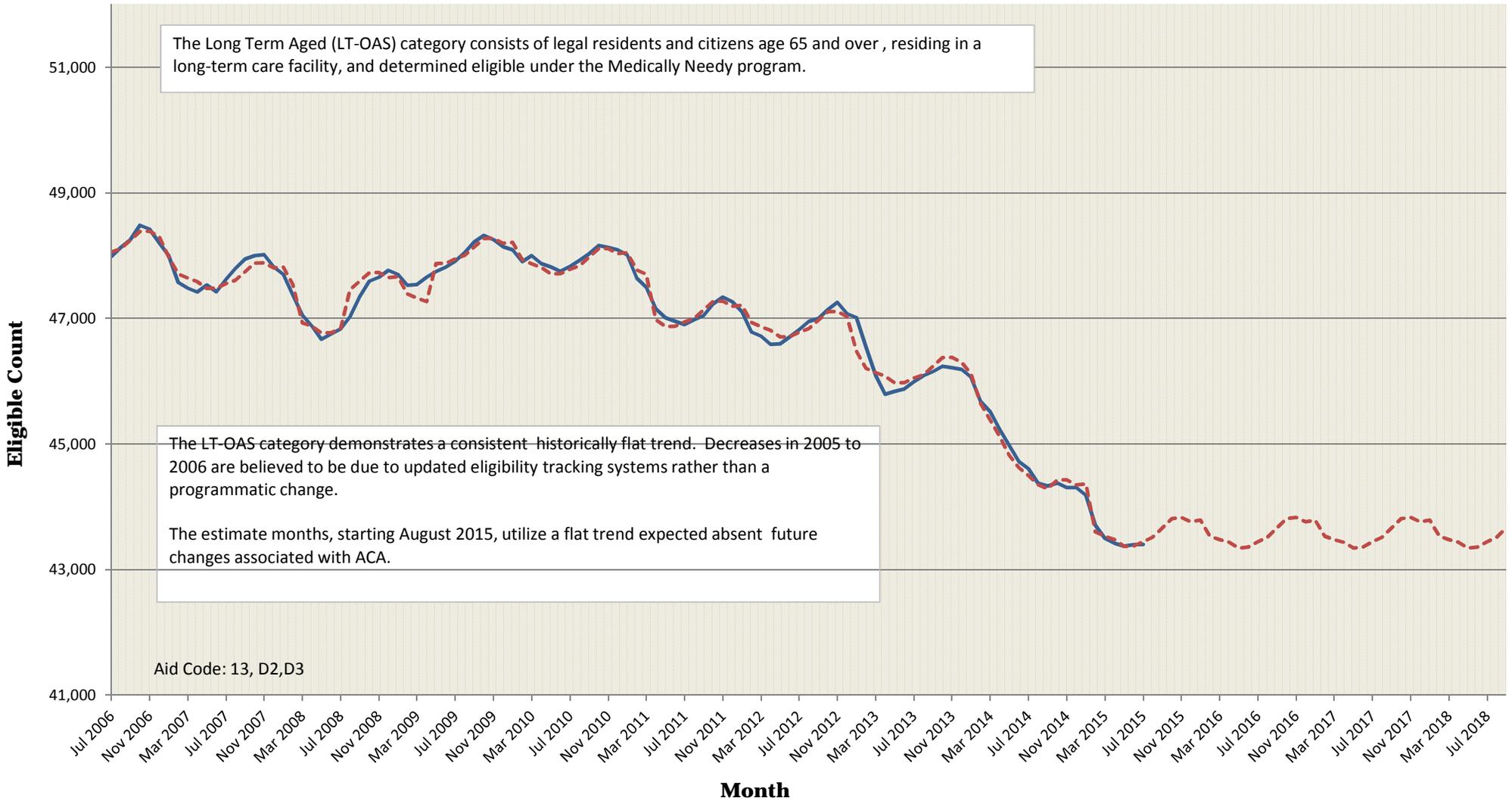
— Actuals
 - - - Estimate

The Long Term Aged (LT-OAS) category consists of legal residents and citizens age 65 and over, residing in a long-term care facility, and determined eligible under the Medically NEEDED program.

The LT-OAS category demonstrates a consistent historically flat trend. Decreases in 2005 to 2006 are believed to be due to updated eligibility tracking systems rather than a programmatic change.

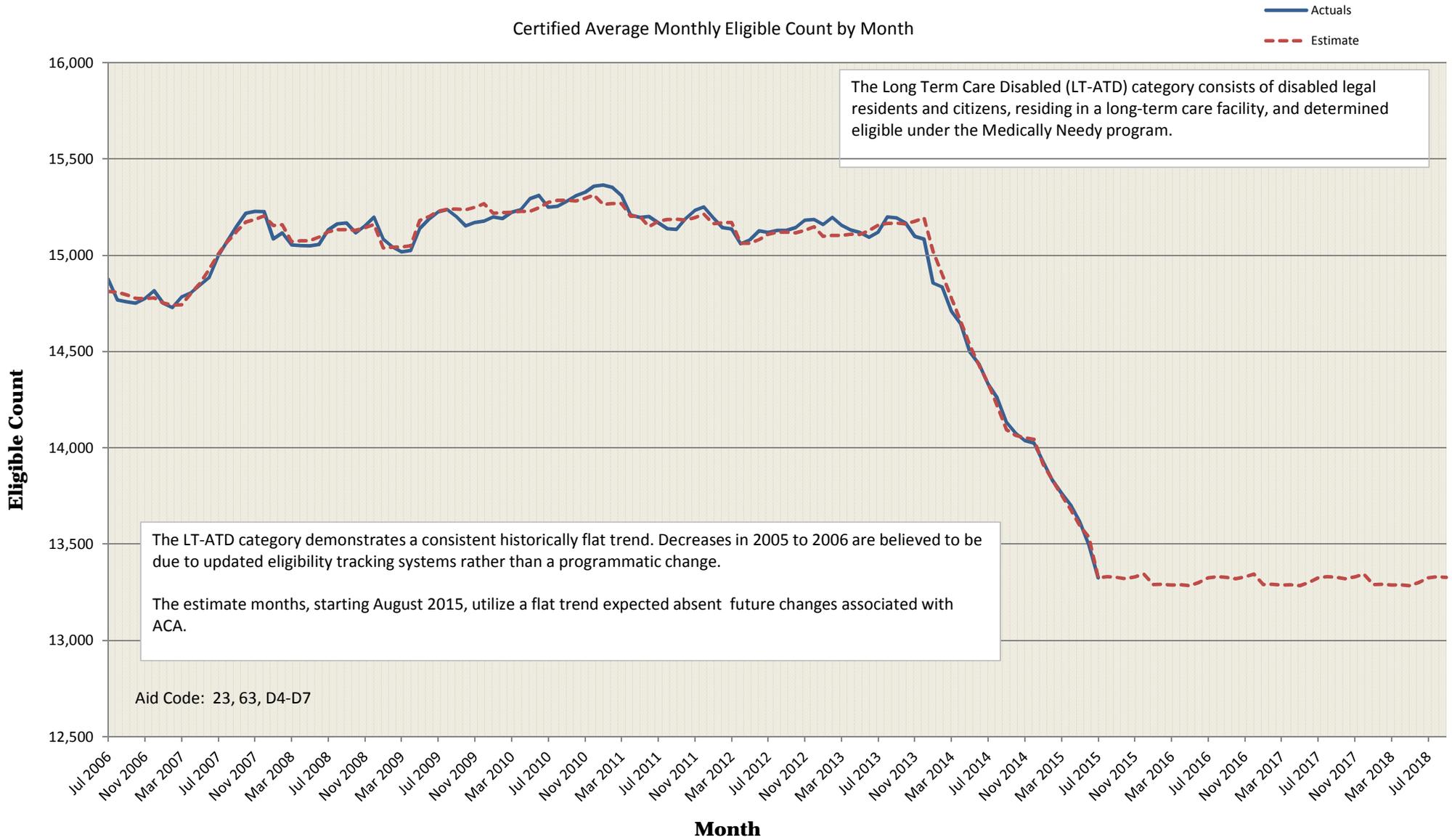
The estimate months, starting August 2015, utilize a flat trend expected absent future changes associated with ACA.

Aid Code: 13, D2,D3



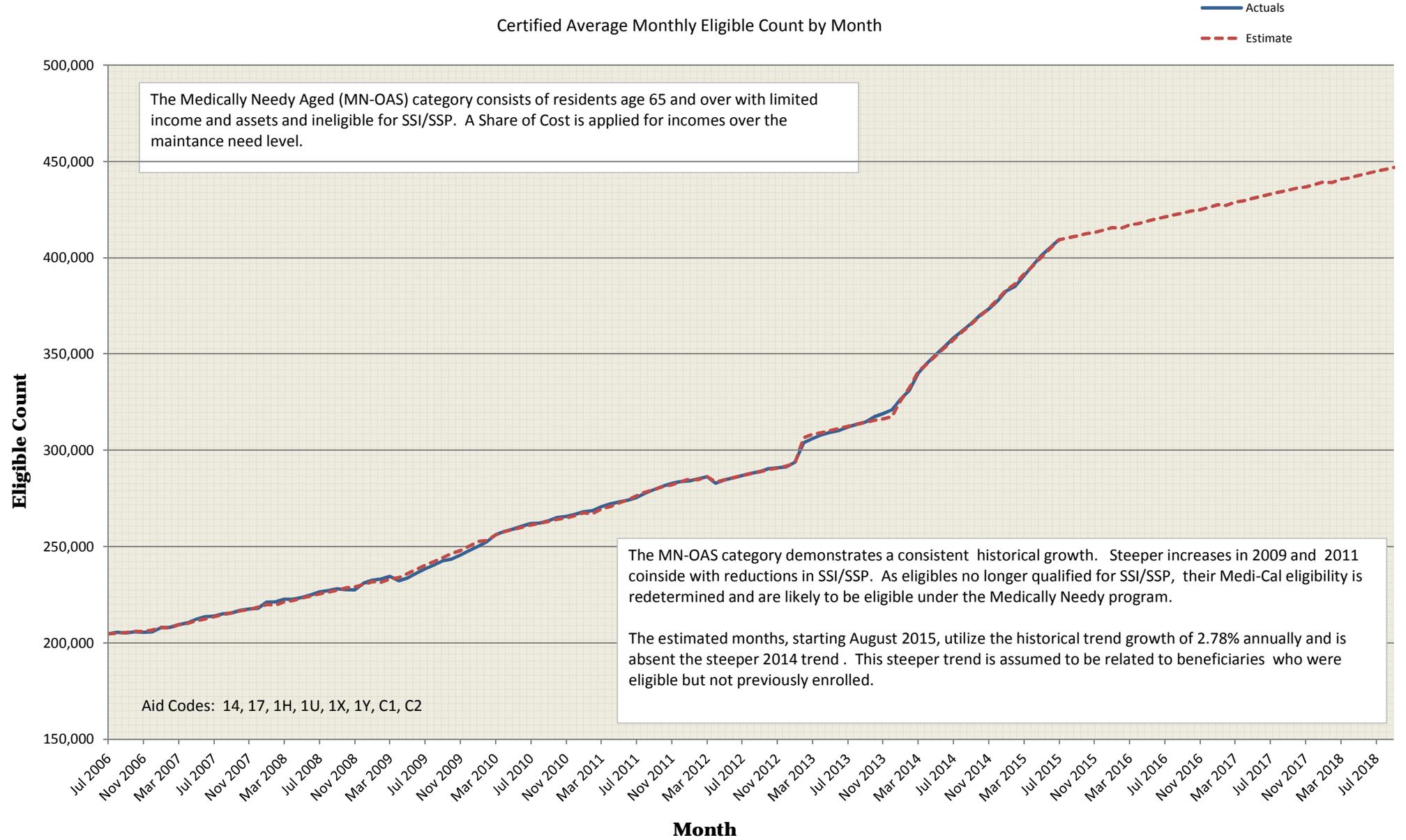
Statewide Expanded Eligible: Long Term Persons with Disabilities (LT-ATD)

Certified Average Monthly Eligible Count by Month



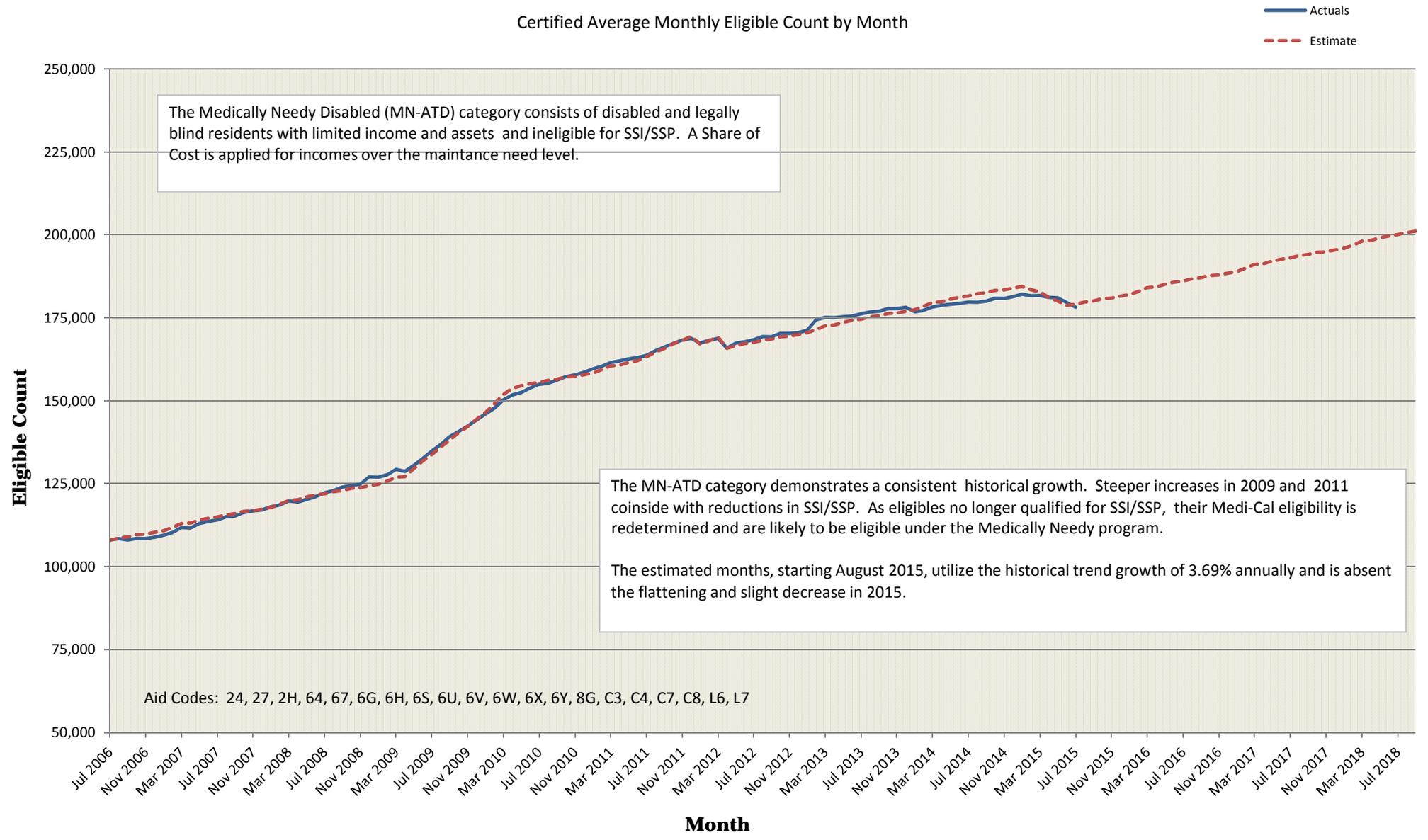
Statewide Expanded Eligible: Medically Needy Seniors (MN-OAS)

Certified Average Monthly Eligible Count by Month



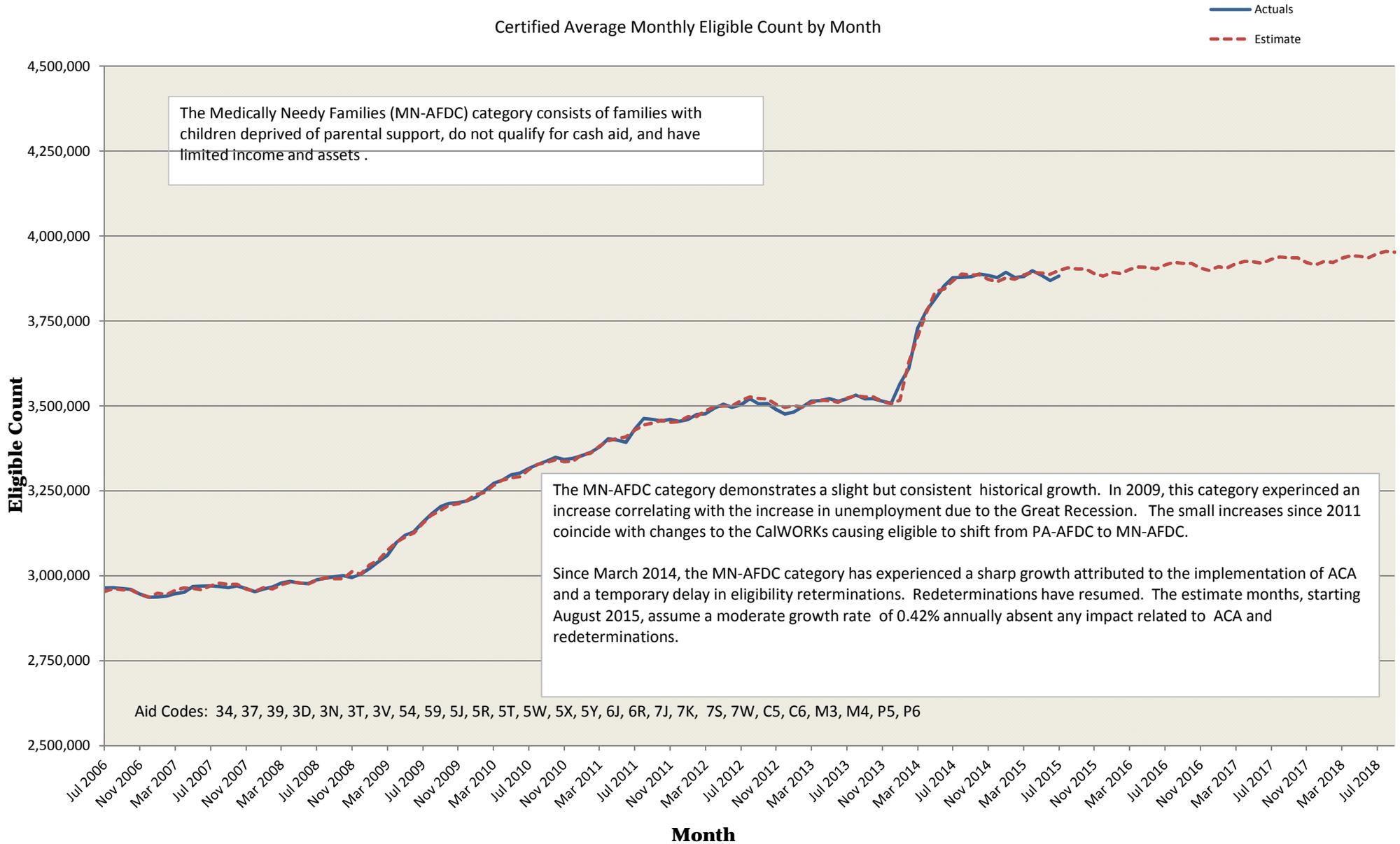
Statewide Expanded Eligible: Medically Needy Persons with Disabilities (MN-ATD)

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Medically Needy Families (MN-AFDC)

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Medically Indigent Children (MI-C)

Certified Average Monthly Eligible Count by Month

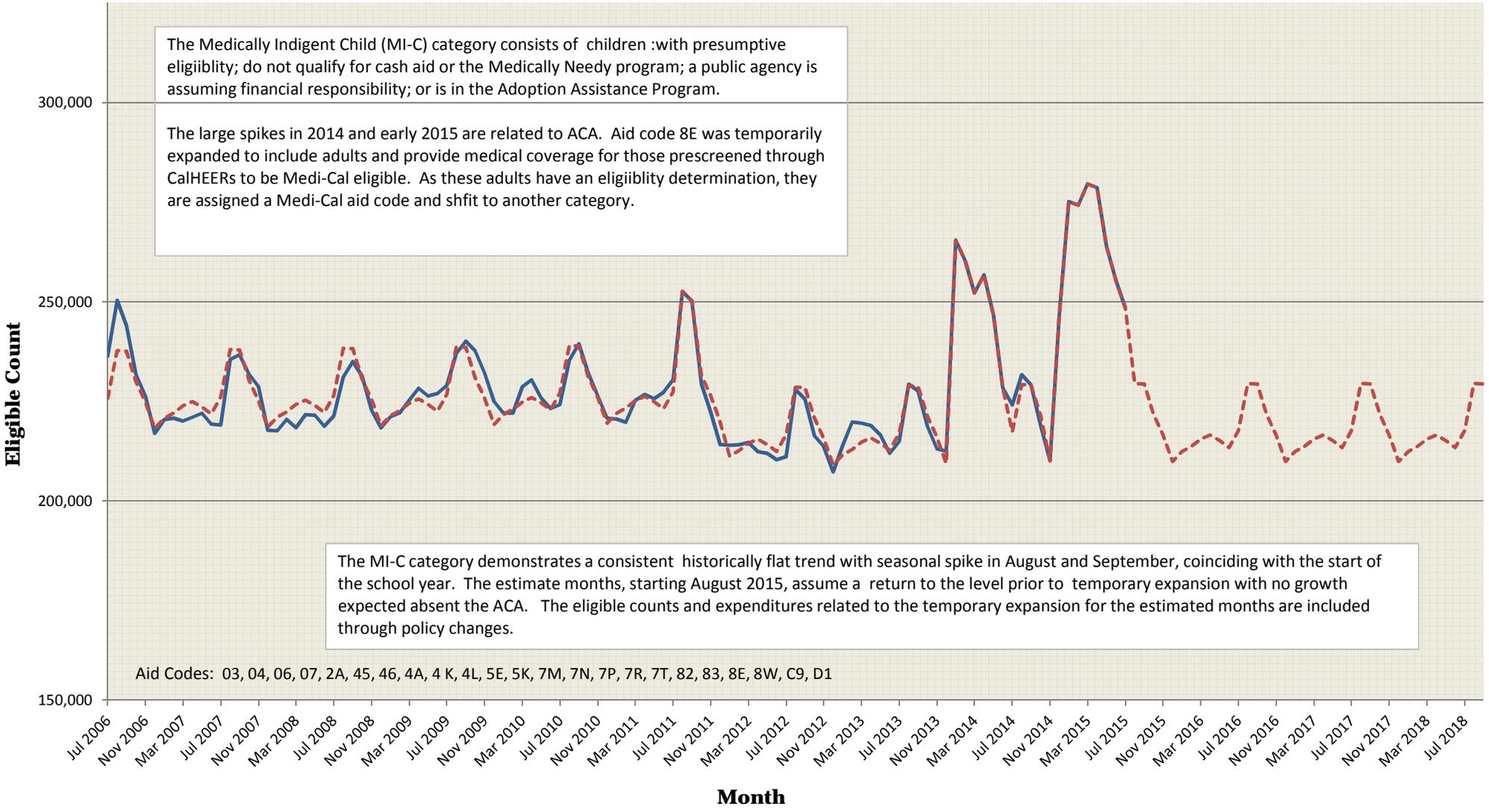
— Actuals
 - - - Estimate

The Medically Indigent Child (MI-C) category consists of children with presumptive eligibility; do not qualify for cash aid or the Medically Needy program; a public agency is assuming financial responsibility; or is in the Adoption Assistance Program.

The large spikes in 2014 and early 2015 are related to ACA. Aid code 8E was temporarily expanded to include adults and provide medical coverage for those prescreened through CalHEERs to be Medi-Cal eligible. As these adults have an eligibility determination, they are assigned a Medi-Cal aid code and shift to another category.

The MI-C category demonstrates a consistent historically flat trend with seasonal spike in August and September, coinciding with the start of the school year. The estimate months, starting August 2015, assume a return to the level prior to temporary expansion with no growth expected absent the ACA. The eligible counts and expenditures related to the temporary expansion for the estimated months are included through policy changes.

Aid Codes: 03, 04, 06, 07, 2A, 45, 46, 4A, 4 K, 4L, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 82, 83, 8E, 8W, C9, D1



Statewide Expanded Eligible: Medically Indigent Adults (MI-A)

Certified Average Monthly Eligible Count by Month

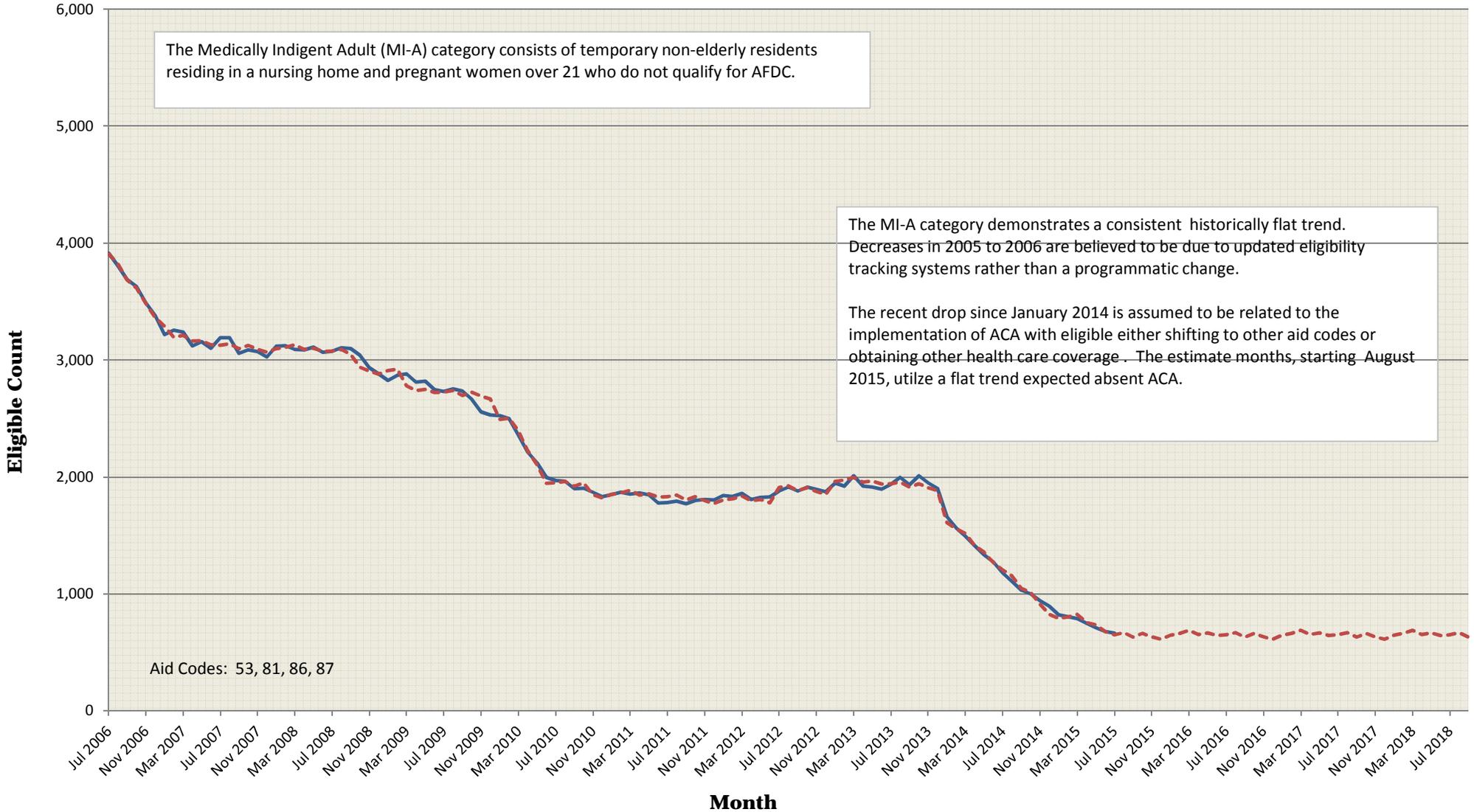
— Actuals
 - - - Estimate

The Medically Indigent Adult (MI-A) category consists of temporary non-elderly residents residing in a nursing home and pregnant women over 21 who do not qualify for AFDC.

The MI-A category demonstrates a consistent historically flat trend. Decreases in 2005 to 2006 are believed to be due to updated eligibility tracking systems rather than a programmatic change.

The recent drop since January 2014 is assumed to be related to the implementation of ACA with eligible either shifting to other aid codes or obtaining other health care coverage. The estimate months, starting August 2015, utilize a flat trend expected absent ACA.

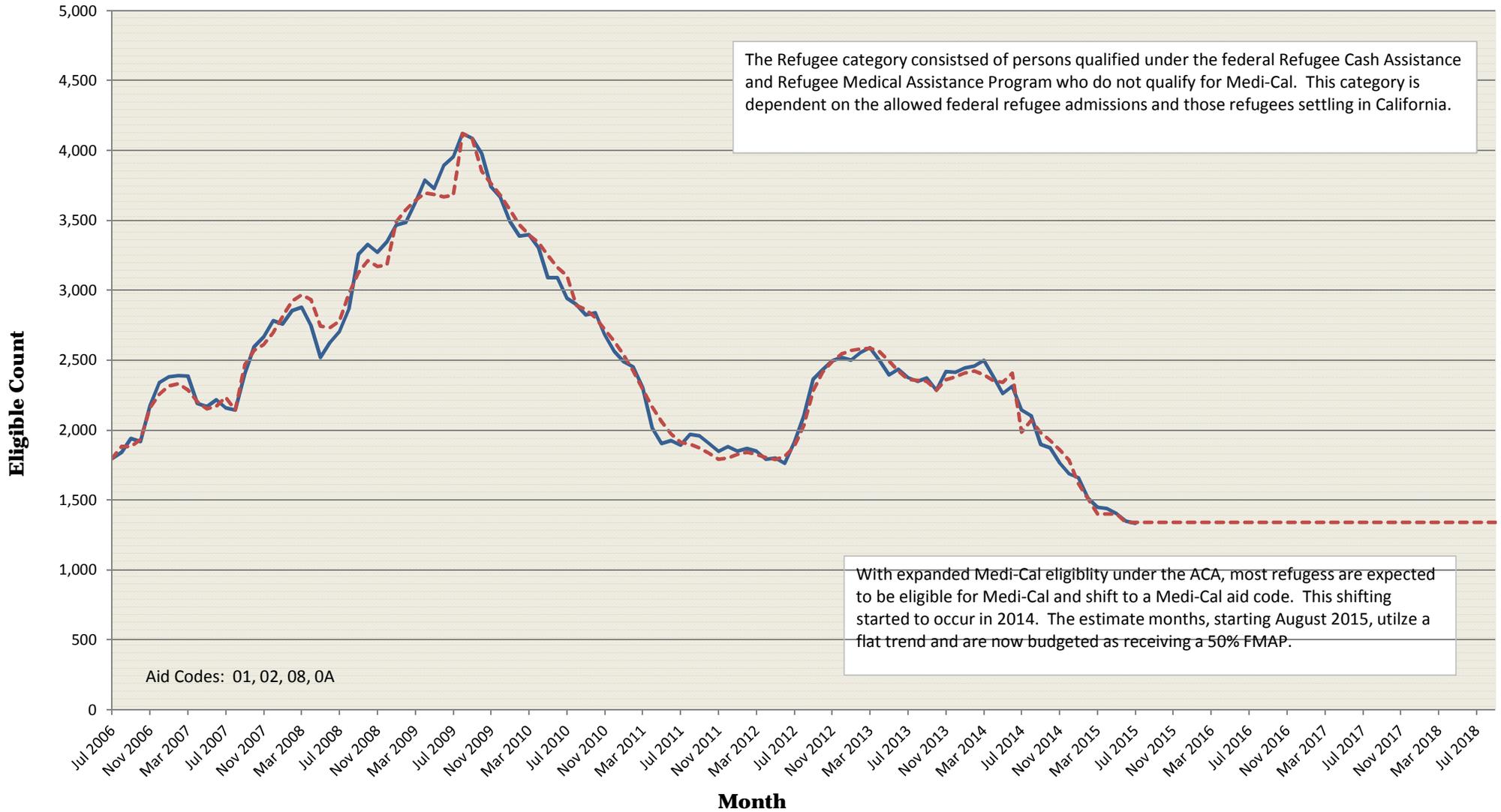
Aid Codes: 53, 81, 86, 87



Statewide Expanded Eligible: Refugee

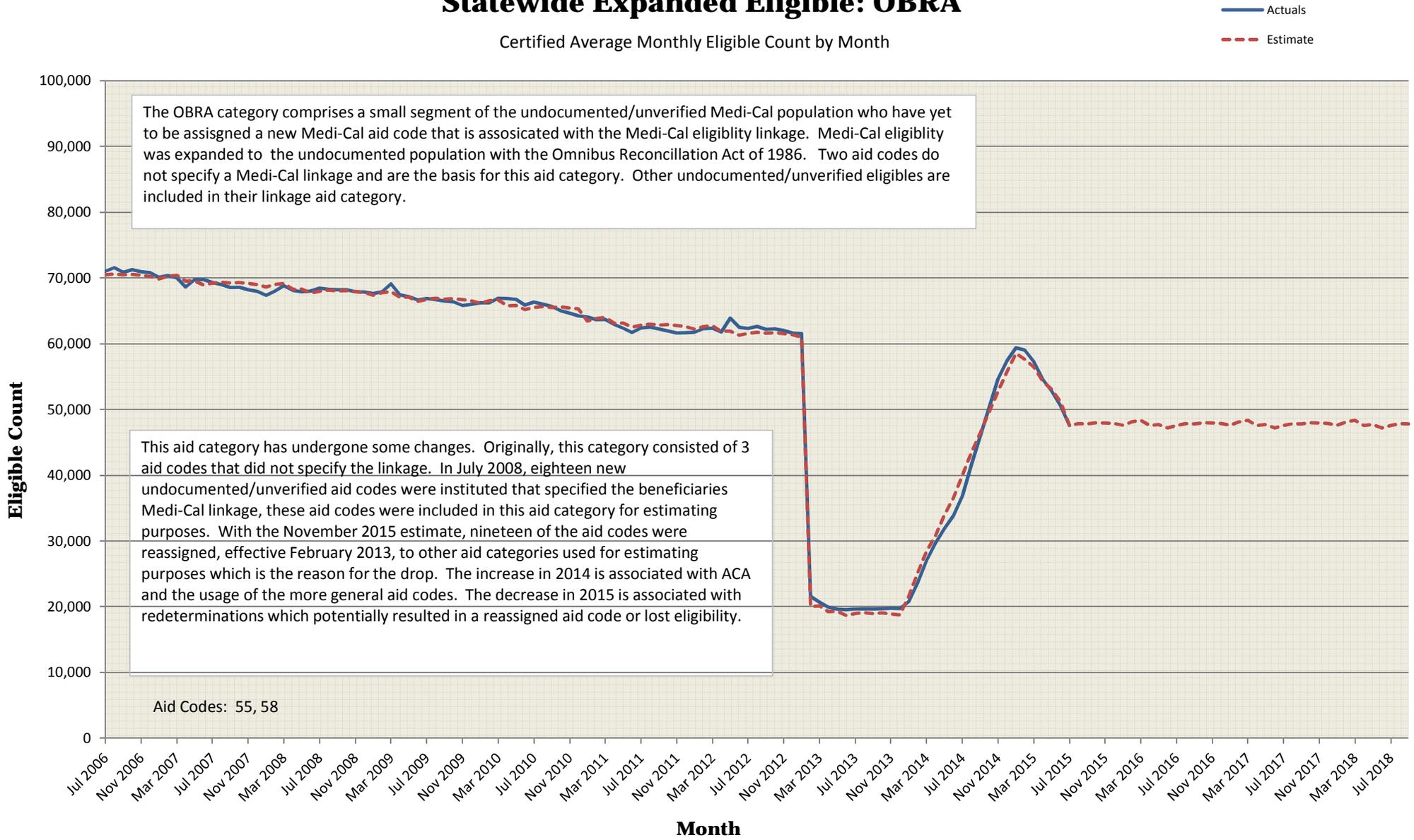
Certified Average Monthly Eligible Count by Month

— Actuals
- - Estimate



Statewide Expanded Eligible: OBRA

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: POV-185

Certified Average Monthly Eligible Count by Month

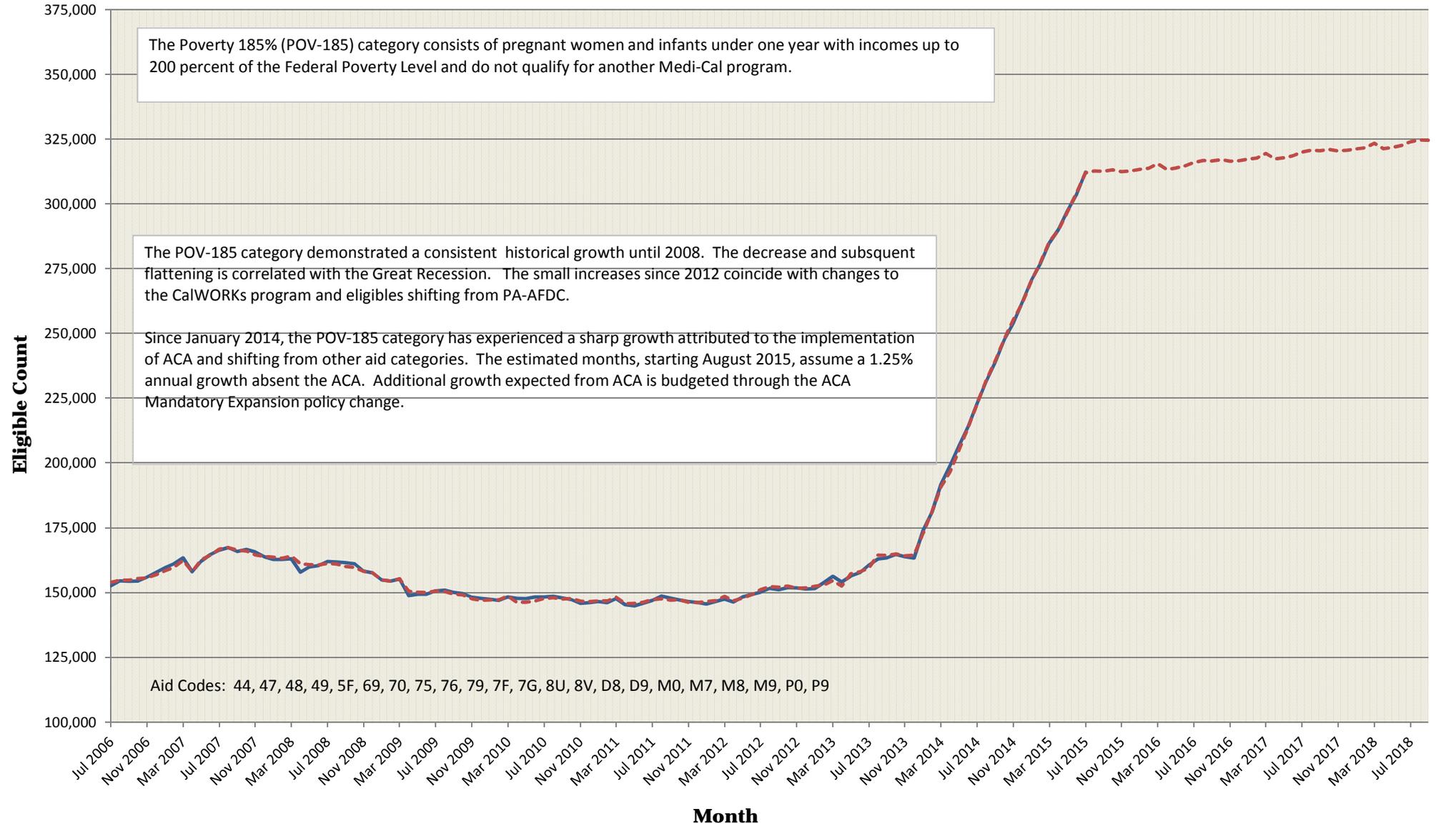
— Actuals
 - - - Estimate

The Poverty 185% (POV-185) category consists of pregnant women and infants under one year with incomes up to 200 percent of the Federal Poverty Level and do not qualify for another Medi-Cal program.

The POV-185 category demonstrated a consistent historical growth until 2008. The decrease and subsequent flattening is correlated with the Great Recession. The small increases since 2012 coincide with changes to the CalWORKs program and eligibles shifting from PA-AFDC.

Since January 2014, the POV-185 category has experienced a sharp growth attributed to the implementation of ACA and shifting from other aid categories. The estimated months, starting August 2015, assume a 1.25% annual growth absent the ACA. Additional growth expected from ACA is budgeted through the ACA Mandatory Expansion policy change.

Aid Codes: 44, 47, 48, 49, 5F, 69, 70, 75, 76, 79, 7F, 7G, 8U, 8V, D8, D9, M0, M7, M8, M9, P0, P9



Statewide Expanded Eligible: POV-133

Certified Average Monthly Eligible Count by Month

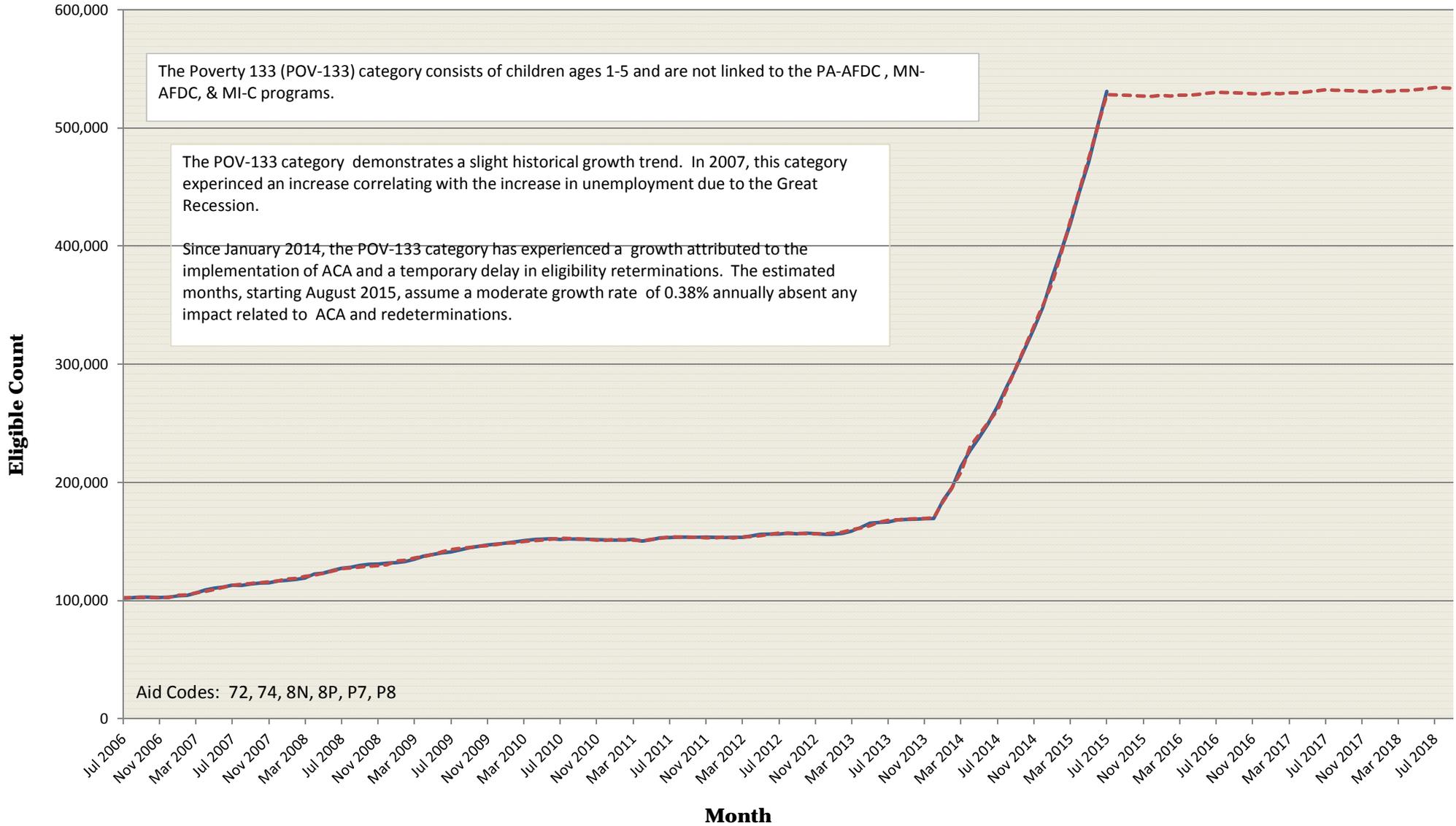
— Actuals
 - - - Estimate

The Poverty 133 (POV-133) category consists of children ages 1-5 and are not linked to the PA-AFDC , MN-AFDC, & MI-C programs.

The POV-133 category demonstrates a slight historical growth trend. In 2007, this category experienced an increase correlating with the increase in unemployment due to the Great Recession.

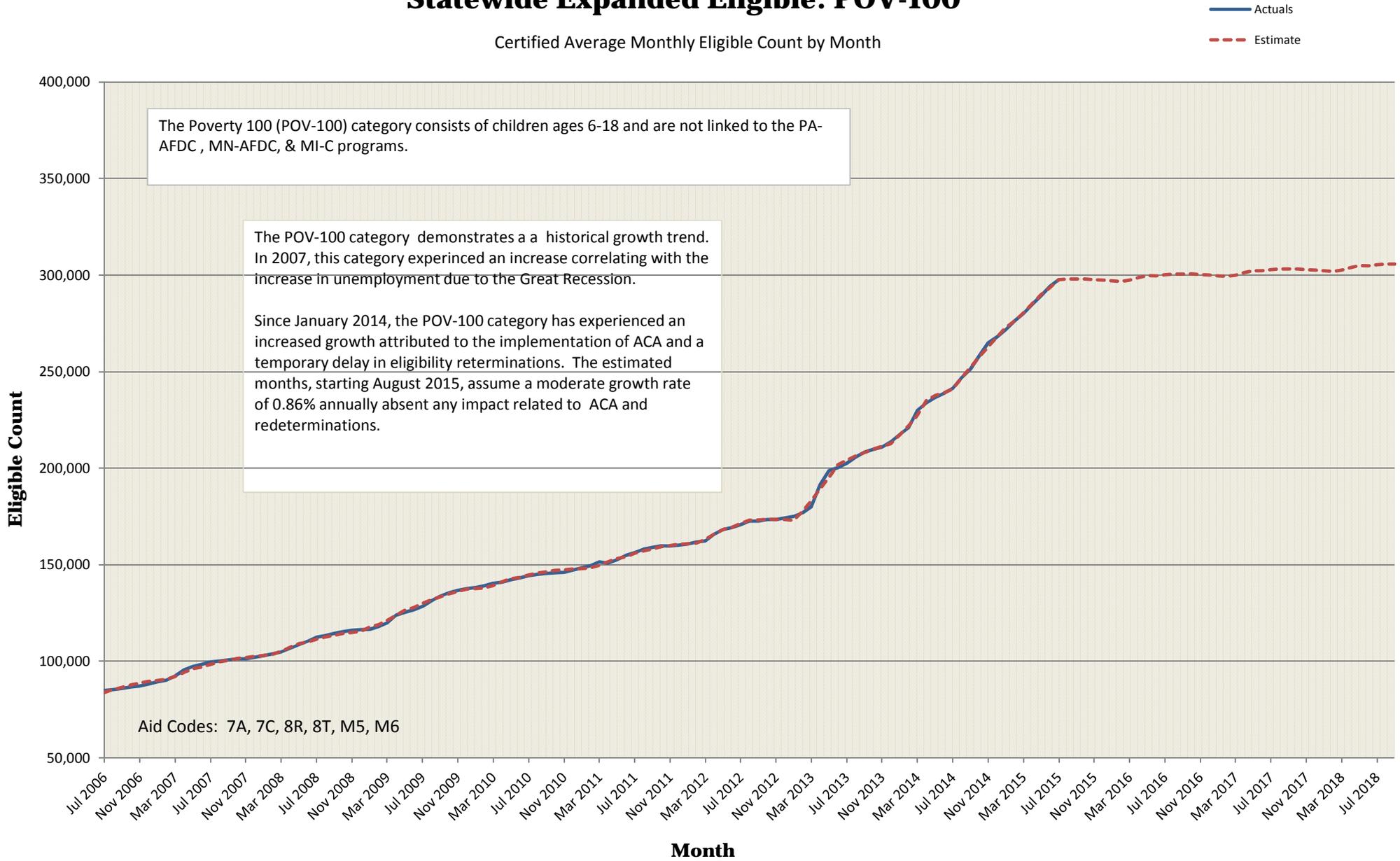
Since January 2014, the POV-133 category has experienced a growth attributed to the implementation of ACA and a temporary delay in eligibility reterminations. The estimated months, starting August 2015, assume a moderate growth rate of 0.38% annually absent any impact related to ACA and redeterminations.

Aid Codes: 72, 74, 8N, 8P, P7, P8



Statewide Expanded Eligible: POV-100

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: POV-250

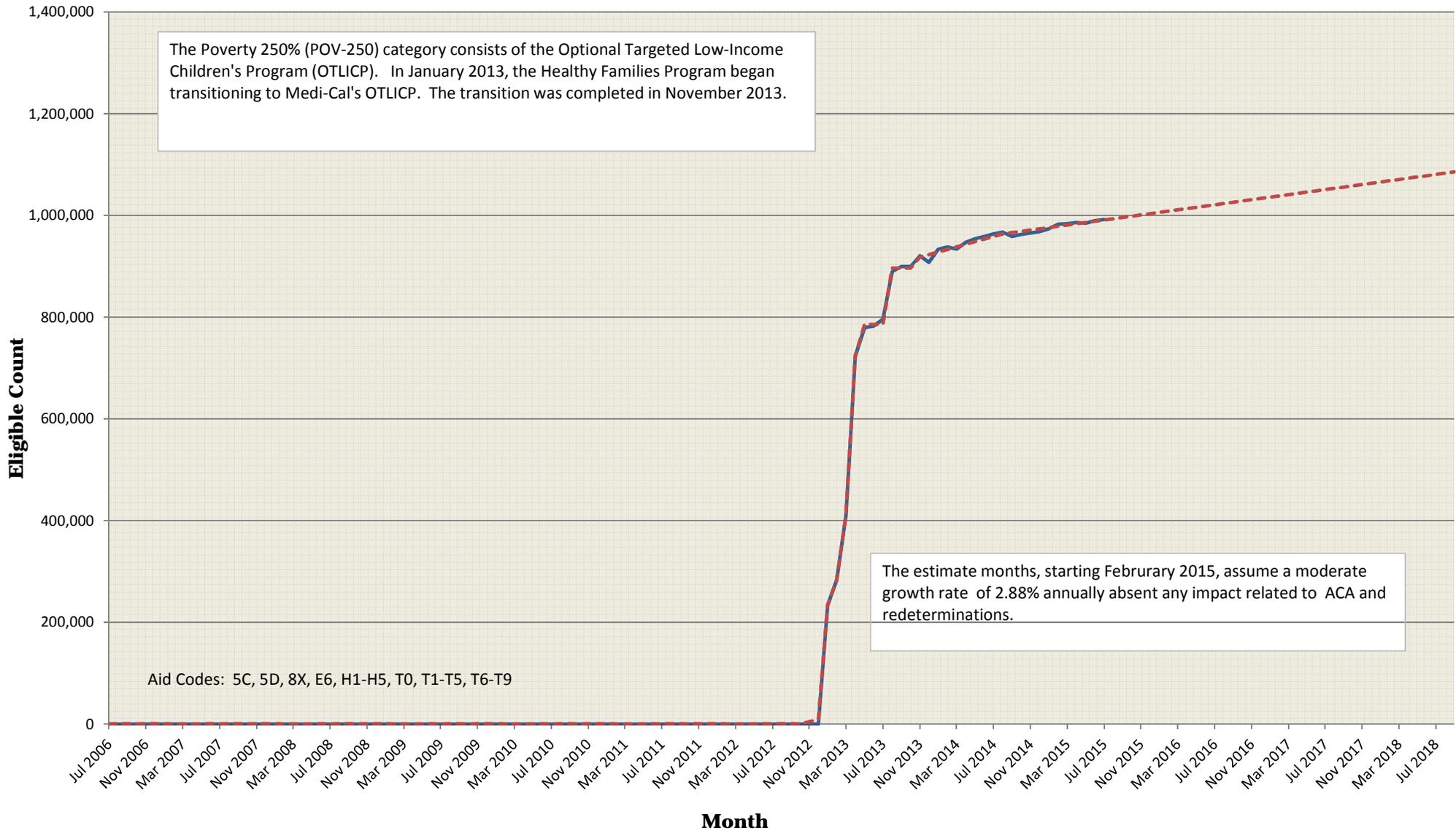
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate

The Poverty 250% (POV-250) category consists of the Optional Targeted Low-Income Children's Program (OTLICP). In January 2013, the Healthy Families Program began transitioning to Medi-Cal's OTLICP. The transition was completed in November 2013.

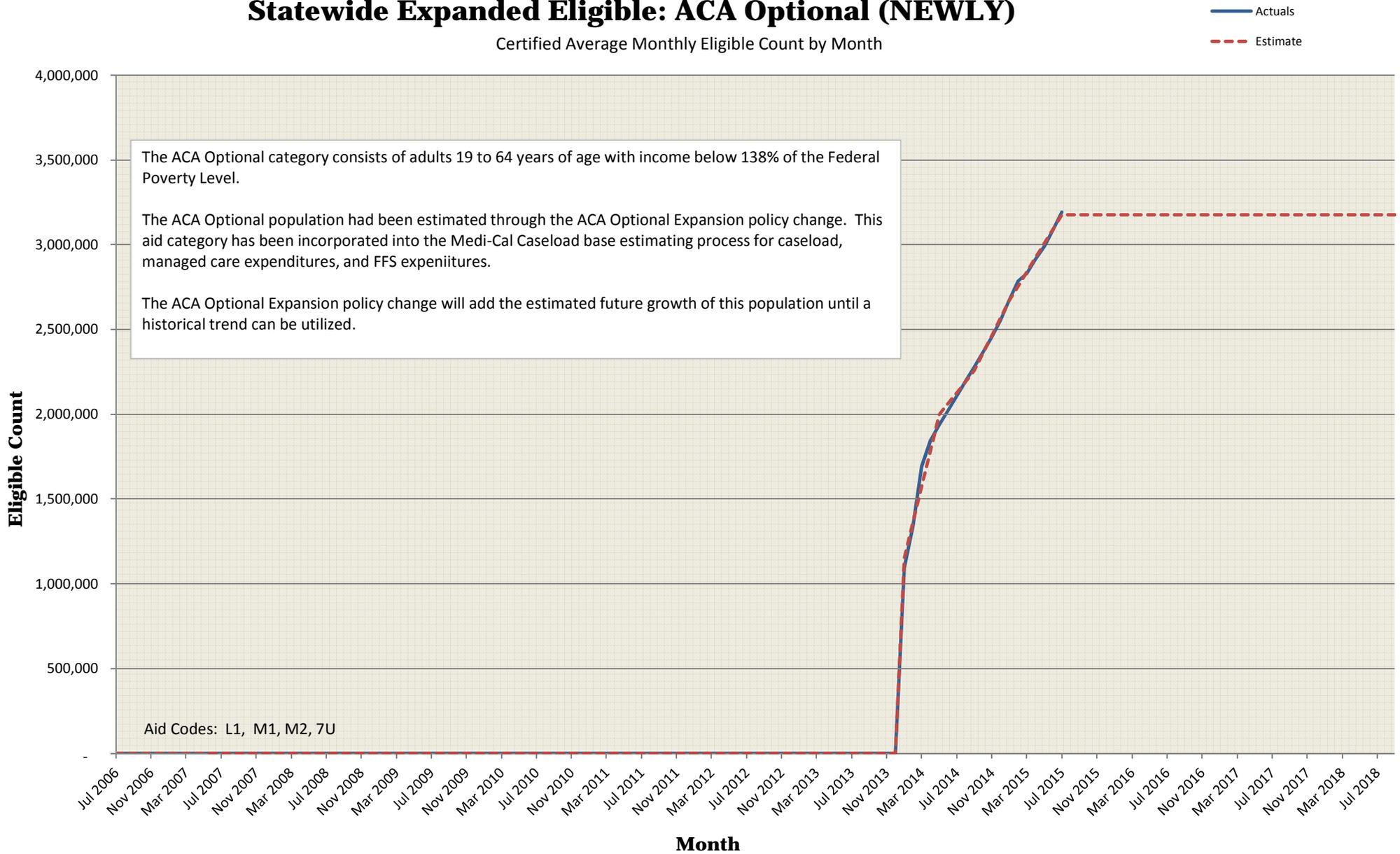
The estimate months, starting February 2015, assume a moderate growth rate of 2.88% annually absent any impact related to ACA and redeterminations.

Aid Codes: 5C, 5D, 8X, E6, H1-H5, T0, T1-T5, T6-T9



Statewide Expanded Eligible: ACA Optional (NEWLY)

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Hospital Presumptive Eligibility (H-PE)

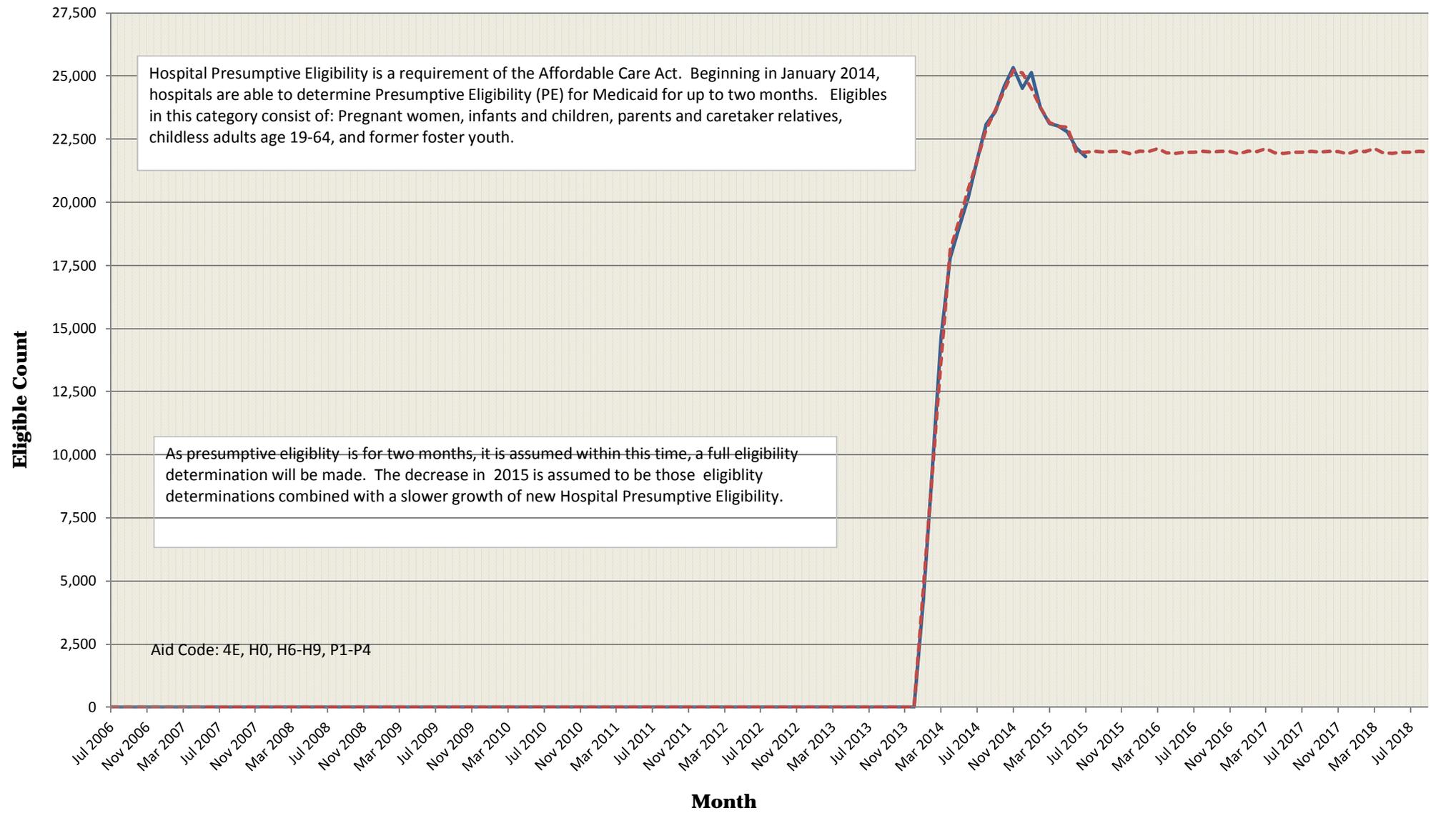
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate

Hospital Presumptive Eligibility is a requirement of the Affordable Care Act. Beginning in January 2014, hospitals are able to determine Presumptive Eligibility (PE) for Medicaid for up to two months. Eligibles in this category consist of: Pregnant women, infants and children, parents and caretaker relatives, childless adults age 19-64, and former foster youth.

As presumptive eligibility is for two months, it is assumed within this time, a full eligibility determination will be made. The decrease in 2015 is assumed to be those eligibility determinations combined with a slower growth of new Hospital Presumptive Eligibility.

Aid Code: 4E, H0, H6-H9, P1-P4



Medi-Cal Fee-For-Service Base Estimate

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

The base expenditure estimate consists of two types. The first type, which has traditionally been called the Fee-for-Service Base (FFS Base) Estimate, is summarized in this section. The FFS Base includes the first 11 service categories (Physicians through Home Health) as displayed in most tables throughout this binder and listed below. The data used for these projections consist of claims that are paid through the main Medi-Cal claims processing system at the Fiscal Intermediary. These claims are paid on a fee-for-service basis.

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

FFS Base Estimate Service Categories:

Physicians
Other Medical
County & Community Outpatient
Pharmacy
County Inpatient
Community Inpatient
Nursing Facilities
Intermediate Care Facilities-Developmentally Disabled (ICF-DD)
Medical Transportation
Other Services
Home Health

With the November 2015 Medi-Cal Estimate, the County Outpatient and Community Outpatient FFS Service Categories were combined into one service category and is now County & Community Outpatient.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2013-14 *	1	1,740,310	4.91	\$179.67	\$882.12	\$4,605,492,300
2013-14 *	2	1,636,680	4.45	\$174.36	\$775.45	\$3,807,509,400
2013-14 *	3	1,783,860	4.18	\$182.50	\$763.09	\$4,083,733,100
2013-14 *	4	1,741,820	3.97	\$183.30	\$727.51	\$3,801,543,600
2013-14 *	TOTAL	1,725,670	4.37	\$179.92	\$787.05	\$16,298,278,400
2014-15 *	1	2,147,740	4.28	\$200.08	\$856.00	\$5,515,409,100
2014-15 *	2	2,023,430	3.75	\$195.70	\$733.26	\$4,451,107,300
2014-15 *	3	2,075,600	3.62	\$202.52	\$733.89	\$4,569,802,800
2014-15 *	4	1,808,410	3.32	\$205.90	\$683.26	\$3,706,853,300
2014-15 *	TOTAL	2,013,800	3.76	\$200.74	\$754.92	\$18,243,172,500
2015-16 **	1	2,103,270	3.64	\$215.40	\$784.25	\$4,948,489,100
2015-16 **	2	2,063,110	3.32	\$209.79	\$697.40	\$4,316,419,000
2015-16 **	3	1,944,210	3.22	\$210.85	\$678.90	\$3,959,765,600
2015-16 **	4	1,835,050	3.33	\$210.34	\$699.69	\$3,851,878,400
2015-16 **	TOTAL	1,986,410	3.38	\$211.76	\$716.39	\$17,076,552,200
2016-17 **	1	2,031,370	3.62	\$216.74	\$785.53	\$4,787,096,800
2016-17 **	2	1,976,460	3.27	\$212.63	\$694.67	\$4,118,950,800
2016-17 **	3	1,999,430	3.34	\$214.10	\$714.65	\$4,286,669,000
2016-17 **	4	1,779,750	3.22	\$213.17	\$686.86	\$3,667,304,200
2016-17 **	TOTAL	1,946,750	3.37	\$214.28	\$721.72	\$16,860,021,000

* ACTUAL

** ESTIMATED

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

Physicians Fee-for-Service Base Estimate

Analyst: Devon Dyer

Background

Physicians include services billed by Physicians (M.D. or D.O) and Physician Group.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2014-15	495,930	--	2.31	--	\$86.82	--	\$1,194,411,500	--
CY	FY 2015-16	427,610	-13.8%	2.20	-4.8%	\$74.61	-14.1%	\$841,957,800	-29.5%
BY	FY 2016-17	416,030	-2.7%	2.18	-0.9%	\$75.54	1.3%	\$822,271,000	-2.3%

Users

Users are estimated to decrease in CY and BY mainly due to the implementation of the CCI shifting seniors and persons with disabilities (SPDs) from Fee-For-Service (FFS) to Managed Care, partially offset by ACA Expansion population increases and offset by payments to the primary care physician (PCP) service rates. ACA required State Medicaid agencies to temporarily increase reimbursement for specific primary care visits to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. In PY, payments related to the PCP rate increase were made for services rendered from January 1, 2013 through December 2014. Nearly all PCP payments were paid in PY and temporarily increased Users and Utilization. CY assumes a return to the historical patterns as the ACA PCP increased reimbursement is complete.

Utilization

Utilization is estimated to decrease by in CY due to the PCP rate increase payments occurred in PY and explained in Users above. No significant changes are projected in BY.

Rate

Physicians' Rate is estimated to decrease in CY. No significant changes are projected in BY. The estimated CY decrease is due the PCP rate increase payments which occurred in PY. The 10% Provider Payment Reduction for Physicians is implemented in January 2014 and decreased rates, however; in March 2014 the PCP rate increase was implemented in Medi-Cal's payment system and temporarily increased rates. The PCP rate increase has ended and rates have returned to the AB97 10% level. As a result, Rate is estimated to decrease from PY to CY.

Total Expenditure

Total expenditure is estimated to decrease by 29.5% in CY and 2.3% in BY. The decreases are mainly due to the implementation of CCI shifting SPDs from FFS to Managed Care and the temporary payments of the ACA required rate increase to PCP services.

Comparison to Prior Estimate

Fiscal Year	Total Expenditures			N15 Total Expenditure wo New Aid Categories	
	M15	N15	% Change	N15	% Change
FY 2014-15	\$870,140,600	\$1,194,411,500	37.3%	\$1,003,685,200	15.4%
FY 2015-16	\$718,474,400	\$841,957,800	17.2%	\$660,190,000	-8.0%

Compared to the May 2015 estimate, the November 2015 estimate is higher by 37.3% and 17.2%, respectively, for FY 2014-15 and FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the November 2015 FFS base expenditure estimate. Absent these two aid categories, the November 2015 estimate would be 15.4% higher than the May 2015 estimate for FY 2014-15. The increase in FY 2014-15 is due to the ACA rate increase retroactive payments occurred in February through June 2015 and were previously budgeted in the Payments to Primary Care Physicians Regular Policy Change. The FY 2015-16 is related to the additional CCI impact incorporated into the estimated expenditure.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

PHYSICIANS

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	481,170	2.25	\$75.84	\$170.32	\$245,851,800
2013-14 *	2	421,280	2.16	\$75.45	\$162.69	\$205,616,100
2013-14 *	3	469,790	2.09	\$69.67	\$145.26	\$204,730,500
2013-14 *	4	429,800	2.11	\$78.58	\$165.56	\$213,470,400
2013-14 *	TOTAL	450,510	2.15	\$74.83	\$160.87	\$869,668,800
2014-15 *	1	546,320	2.31	\$84.52	\$195.48	\$320,385,400
2014-15 *	2	496,730	2.23	\$81.82	\$182.17	\$271,463,000
2014-15 *	3	530,270	2.53	\$102.04	\$258.51	\$411,243,000
2014-15 *	4	410,420	2.13	\$73.07	\$155.38	\$191,320,100
2014-15 *	TOTAL	495,930	2.31	\$86.82	\$200.70	\$1,194,411,500
2015-16 **	1	456,530	2.33	\$75.38	\$175.33	\$240,137,800
2015-16 **	2	422,930	2.20	\$75.40	\$166.23	\$210,917,400
2015-16 **	3	436,000	2.11	\$73.15	\$154.26	\$201,774,900
2015-16 **	4	394,960	2.15	\$74.35	\$159.62	\$189,127,700
2015-16 **	TOTAL	427,610	2.20	\$74.61	\$164.08	\$841,957,800
2016-17 **	1	439,080	2.28	\$77.13	\$175.96	\$231,782,900
2016-17 **	2	396,280	2.17	\$76.69	\$166.67	\$198,143,400
2016-17 **	3	449,630	2.15	\$73.67	\$158.52	\$213,825,200
2016-17 **	4	379,140	2.10	\$74.57	\$156.95	\$178,519,500
2016-17 **	TOTAL	416,030	2.18	\$75.54	\$164.70	\$822,271,000

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Medical Fee-for-Service Base Estimate

Analyst: Joulia Dib

Background

The Other Medical service category consists of twenty-eight provider types. Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are responsible for 75% of expenditures in this category, followed by community clinics with 6%, and clinical labs and chronic dialysis with 5% each. The twenty-eight provider types (not all provider types currently submit claims but are shown for historical purposes) are:

- Audiologist
- Certified Nurse Midwife
- Chiropractor
- Certified Pediatric/Family Nurse Pract.
- Clinical Laboratory
- Group Pediatric/Family Nurse Pract.
- Dispensing Optician
- Nurse Anesthetist
- Occupational Therapist
- Optometrist
- Orthotist
- Optometric Group
- Physical Therapist
- Podiatrist
- Psychologist
- Certified Acupuncturist
- Rural Health Clinic & FQHC
- Employer/Employee Clinic
- Speech Therapist
- Free Clinic
- Community Clinic
- Community Dialysis Center
- Multispecialty Clinic
- Surgical Clinic
- Exempt From Licensure Clinic
- Independent Rehabilitation Facilities
- County Clinic Not Associate With A Hospital
- Birthing Centers-Primary Care Clinic
- Clinic-Otherwise Undesignated
- Outpatient Heroin Detox Center
- Alternative Birthing Center
- Respiratory Care Practitioner
- Health Access Program (Formerly Family PACT)
- Group Respiratory Care Practitioner
- Indian Health Clinic Services
- Licensed Midwife

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2014-15	1,035,010	--	1.57	--	\$144.28	--	\$2,805,172,400	--
CY	FY 2015-16	1,108,990	7.2%	1.55	-1.3%	\$145.30	0.7%	\$2,991,568,600	6.6%
BY	FY 2016-17	1,108,360	-0.1%	1.53	-1.3%	\$145.57	0.2%	\$2,971,754,600	-0.7%

Users

Users are estimated to increase in CY due to growth in the ACA Expansions. No significant changes are projected in BY. FQHC/RHC expenditures estimated in the FFS base include visits for beneficiaries in the FFS and the Managed Care delivery systems. For Medi-Cal beneficiaries enrolled in the Managed Care delivery system, the managed care plan pays a contracted amount to the FQHC/RHC and FFS reimburses the remaining amount up to the facility specific cost-based reimbursement rate. .

Utilization

Utilization is estimated to decrease marginally in CY and BY. This reduction is expected as there are some services provided will shift to the Managed Care delivery systems with the beneficiaries.

Rate

The estimated rate is fairly consistent in CY and BY. The estimate incorporates the July 2014 Los Angeles Cost Based Reimbursement Clinics (LA CBRC) and the October 2014 FQHC/RHC rate increases. CY would have a full year of the rate increase. Future rate increases estimated to occur are shown in the Regular Policy Changes.

Total Expenditure

Estimated expenditures are projected to increase in CY mainly due to the growth in Users from the ACA Expansions. BY is projected to remain relatively stable.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$2,186,412,300	\$2,805,172,400	28.3%	\$2,161,545,000	-1.1%
FY 2015-16	\$2,308,964,300	\$2,991,568,900	29.6%	\$2,292,838,200	-0.7%

The November 2015 estimate is approximately 30% higher in PY and CY than the May 2015 estimate. Two new categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been added to the FFS Base estimated expenditures. Absent these two categories, there is little change from the prior estimate.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

OTHER MEDICAL

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	803,930	1.68	\$156.64	\$263.09	\$634,517,000
2013-14 *	2	741,000	1.62	\$136.83	\$222.04	\$493,594,800
2013-14 *	3	826,880	1.58	\$140.43	\$221.82	\$550,260,000
2013-14 *	4	826,980	1.56	\$139.84	\$217.86	\$540,496,000
2013-14 *	TOTAL	799,700	1.61	\$143.69	\$231.22	\$2,218,867,800
2014-15 *	1	1,090,960	1.65	\$145.53	\$239.67	\$784,417,100
2014-15 *	2	1,027,560	1.55	\$142.34	\$221.20	\$681,889,500
2014-15 *	3	1,065,800	1.53	\$144.55	\$221.84	\$709,296,200
2014-15 *	4	955,740	1.52	\$144.58	\$219.57	\$629,569,700
2014-15 *	TOTAL	1,035,010	1.57	\$144.28	\$225.86	\$2,805,172,400
2015-16 **	1	1,166,750	1.62	\$145.26	\$234.71	\$821,539,000
2015-16 **	2	1,152,600	1.55	\$145.09	\$224.59	\$776,579,900
2015-16 **	3	1,084,850	1.50	\$145.79	\$218.71	\$711,816,400
2015-16 **	4	1,031,740	1.52	\$145.10	\$220.22	\$681,633,600
2015-16 **	TOTAL	1,108,990	1.55	\$145.30	\$224.80	\$2,991,568,900
2016-17 **	1	1,173,740	1.59	\$146.04	\$232.81	\$819,759,600
2016-17 **	2	1,122,920	1.52	\$145.13	\$221.10	\$744,827,700
2016-17 **	3	1,136,600	1.53	\$145.83	\$222.51	\$758,721,300
2016-17 **	4	1,000,170	1.49	\$145.21	\$216.11	\$648,445,900
2016-17 **	TOTAL	1,108,360	1.53	\$145.57	\$223.44	\$2,971,754,600

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background

Outpatient Services are operated by the county or community hospitals providing services that do not require an overnight stay. As of the November 2015 Estimate, County and Community Outpatient were combined.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2014-15	280,450	--	1.58	--	\$107.68	--	\$571,067,600	--
CY	FY 2015-16	265,820	-5.2%	1.51	-4.4%	\$126.22	17.2%	\$609,110,900	6.7%
BY	FY 2016-17	261,110	-1.8%	1.50	-0.7%	\$125.23	-0.8%	\$589,801,900	-3.2%

Users

The estimated User decrease for CY and BY is due to CCI transitioning Seniors and Persons with Disabilities (SPDs) to Managed Care along with a retroactive claims reprocessing adjustment occurring in PY. This adjustment reprocessed crossover claims that had been incorrectly denied and temporarily increased the user count. A beneficiary with Medicare and Medi-Cal eligibility, Medicare is the first payer. If the Medi-Cal reimbursement is higher than the Medicare payment, Medi-Cal reimburses the provider the difference; this is known as a crossover claim.

Utilization

Utilization is estimated to decrease in CY. This decrease is related to the PY reprocessing of the crossover claims previously denied. This reprocessing temporarily increased the utilization in PY. CY returns to a normalized utilization and BY is projected to remain stable.

Rate

Rate is estimated to increase in CY as the reprocessing of the crossover claims caused a temporarily lower rate in PY. Since Medi-Cal only pays the difference between the Medicare reimbursement and the Medi-Cal reimbursement, crossover claims are less expensive than a non-crossover claim. CY returns to a normalized rate and is projected to remain stable in BY.

Total Expenditures

Total expenditure is estimated to increase from PY to CY as the crossover reprocessing is projected to be complete as utilization and rates return to a normal level. BY decreases slightly due to the CCI eligibles moving to the managed care delivery system.

Reason for Change from Prior Estimate:

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$426,000,200	\$571,067,600	34.1%	\$434,899,200	2.1%
FY 2015-16	\$424,998,100	\$609,110,900	43.3%	\$451,740,000	6.3%

Compared to the May 2015 Estimate, the November 2015 Estimate is higher by 34.1% for FY 2014-15 and 43.3% for FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the November 2015 estimated expenditures. Absent these two aid categories, the November 2015 estimate would be higher than the May 2015 Estimate by 2.1% for FY 2014-15 and 6.3% in FY 2015-16. The November 2015 Estimate has additional months of expenditures representing a return to more normal utilization and rates.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

CO. & COMM. OUTPATIENT

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	264,640	1.61	\$116.35	\$187.71	\$149,027,100
2013-14 *	2	251,740	1.58	\$95.81	\$151.76	\$114,613,400
2013-14 *	3	233,240	1.56	\$104.30	\$163.09	\$114,112,200
2013-14 *	4	244,050	1.56	\$102.74	\$160.78	\$117,713,100
2013-14 *	TOTAL	248,420	1.58	\$105.04	\$166.21	\$495,465,800
2014-15 *	1	350,920	1.67	\$97.15	\$162.69	\$171,271,800
2014-15 *	2	281,960	1.61	\$98.48	\$158.25	\$133,857,300
2014-15 *	3	256,170	1.49	\$124.53	\$186.00	\$142,941,600
2014-15 *	4	232,740	1.48	\$119.04	\$176.16	\$122,996,900
2014-15 *	TOTAL	280,450	1.58	\$107.68	\$169.69	\$571,067,600
2015-16 **	1	292,700	1.57	\$132.05	\$206.93	\$181,709,500
2015-16 **	2	286,500	1.52	\$123.82	\$188.56	\$162,063,800
2015-16 **	3	244,520	1.46	\$125.26	\$183.32	\$134,469,900
2015-16 **	4	239,560	1.49	\$122.61	\$182.09	\$130,867,800
2015-16 **	TOTAL	265,820	1.51	\$126.22	\$190.95	\$609,110,900
2016-17 **	1	286,690	1.55	\$128.38	\$199.05	\$171,193,900
2016-17 **	2	272,270	1.50	\$123.92	\$186.37	\$152,229,500
2016-17 **	3	257,640	1.48	\$125.27	\$185.91	\$143,692,300
2016-17 **	4	227,840	1.46	\$122.58	\$179.49	\$122,686,300
2016-17 **	TOTAL	261,110	1.50	\$125.23	\$188.24	\$589,801,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Pharmacy Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

Background

Pharmacy consists of the following service types provided by pharmacies: Prescribed Drugs, Medical Supplies, and Drug Medical Equipment.

Fiscal Year		Users		Utilization (Prescriptions per User)		Rate (Dollar per Prescription)		Total Expenditure	
PY	FY 2014-15	560,830	--	2.96	--	\$167.36	--	\$3,336,647,100	----
CY	FY 2015-16	496,930	-11.4%	2.93	-1.0%	\$206.87	23.6%	\$3,613,201,600	8.3%
BY	FY 2016-17	489,535	-1.5%	2.89	-1.4%	\$221.97	7.3%	\$3,765,208,100	4.2%

Users

The estimated User decreases in CY and BY are mainly due to the implementation of Coordinated Care Initiative (CCI) shifting Seniors and Persons with Disabilities (SPDs) from Fee-For-Service (FFS) to Managed Care and, partially offset by the ACA Expansion population increases.

Utilization

The estimated Utilization is projected to remain relatively stable.

Rate

The estimated Rate increases in CY and BY are related to CCI and a historical rate growth. Under the Managed Care delivery system, some prescribed drugs are carved out of the managed care capitation rate and are paid through FFS. These carve out prescribed drugs vary within the managed care plans. When beneficiaries shift from FFS to the Managed Care delivery system some prescribed drugs and other pharmacy expenditures shift to the managed care delivery system while others remain in the FFS system. On average the carved-out drugs are more expensive per prescription than those shifting to the Managed Care delivery system. The estimated rate also projects a historical rate increase absent a change in policy.

Total Expenditure

The total estimated expenditure is projected to increase year over year. The estimated increase in total expenditure is attributed to the increase in the ACA population experienced from PY to CY. The projected increase from CY to BY is mainly attributed to the historical increase in pharmacy costs.

Reasons for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$2,514,408,300	\$3,336,647,100	32.7%	\$2,660,083,000	5.8%
FY 2015-16	\$2,520,121,800	\$3,613,201,600	43.4%	\$2,715,590,200	7.8%

Compared to the May 2015 estimate, the November 2015 estimate is higher by 32.7% and 43.4%, respectively, for FY 2014-15 and FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into then estimated expenditures with the November 2015 estimate. Absent these two aid categories, the November 2015 estimate is still higher than projected in the May 2015 Estimate. These increases can be attributed to higher FFS users than previously estimated.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

PHARMACY

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	621,950	3.22	\$117.10	\$377.62	\$704,586,200
2013-14 *	2	543,530	2.99	\$121.62	\$363.56	\$592,812,000
2013-14 *	3	589,010	2.91	\$135.01	\$392.51	\$693,566,700
2013-14 *	4	541,220	2.94	\$133.35	\$391.98	\$636,428,900
2013-14 *	TOTAL	573,920	3.02	\$126.31	\$381.50	\$2,627,393,700
2014-15 *	1	639,240	3.21	\$148.65	\$477.92	\$916,511,100
2014-15 *	2	579,450	2.89	\$163.55	\$471.94	\$820,392,500
2014-15 *	3	557,430	2.87	\$176.83	\$506.68	\$847,307,900
2014-15 *	4	467,210	2.83	\$189.82	\$536.83	\$752,435,600
2014-15 *	TOTAL	560,830	2.96	\$167.36	\$495.79	\$3,336,647,100
2015-16 **	1	521,750	3.17	\$203.83	\$646.37	\$1,011,735,800
2015-16 **	2	514,160	2.91	\$203.57	\$592.50	\$913,920,700
2015-16 **	3	488,520	2.77	\$208.22	\$576.41	\$844,761,500
2015-16 **	4	463,290	2.85	\$213.05	\$606.38	\$842,783,600
2015-16 **	TOTAL	496,930	2.93	\$206.87	\$605.92	\$3,613,201,600
2016-17 **	1	516,260	3.09	\$218.19	\$673.46	\$1,043,025,500
2016-17 **	2	492,520	2.84	\$219.24	\$621.69	\$918,572,400
2016-17 **	3	507,350	2.85	\$223.10	\$635.70	\$967,573,500
2016-17 **	4	442,010	2.76	\$228.71	\$630.48	\$836,036,600
2016-17 **	TOTAL	489,530	2.89	\$221.97	\$640.95	\$3,765,208,100

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of prescriptions

County Inpatient Fee-for-Service Base Estimate

Analyst: Grace Liu

Background

County Inpatient includes acute inpatient services rendered by county hospitals. A county hospital is a not-for-profit public hospital operated and supported by the county. This service category consists mostly of Designated Public Hospitals (DPHs). DPHs receive annual rate increases in July to reflect an increase in hospital costs.

Fiscal Year		Users		Utilization (Days per User)		Rate (Dollar per Day)		Total Expenditure	
PY	FY 2014-15	6,280	--	5.55	--	\$2,199.03	--	\$919,732,900	--
CY	FY 2015-16	5,870	-6.5%	5.47	-1.4%	\$2,427.60	10.4%	\$935,708,400	1.7%
BY	FY 2016-17	5,630	-4.1%	5.40	-1.3%	\$2,462.22	1.4%	\$899,513,900	-3.9%

Users

The estimated User decreases in CY and BY are primarily due to the implementation of Coordinated Care Initiative (CCI) shifting Seniors and Persons with Disabilities (SPDs) from Fee-For-Service (FFS) to Managed Care, partially offset by ACA Expansion population increases.

Utilization

Utilization is estimated to decrease moderately in CY and BY.

Rate

Rate is estimated to increase in CY, related to the FY 2014-15 DPH interim rate increase of 9.0% implemented in July 2014. CY incorporates a full year of the rate increase. BY is projected to remain stable. The FY 2015-16 rate increase is estimated in the MH/UCD & BTR – DPH Interim Rate Growth Regular Policy Change.

Total Expenditure

Total expenditure is estimated to increase by 1.7% in CY, related to the estimated Rate increase, partially offset by the estimated decreases in Users and Utilization. Total expenditure is estimated to decrease by 3.9% in BY, which is mainly shown in SPDs aid categories due to the CCI impact shifting SPDs from FFS to Managed Care.

Reason for Change From Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$554,017,700	\$919,732,900	66.0%	\$486,880,400	-12.1%
FY 2015-16	\$578,117,900	\$935,708,400	61.9%	\$403,482,200	-30.2%

Compared to the May 2015 estimate, the November 2015 estimate is higher by 66.0% and 62.0%, respectively, for FY 2014-15 and FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the November 2015 FFS Base expenditure estimate. Without these two aid categories, the November 2015 expenditure estimate would be lower than the May 2015 estimate by 12.1% and 30.2%, respectively, for FY 2014-15 and FY 2015-16 as CCI continues to be incorporated.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

COUNTY INPATIENT

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	4,740	5.36	\$1,640.27	\$8,787.45	\$124,983,900
2013-14 *	2	4,530	5.31	\$1,620.57	\$8,602.67	\$117,013,600
2013-14 *	3	4,790	5.73	\$1,680.01	\$9,633.49	\$138,519,900
2013-14 *	4	5,230	5.05	\$1,826.49	\$9,229.00	\$144,876,900
2013-14 *	TOTAL	4,830	5.36	\$1,693.87	\$9,073.85	\$525,394,300
2014-15 *	1	7,890	5.61	\$2,007.13	\$11,252.27	\$266,195,100
2014-15 *	2	6,050	5.66	\$2,239.01	\$12,674.44	\$229,977,800
2014-15 *	3	5,660	5.45	\$2,303.69	\$12,556.15	\$213,153,200
2014-15 *	4	5,530	5.45	\$2,328.08	\$12,690.40	\$210,406,900
2014-15 *	TOTAL	6,280	5.55	\$2,199.03	\$12,204.85	\$919,732,900
2015-16 **	1	6,680	5.58	\$2,387.72	\$13,326.02	\$266,871,000
2015-16 **	2	5,910	5.49	\$2,397.69	\$13,167.51	\$233,656,000
2015-16 **	3	5,350	5.47	\$2,464.91	\$13,479.73	\$216,285,800
2015-16 **	4	5,560	5.31	\$2,473.91	\$13,130.69	\$218,895,600
2015-16 **	TOTAL	5,870	5.47	\$2,427.60	\$13,274.91	\$935,708,400
2016-17 **	1	6,190	5.44	\$2,449.76	\$13,317.26	\$247,172,600
2016-17 **	2	5,430	5.43	\$2,452.72	\$13,325.54	\$216,884,100
2016-17 **	3	5,700	5.44	\$2,454.51	\$13,361.22	\$228,519,000
2016-17 **	4	5,220	5.29	\$2,496.17	\$13,212.47	\$206,938,200
2016-17 **	TOTAL	5,630	5.40	\$2,462.22	\$13,306.10	\$899,513,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Community Inpatient Fee-for-Service Base Estimate

Analyst: Grace Liu

Background

Community Inpatient includes acute inpatient services rendered by community-based hospitals. This service category consists of private hospitals, Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs). Private hospitals and NDPHs are subject to the Diagnosis Related Group (DRG) payment methodology.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2014-15	42,270	--	4.32	--	\$2,017.53	--	\$4,419,153,400	--
CY	FY 2015-16	36,460	-13.7%	4.76	10.2%	\$2,007.36	-0.5%	\$4,181,433,900	-5.4%
BY	FY 2016-17	35,290	-3.2%	4.76	0%	\$2,002.63	-0.2%	\$4,038,520,600	-3.4%

Users

The estimated User decreases in CY and BY are primarily due to the implementation of the Coordinated Care Initiative (CCI) shifting seniors and persons with disabilities (SPDs) from Fee-For-Service (FFS) to Managed Care, partially offset by the ACA Expansion population increases.

Utilization

The estimated Utilization increase in CY is attributed to the CCI impact on SPD aid categories and the DRG impact on Family aid categories. Utilization is projected to remain unchanged in BY. With the CCI, SPDs have shifted over to the managed care delivery systems. This population consists of those beneficiaries with Medicare and Medi-Cal eligibility. For the dual eligible population, their inpatient claims are paid by Medicare. If the Medi-Cal reimbursement is higher than the Medicare payment, Medi-Cal reimburses the provider the difference; this is known as a crossover claim. While the dual eligibles users are counted, their crossover claims are not included as an inpatient day stay for estimating purposes. Less users with a zero (0) inpatient day stay results in a higher utilization for Community Inpatient SPD aid categories. The DRG affected Family aid categories involving pregnancy service by increasing Utilization. Under DRG, the mother and baby are billed on separate claims for deliveries. Because the baby's claim uses their mother's identification number, Users would be unchanged, and Utilization (Days per User) would increase.

Rate

The estimated Rate is projected to fairly consistent in CY and BY.

Total Expenditure

Total expenditure is estimated to decrease by 5.4% and 3.4%, respectively, in CY and BY. The decreases are mainly due to the CCI impact shifting SPDs from FFS to Managed Care.

Reason for Change From Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$3,395,696,900	\$4,419,153,400	3.0%	\$3,228,461,200	-4.9%
FY 2015-16	\$3,453,091,300	\$4,181,433,900	21.1%	\$2,818,648,000	-18.4%

Compared to the May 2015 estimate, the November 2015 estimate is higher by 3.0% and 21.1%, respectively, for FY 2014-15 and FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the estimated expenditures with the November 2015 estimate. Without these two aid categories, the November 2015 estimate would be lower than the May 2015 estimate by 4.9% and 18.4%, respectively, for FY 2014-15 and FY 2015-16 as the CCI eligibles shift to managed care has been incorporated into the estimated expenditures

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

COMMUNITY INPATIENT

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	47,080	3.73	\$1,937.94	\$7,235.75	\$1,021,912,800
2013-14 *	2	42,510	3.62	\$1,847.91	\$6,691.33	\$853,378,200
2013-14 *	3	44,370	3.93	\$1,917.42	\$7,544.48	\$1,004,178,200
2013-14 *	4	40,720	3.89	\$2,019.37	\$7,850.54	\$959,030,200
2013-14 *	TOTAL	43,670	3.79	\$1,931.07	\$7,324.99	\$3,838,499,500
2014-15 *	1	50,740	4.31	\$2,027.55	\$8,742.57	\$1,330,811,200
2014-15 *	2	41,520	4.18	\$2,034.25	\$8,501.81	\$1,059,045,300
2014-15 *	3	41,360	4.34	\$1,999.68	\$8,688.56	\$1,078,024,600
2014-15 *	4	35,460	4.46	\$2,005.61	\$8,943.39	\$951,272,400
2014-15 *	TOTAL	42,270	4.32	\$2,017.53	\$8,712.34	\$4,419,153,400
2015-16 **	1	41,350	4.86	\$2,035.64	\$9,901.24	\$1,228,306,700
2015-16 **	2	36,610	4.72	\$1,987.21	\$9,388.20	\$1,030,983,200
2015-16 **	3	34,400	4.75	\$1,990.67	\$9,462.30	\$976,558,900
2015-16 **	4	33,500	4.68	\$2,010.71	\$9,408.71	\$945,585,100
2015-16 **	TOTAL	36,460	4.76	\$2,007.36	\$9,555.84	\$4,181,433,900
2016-17 **	1	39,360	4.81	\$2,015.17	\$9,694.98	\$1,144,816,700
2016-17 **	2	33,760	4.79	\$1,989.19	\$9,523.54	\$964,497,100
2016-17 **	3	36,680	4.74	\$1,990.53	\$9,427.13	\$1,037,432,600
2016-17 **	4	31,360	4.70	\$2,015.52	\$9,478.18	\$891,774,300
2016-17 **	TOTAL	35,290	4.76	\$2,002.63	\$9,536.21	\$4,038,520,600

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Nursing Facilities Fee-for-Service Base Estimate

Analyst: Joulia Dib

Background

Nursing Facilities consists of Freestanding and Distinct Part Nursing Facilities A, Nursing Facilities B, Adult Subacute, Pediatric Subacute and Rural Swing Beds.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2014-15	47,870	--	32.00	--	\$192.89	--	\$3,545,552,700	--
CY	FY 2015-16	33,290	-30.5%	31.84	-0.5%	\$199.80	3.6%	\$2,541,742,500	-28.3%
BY	FY 2016-17	32,850	-1.3%	31.29	-1.7%	\$196.64	-1.6%	\$2,426,196,300	-4.6%

Users

The decline in CY Users is primarily due to CCI, shifting seniors and persons with disabilities (SPDs) into managed care plans. Offsetting some of the CCI declines are increases in the ACA Expansion populations. No significant changes are estimated in BY.

Utilization

The Utilization estimate is relatively unchanged in CY, with a modest decline in BY due to fewer claims processing days. The number of claims processing days reflect the number of days Medi-Cal will adjudicate and make payment to the providers.

Rate

Nursing facilities rates are updated each year based on audited costs and add-ons for new state and federal mandates. Overall, the facilities in this category had a rate increase for FY 2014-15, CY incorporates this rate increase for the full year and is projected to be fairly stable in BY.

Total Expenditure

Total expenditures are estimated to decline from PY to CY due to the CCI and beneficiaries shifting to the Managed Care delivery system. Total expenditures are estimated to decline in BY due to fewer claim processing days compared to CY and slight decreases projected in users and rate.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$3,639,056,000	\$3,545,552,700	-2.6%	\$3,491,300,100	-4.1%
FY 2015-16	\$3,190,218,700	\$2,541,742,500	-20.3%	\$2,457,818,000	-23.0%

The November 2015 estimate is 2.6% lower for FY 2014-15 and 20.3% for FY 2015-16, compared to the May 2015 estimate. Two new aid categories, ACA Optional Expansion and H-

PE, were incorporated in the November 2015 FFS Base Estimate. Without these two aid categories, the November 2015 estimate would be lower than the May 2015 estimate by 4.1% and 23%, respectively, for FY 2014-15 and FY 2015-16 as the CCI eligibles shifting to managed care has been incorporated into the estimated expenditures.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

NURSING FACILITIES

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	64,340	36.90	\$180.35	\$6,654.73	\$1,284,555,500
2013-14 *	2	61,930	31.49	\$182.49	\$5,747.29	\$1,067,841,000
2013-14 *	3	60,300	31.08	\$181.25	\$5,633.06	\$1,019,026,200
2013-14 *	4	55,870	28.58	\$182.15	\$5,206.46	\$872,634,700
2013-14 *	TOTAL	60,610	32.15	\$181.47	\$5,835.08	\$4,244,057,400
2014-15 *	1	60,360	35.45	\$199.75	\$7,081.79	\$1,282,356,400
2014-15 *	2	52,440	30.58	\$187.48	\$5,732.16	\$901,721,100
2014-15 *	3	44,500	31.51	\$192.13	\$6,054.24	\$808,168,400
2014-15 *	4	34,190	28.71	\$187.89	\$5,394.64	\$553,306,800
2014-15 *	TOTAL	47,870	32.00	\$192.89	\$6,172.18	\$3,545,552,700
2015-16 **	1	36,040	35.30	\$208.57	\$7,363.34	\$796,227,100
2015-16 **	2	33,980	32.33	\$195.80	\$6,330.56	\$645,341,100
2015-16 **	3	32,580	29.48	\$197.17	\$5,812.61	\$568,122,800
2015-16 **	4	30,570	29.73	\$195.13	\$5,801.20	\$532,051,400
2015-16 **	TOTAL	33,290	31.84	\$199.80	\$6,361.86	\$2,541,742,500
2016-17 **	1	35,530	34.86	\$198.51	\$6,919.52	\$737,619,400
2016-17 **	2	33,110	30.66	\$195.86	\$6,005.95	\$596,596,900
2016-17 **	3	32,880	31.25	\$196.48	\$6,140.41	\$605,624,800
2016-17 **	4	29,900	27.80	\$195.04	\$5,422.67	\$486,355,300
2016-17 **	TOTAL	32,850	31.29	\$196.64	\$6,153.91	\$2,426,196,300

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

ICF-DD Fee-for-Service Base Estimate

Analyst: Toni Richardson

Background

Intermediate Care Facilities/Developmentally Disabled (ICF/DD) are health facilities providing 24-hour personal care, rehabilitation, developmental, and supportive health services and skilled nursing services for those with intermittent needs.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2014-15	5,050	--	31.94	--	\$182.18	--	\$352,564,700	--
CY	FY 2015-16	5,030	-0.4%	32.89	3.0%	\$182.58	0.2%	\$362,512,300	2.8%
BY	FY 2016-17	5,030	0.0%	32.13	-2.3%	\$182.68	0.1%	\$354,126,900	-2.3%

Users

Users are projected to remain steady.

Utilization

Utilization is projected to increase from PY to CY and decrease in BY. These variances are attributed to an increase in CY of claims processing days and a decrease in BY. The number of claims processing days reflect the number of days Medi-Cal will adjudicate and make payment to the providers.

Rate

The rate is projected to remain relatively steady. ICF/DD facilities received their FY 2014-15 rate increase in late June 2015. One month of this rate increase has been incorporated into this estimate and the remaining estimated rate increase is included in the LTC Rate Adjustment Regular Policy Change.

Total Expenditure

Total expenditures are estimated to increase by 2.8% from PY to CY and decrease 2.3% from CY to BY and correspond to the changes in processing days.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$351,176,300	\$352,564,700	0.4%	\$351,739,100	0.2%
FY 2015-16	\$360,358,500	\$362,512,300	0.6%	\$360,978,100	0.2%

Absent the new ACA Optional Expansion aid category, the November 2015 Estimate assumes there are no significant changes in expenditures from the May 2015 Estimate to the November 2015 Estimate for both FY 2014-15 and FY 2015-16.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

ICF-DD

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	5,400	36.26	\$193.27	\$7,008.77	\$113,486,000
2013-14 *	2	5,220	31.37	\$178.43	\$5,597.81	\$87,734,500
2013-14 *	3	5,240	31.36	\$178.75	\$5,605.23	\$88,147,800
2013-14 *	4	4,800	28.27	\$180.13	\$5,092.85	\$73,316,600
2013-14 *	TOTAL	5,170	31.93	\$183.26	\$5,850.98	\$362,684,900
2014-15 *	1	5,070	37.48	\$177.28	\$6,644.86	\$100,968,700
2014-15 *	2	5,160	30.81	\$180.51	\$5,562.35	\$86,110,700
2014-15 *	3	5,120	31.67	\$190.14	\$6,022.33	\$92,575,300
2014-15 *	4	4,850	27.62	\$181.46	\$5,012.37	\$72,910,000
2014-15 *	TOTAL	5,050	31.94	\$182.18	\$5,818.48	\$352,564,700
2015-16 **	1	5,080	38.05	\$181.96	\$6,923.22	\$105,603,800
2015-16 **	2	5,100	33.84	\$182.61	\$6,178.87	\$94,590,800
2015-16 **	3	5,000	29.60	\$183.03	\$5,417.78	\$81,199,300
2015-16 **	4	4,940	29.93	\$182.93	\$5,475.22	\$81,118,500
2015-16 **	TOTAL	5,030	32.89	\$182.58	\$6,005.30	\$362,512,300
2016-17 **	1	5,110	37.24	\$182.20	\$6,785.18	\$104,083,700
2016-17 **	2	5,060	31.64	\$182.69	\$5,779.95	\$87,741,000
2016-17 **	3	5,040	31.83	\$182.90	\$5,821.86	\$88,038,800
2016-17 **	4	4,900	27.62	\$183.07	\$5,056.40	\$74,263,500
2016-17 **	TOTAL	5,030	32.13	\$182.68	\$5,869.91	\$354,126,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Medical Transportation Fee-for-Service Base Estimate

Analyst: Toni Richardson

Background

The Medical Transportation service category includes services billed for Ground Medical Transportation and Air Ambulance Transportation. Medi-Cal covers both emergency and non-emergency medical transportation for Air and Ground transportation services.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2014-15	33,230	--	3.36	--	\$91.36	--	\$122,256,100	--
CY	FY 2015-16	27,060	-18.6%	2.88	-14.3%	\$97.67	6.9%	\$91,284,900	-25.3%
BY	FY 2016-17	26,400	-2.4%	2.92	1.4%	\$98.12	0.5%	\$90,857,100	-0.5%

Users

The estimated User decrease is primarily due to the implementation of the Coordinated Care Initiative (CCI) shifting seniors and persons with disabilities (SPDs) from Fee-For-Service (FFS) to Managed Care.

Utilization

The estimated Utilization decrease of 14.3% from PY to CY this is attributed to the CCI impact on SPDs. This estimate assumes Utilization will remain relatively unchanged from CY to BY.

Rate

The estimated Rate increase of from PY to CY and remain steady in BY. The rate increase occurs in the SPD categories.

Total Expenditure

Total expenditures are estimated to decrease from PY to CY. This decrease reflects the impact of the implementation of CCI. This estimate assumes CY to BY, will remain relatively unchanged.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Category	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$111,616,300	\$122,256,100	9.5%	\$104,224,500	-6.6%
FY 2015-16	\$104,402,900	\$91,284,900	-12.6%	\$72,273,000	-30.8%

The November 2015 estimate assumes a 9.5% increase in expenditures in FY 2014-15 compared to the May 2015 estimate, and a decrease of 12.6% in FY 2015-16. Two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the estimated expenditures with the November 2015 estimate. Absent these

two aid categories, the November 2015 estimate projection would assume a decrease of 6.6% in 2014-15 and a decrease of 30.8% in 2015-16 compared May 2015 estimate as CCI eligibles continue to shift from FFS to Managed Care plans.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MEDICAL TRANSPORTATION

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	38,690	3.93	\$93.20	\$366.55	\$42,549,700
2013-14 *	2	34,170	3.81	\$83.96	\$320.26	\$32,829,600
2013-14 *	3	37,900	3.72	\$79.86	\$296.71	\$33,732,300
2013-14 *	4	35,250	3.40	\$83.71	\$284.82	\$30,121,500
2013-14 *	TOTAL	36,500	3.72	\$85.43	\$317.86	\$139,233,100
2014-15 *	1	41,720	3.76	\$89.68	\$337.36	\$42,223,700
2014-15 *	2	34,210	3.37	\$90.20	\$304.13	\$31,211,800
2014-15 *	3	31,960	3.22	\$91.71	\$295.40	\$28,320,700
2014-15 *	4	25,010	2.83	\$96.46	\$273.17	\$20,499,900
2014-15 *	TOTAL	33,230	3.36	\$91.36	\$306.64	\$122,256,100
2015-16 **	1	30,220	2.92	\$97.34	\$284.55	\$25,799,600
2015-16 **	2	26,440	2.94	\$98.87	\$290.26	\$23,025,600
2015-16 **	3	26,850	2.84	\$96.25	\$273.21	\$22,010,200
2015-16 **	4	24,710	2.81	\$98.32	\$275.86	\$20,449,500
2015-16 **	TOTAL	27,060	2.88	\$97.67	\$281.15	\$91,284,900
2016-17 **	1	29,140	3.07	\$98.61	\$302.47	\$26,442,300
2016-17 **	2	25,100	2.88	\$99.57	\$286.60	\$21,580,300
2016-17 **	3	27,920	2.96	\$95.75	\$283.79	\$23,769,200
2016-17 **	4	23,430	2.74	\$98.87	\$271.21	\$19,065,400
2016-17 **	TOTAL	26,400	2.92	\$98.12	\$286.82	\$90,857,100

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Services Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background:

Other Services includes those Provider Types whose services are not included in another service category. Certified Hospice Services and Local Education Agency represent nearly half of the expenditures. Other providers with current expenditures include:

- Adult Day Health Care Center
- Assistive Device & Sick Room Supply Dealers
- Blood Banks
- Fabricating Optical Laboratory
- Optometric Supplies
- Hearing Aid Dispensers
- Home Health Agency -Home & Comm. Based Svcs.
- Optometric Supplies
- Orthotists
- Optometric Supplies
- Portable X-Ray
- Prosthetists
- Genetic Disease Testing
- Medicare Crossover Provider Only
- Certified Hospice Service
- Local Education Agency
- EPSDT Supplemental Services Provider
- HCBS Congregate Living Health Facility
- HCBS Personal Care Agency
- RVN Individual Nurse Provider
- HCBS Professional Corporation
- AIDS Waiver Provider
- Multipurpose Senior Services Program
- CCS/GHPP Non-Institutional
- Independent Diagnostic Center (Medicare Crossover Provider Only)
- ALWPP Residential Care Facility for the Elderly
- ALWPP Care Coordinator
- HCBS Private Non-Profit Proprietary Agency
- Clinical Nurse Specialist (Medicare Crossover Provider Only)

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2014-15	209,440	--	3.18	--	\$91.49	--	\$730,555,200	--
CY	FY 2015-16	205,750	-1.8%	3.31	4.1%	\$79.86	-12.7%	\$652,109,400	-10.7%
BY	FY 2016-17	203,420	-1.1%	3.25	-1.8%	\$80.99	1.4%	\$641,870,800	-1.6%

Users

The estimated User decrease in CY and BY are due CCI shifting Seniors and Persons with Disabilities (SPDs) into managed care plans and offset by the ACA Expansion population increase.

Utilization

Utilization is projected to increase in CY and is related to changes occurring due to CCI shifting SPDs to the Managed Care delivery system and the new ACA population. The mix of services

within this category is changing. These changes are partially offset with the decrease in the projected Rate. BY is estimated to stabilize at the current level.

Rate

The Rate is projected to decrease in CY and is related to changes occurring due to CCI shifting SPDs to the Managed Care delivery system and the new ACA population. The mix of services within this category is changing. These changes are partially offset with the decrease in the projected Utilization. BY is estimated to stabilize at the current level.

Total Expenditures

Total expenditure is estimated to decrease by 10.7% from PY to CY and by 1.6% from CY to BY, which is mainly shown in SPD aid categories due the CCI impact shifting from FFS to Managed Care delivery system.

Reason for Change From Prior Estimate:

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$704,706,000	\$730,555,200	3.7%	\$728,635,400	3.4%
FY 2015-16	\$669,267,800	\$652,109,500	-2.6%	\$649,715,400	-2.9%

Compared to the May 2015 Estimate, the November 2015 Estimate is higher by 3.7% for FY 2014-15 and lower by 2.6% for FY 2015-16. In addition, two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into these estimated expenditures. Absent these two aid categories, the November 2015 estimate would be higher than the May 2015 Estimate by 3.4% for FY 2014-15 and lower by 2.9% in FY 2015-16.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

OTHER SERVICES

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	216,820	3.42	\$96.81	\$330.88	\$215,227,700
2013-14 *	2	217,900	3.25	\$86.75	\$281.69	\$184,138,500
2013-14 *	3	225,470	3.10	\$85.08	\$264.08	\$178,628,300
2013-14 *	4	206,730	3.37	\$78.11	\$262.98	\$163,098,300
2013-14 *	TOTAL	216,730	3.28	\$86.85	\$284.95	\$741,092,900
2014-15 *	1	207,680	3.46	\$105.60	\$364.92	\$227,359,800
2014-15 *	2	206,950	3.15	\$89.56	\$282.50	\$175,386,300
2014-15 *	3	228,040	2.93	\$89.00	\$260.91	\$178,493,800
2014-15 *	4	195,090	3.19	\$79.94	\$255.12	\$149,315,400
2014-15 *	TOTAL	209,440	3.18	\$91.49	\$290.68	\$730,555,200
2015-16 **	1	208,600	3.77	\$83.71	\$315.47	\$197,427,800
2015-16 **	2	208,240	3.06	\$83.32	\$255.04	\$159,323,200
2015-16 **	3	199,960	3.05	\$78.72	\$240.07	\$144,016,000
2015-16 **	4	206,220	3.34	\$73.27	\$244.63	\$151,342,400
2015-16 **	TOTAL	205,750	3.31	\$79.86	\$264.11	\$652,109,400
2016-17 **	1	203,460	3.40	\$89.87	\$305.25	\$186,316,300
2016-17 **	2	201,300	3.10	\$82.15	\$254.58	\$153,742,400
2016-17 **	3	209,380	3.11	\$79.11	\$246.21	\$154,652,200
2016-17 **	4	199,560	3.38	\$72.65	\$245.81	\$147,159,800
2016-17 **	TOTAL	203,420	3.25	\$80.99	\$262.94	\$641,870,800

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Home Health Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

Background

Home Health provides services to assist in supporting a beneficiary in his/her home as an alternative to care in a licensed health care facility. Home Health provides a level of care that is deemed medically necessary by a physician.

Fiscal Year		Users		Utilization (Claim per User)		Rate (Dollar per Claim)		Total Expenditure	
PY	FY 2014-15	5,030	----	3.18	----	\$1,283.09	-----	\$246,058,800	-----
CY	FY 2015-16	5,091	1.2%	3.29	3.5%	\$1,273.60	-0.7%	\$255,921,600	4.0%
BY	FY 2016-17	5,050	-0.8%	3.35	1.8%	\$1,280.02	0.5%	\$259,899,900	1.6%

Users

Users are projected to remain relatively stable.

Utilization

Utilization is estimated to increase in CY and BY as processing days increase from PY to CY and then decrease in BY. The number of claims processing days reflect the number of days Medi-Cal will adjudicate and make payment to the providers.

Rate

The rate is projected to remain stable.

Total Expenditures

The estimated increases in total expenditure from PY to CY and from CY to BY are primarily related to the fluctuation in processing days.

Reasons for Change from Prior Estimate

Fiscal Year	Total Expenditure			N15 Total Expenditure w/o New Aid Categories	
	M15	N15	% Chng	N15	% Chng
FY 2014-15	\$246,900,200	\$246,058,800	-0.3%	\$244,139,000	-1.1%
FY 2015-16	\$262,970,800	\$255,921,600	-2.7%	\$253,527,500	-3.6%

Compared to the May 2015 Estimate, the November 2015 estimate shows very little change. While two new aid categories, ACA Optional Expansion and Hospital Presumptive Eligibility (H-PE), have been incorporated into the November 2015 expenditure estimate, they have a small impact. Absent these two aid categories, the November 2015 estimate would be lower than the May 2015 estimate by 1.1% and 3.6%, respectively, for FY 2014-15 and FY 2015-16.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

HOME HEALTH

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	4,730	3.50	\$1,384.39	\$4,847.43	\$68,794,700
2013-14 *	2	4,570	3.16	\$1,336.45	\$4,227.79	\$57,937,700
2013-14 *	3	4,810	3.12	\$1,308.40	\$4,079.82	\$58,831,000
2013-14 *	4	4,420	2.93	\$1,293.79	\$3,793.64	\$50,356,800
2013-14 *	TOTAL	4,630	3.18	\$1,333.40	\$4,243.93	\$235,920,200
2014-15 *	1	5,310	3.46	\$1,322.40	\$4,574.54	\$72,909,000
2014-15 *	2	4,770	3.22	\$1,303.58	\$4,194.75	\$60,052,000
2014-15 *	3	5,210	3.14	\$1,229.59	\$3,859.04	\$60,278,200
2014-15 *	4	4,830	2.86	\$1,271.35	\$3,641.98	\$52,819,600
2014-15 *	TOTAL	5,030	3.18	\$1,283.09	\$4,075.37	\$246,058,800
2015-16 **	1	5,300	3.54	\$1,298.83	\$4,600.43	\$73,131,000
2015-16 **	2	5,100	3.35	\$1,286.78	\$4,316.83	\$66,017,300
2015-16 **	3	5,080	3.10	\$1,244.40	\$3,853.71	\$58,750,000
2015-16 **	4	4,890	3.15	\$1,258.02	\$3,958.69	\$58,023,300
2015-16 **	TOTAL	5,090	3.29	\$1,273.60	\$4,189.13	\$255,921,600
2016-17 **	1	5,250	3.61	\$1,314.66	\$4,750.23	\$74,884,000
2016-17 **	2	4,980	3.33	\$1,288.08	\$4,293.91	\$64,136,200
2016-17 **	3	5,200	3.32	\$1,250.99	\$4,154.87	\$64,820,200
2016-17 **	4	4,770	3.11	\$1,260.44	\$3,919.93	\$56,059,400
2016-17 **	TOTAL	5,050	3.35	\$1,280.02	\$4,288.56	\$259,899,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

PA-OAS

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	154,330	4.91	\$128.92	\$633.40	\$293,267,400
2013-14 *	2	142,410	4.51	\$118.10	\$533.18	\$227,797,200
2013-14 *	3	152,130	4.35	\$116.37	\$506.08	\$230,966,100
2013-14 *	4	135,720	4.26	\$118.07	\$502.80	\$204,728,000
2013-14 *	TOTAL	146,150	4.52	\$120.77	\$545.53	\$956,758,700
2014-15 *	1	157,390	4.79	\$129.83	\$622.40	\$293,875,900
2014-15 *	2	135,090	4.25	\$121.12	\$514.55	\$208,534,900
2014-15 *	3	121,850	4.43	\$120.03	\$532.16	\$194,538,400
2014-15 *	4	78,810	3.63	\$141.56	\$513.89	\$121,498,200
2014-15 *	TOTAL	123,290	4.37	\$126.61	\$553.22	\$818,447,400
2015-16 **	1	80,210	4.04	\$148.40	\$600.29	\$144,450,300
2015-16 **	2	66,290	4.14	\$128.19	\$531.25	\$105,652,400
2015-16 **	3	51,520	4.73	\$125.40	\$592.60	\$91,598,700
2015-16 **	4	38,810	5.74	\$130.98	\$751.88	\$87,530,700
2015-16 **	TOTAL	59,210	4.50	\$134.29	\$604.13	\$429,232,100
2016-17 **	1	50,270	5.91	\$138.86	\$820.04	\$123,665,100
2016-17 **	2	44,510	5.28	\$126.92	\$669.81	\$89,444,700
2016-17 **	3	45,590	5.58	\$126.95	\$708.16	\$96,854,200
2016-17 **	4	34,040	5.83	\$130.07	\$758.58	\$77,477,100
2016-17 **	TOTAL	43,600	5.65	\$131.16	\$740.46	\$387,441,100

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

NEWLY

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	0		\$0.00	\$0.00	\$0
2013-14 *	2	0		\$0.00	\$0.00	\$0
2013-14 *	3	108,180	2.33	\$185.57	\$431.56	\$140,056,700
2013-14 *	4	193,680	2.66	\$241.51	\$641.71	\$372,859,500
2013-14 *	TOTAL	75,460	2.54	\$223.14	\$566.40	\$512,916,200
2014-15 *	1	315,480	2.87	\$263.95	\$756.22	\$715,722,600
2014-15 *	2	322,580	2.49	\$271.45	\$675.10	\$653,320,000
2014-15 *	3	348,900	2.44	\$276.98	\$674.74	\$706,253,500
2014-15 *	4	330,660	2.39	\$282.99	\$677.33	\$671,904,400
2014-15 *	TOTAL	329,410	2.54	\$273.56	\$694.99	\$2,747,200,500
2015-16 **	1	436,230	2.41	\$294.60	\$709.40	\$928,381,400
2015-16 **	2	430,520	2.19	\$290.91	\$636.26	\$821,772,900
2015-16 **	3	424,780	2.08	\$292.74	\$607.78	\$774,521,400
2015-16 **	4	393,960	2.20	\$299.07	\$656.64	\$776,056,600
2015-16 **	TOTAL	421,370	2.22	\$294.27	\$652.78	\$3,300,732,300
2016-17 **	1	427,670	2.29	\$304.90	\$698.83	\$896,591,000
2016-17 **	2	425,740	2.13	\$301.40	\$642.62	\$820,766,800
2016-17 **	3	431,410	2.13	\$299.47	\$636.95	\$824,361,100
2016-17 **	4	387,440	2.14	\$309.85	\$662.98	\$770,591,600
2016-17 **	TOTAL	418,060	2.17	\$303.78	\$660.25	\$3,312,310,600

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

PA-ATD

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	374,300	6.05	\$196.53	\$1,189.10	\$1,335,256,200
2013-14 *	2	348,850	5.43	\$189.35	\$1,027.57	\$1,075,412,900
2013-14 *	3	359,760	5.19	\$198.68	\$1,030.94	\$1,112,679,800
2013-14 *	4	326,880	5.05	\$191.88	\$969.36	\$950,596,900
2013-14 *	TOTAL	352,450	5.44	\$194.28	\$1,057.82	\$4,473,945,900
2014-15 *	1	369,850	5.74	\$209.64	\$1,204.26	\$1,336,196,800
2014-15 *	2	345,140	5.04	\$210.84	\$1,061.98	\$1,099,580,500
2014-15 *	3	330,600	4.94	\$225.15	\$1,111.32	\$1,102,215,000
2014-15 *	4	275,070	4.59	\$233.55	\$1,071.92	\$884,545,000
2014-15 *	TOTAL	330,160	5.12	\$218.16	\$1,116.25	\$4,422,537,300
2015-16 **	1	278,220	5.69	\$245.27	\$1,395.28	\$1,164,574,100
2015-16 **	2	256,470	5.14	\$244.40	\$1,257.16	\$967,284,600
2015-16 **	3	231,810	5.16	\$242.42	\$1,250.40	\$869,581,400
2015-16 **	4	222,780	5.39	\$240.54	\$1,297.71	\$867,308,500
2015-16 **	TOTAL	247,320	5.36	\$243.34	\$1,303.55	\$3,868,748,600
2016-17 **	1	230,680	6.28	\$253.85	\$1,593.55	\$1,102,805,900
2016-17 **	2	219,880	5.41	\$249.19	\$1,347.66	\$888,954,300
2016-17 **	3	226,180	5.55	\$250.92	\$1,393.21	\$945,365,900
2016-17 **	4	204,020	5.35	\$243.48	\$1,301.60	\$796,672,200
2016-17 **	TOTAL	220,190	5.66	\$249.73	\$1,413.09	\$3,733,798,300

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

PA-AFDC

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	187,230	2.53	\$163.45	\$413.72	\$232,379,200
2013-14 *	2	176,070	2.33	\$156.09	\$363.01	\$191,740,000
2013-14 *	3	175,440	2.21	\$173.23	\$382.76	\$201,453,200
2013-14 *	4	163,090	2.21	\$167.44	\$370.72	\$181,384,900
2013-14 *	TOTAL	175,460	2.33	\$164.81	\$383.27	\$806,957,400
2014-15 *	1	185,690	2.31	\$184.03	\$424.86	\$236,671,600
2014-15 *	2	182,760	2.18	\$173.37	\$378.78	\$207,679,500
2014-15 *	3	193,720	2.20	\$178.10	\$392.41	\$228,047,100
2014-15 *	4	171,430	2.22	\$169.62	\$376.81	\$193,786,700
2014-15 *	TOTAL	183,400	2.23	\$176.52	\$393.58	\$866,184,900
2015-16 **	1	201,810	2.35	\$172.66	\$405.85	\$245,719,300
2015-16 **	2	207,700	2.21	\$170.43	\$375.79	\$234,151,700
2015-16 **	3	200,180	2.15	\$170.94	\$368.09	\$221,054,300
2015-16 **	4	193,710	2.22	\$167.25	\$371.02	\$215,609,400
2015-16 **	TOTAL	200,850	2.23	\$170.38	\$380.27	\$916,534,600
2016-17 **	1	208,220	2.26	\$177.71	\$401.93	\$251,061,800
2016-17 **	2	203,780	2.14	\$172.52	\$369.16	\$225,684,100
2016-17 **	3	206,990	2.21	\$173.95	\$384.14	\$238,538,900
2016-17 **	4	186,800	2.17	\$168.98	\$366.66	\$205,481,900
2016-17 **	TOTAL	201,450	2.20	\$173.46	\$380.90	\$920,766,800

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

LT-OAS

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	36,450	35.94	\$161.53	\$5,804.94	\$634,683,100
2013-14 *	2	35,300	30.41	\$162.36	\$4,937.91	\$522,973,900
2013-14 *	3	34,800	29.81	\$159.23	\$4,746.87	\$495,635,200
2013-14 *	4	32,070	26.68	\$161.23	\$4,301.35	\$413,875,700
2013-14 *	TOTAL	34,660	30.85	\$161.12	\$4,970.61	\$2,067,167,900
2014-15 *	1	34,040	33.37	\$178.88	\$5,968.56	\$609,491,300
2014-15 *	2	30,840	27.93	\$165.39	\$4,619.43	\$427,380,800
2014-15 *	3	29,380	27.01	\$162.74	\$4,394.83	\$387,298,500
2014-15 *	4	21,960	24.28	\$164.58	\$3,995.13	\$263,239,300
2014-15 *	TOTAL	29,050	28.60	\$169.24	\$4,839.82	\$1,687,409,800
2015-16 **	1	21,950	30.85	\$183.15	\$5,650.38	\$372,095,100
2015-16 **	2	20,080	30.57	\$171.86	\$5,254.60	\$316,548,700
2015-16 **	3	17,460	30.42	\$170.34	\$5,181.14	\$271,349,300
2015-16 **	4	14,940	34.21	\$172.51	\$5,901.98	\$264,587,400
2015-16 **	TOTAL	18,610	31.35	\$174.93	\$5,484.06	\$1,224,580,400
2016-17 **	1	17,310	39.12	\$175.63	\$6,870.42	\$356,718,800
2016-17 **	2	17,090	33.25	\$172.36	\$5,731.53	\$293,937,100
2016-17 **	3	17,100	33.75	\$170.61	\$5,757.85	\$295,396,600
2016-17 **	4	14,980	31.15	\$172.49	\$5,373.69	\$241,553,200
2016-17 **	TOTAL	16,620	34.43	\$172.91	\$5,954.12	\$1,187,605,700

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

H-PE

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2013-14 *	1	0		\$0.00	\$0.00	\$0
2013-14 *	2	0		\$0.00	\$0.00	\$0
2013-14 *	3	4,380	5.38	\$253.19	\$1,362.19	\$17,891,000
2013-14 *	4	20,750	4.48	\$313.51	\$1,405.20	\$87,455,300
2013-14 *	TOTAL	6,280	4.64	\$301.32	\$1,397.70	\$105,346,300
2014-15 *	1	37,390	4.48	\$337.88	\$1,512.12	\$169,635,700
2014-15 *	2	39,310	4.07	\$311.66	\$1,267.00	\$149,431,900
2014-15 *	3	42,880	3.89	\$326.79	\$1,270.01	\$163,364,500
2014-15 *	4	36,570	3.59	\$328.18	\$1,176.55	\$129,074,400
2014-15 *	TOTAL	39,040	4.00	\$326.18	\$1,305.34	\$611,506,600
2015-16 **	1	44,160	3.95	\$356.79	\$1,410.38	\$186,858,300
2015-16 **	2	42,730	3.74	\$341.50	\$1,277.34	\$163,740,500
2015-16 **	3	42,250	3.64	\$348.23	\$1,268.30	\$160,757,900
2015-16 **	4	40,220	3.53	\$342.23	\$1,209.76	\$145,985,400
2015-16 **	TOTAL	42,340	3.72	\$347.54	\$1,293.73	\$657,342,000
2016-17 **	1	42,580	3.90	\$357.84	\$1,394.41	\$178,109,600
2016-17 **	2	41,920	3.70	\$345.01	\$1,277.22	\$160,631,700
2016-17 **	3	43,060	3.68	\$346.27	\$1,274.62	\$164,647,500
2016-17 **	4	39,420	3.49	\$346.35	\$1,208.49	\$142,904,600
2016-17 **	TOTAL	41,740	3.70	\$349.08	\$1,290.21	\$646,293,300

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

LT-ATD

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	11,800	36.70	\$197.02	\$7,230.22	\$256,014,900
2013-14 *	2	11,550	32.06	\$196.05	\$6,286.07	\$217,837,400
2013-14 *	3	11,510	31.01	\$199.43	\$6,183.97	\$213,557,200
2013-14 *	4	10,740	27.24	\$199.07	\$5,422.73	\$174,644,500
2013-14 *	TOTAL	11,400	31.86	\$197.78	\$6,301.43	\$862,053,900
2014-15 *	1	11,330	34.94	\$213.12	\$7,445.79	\$253,179,100
2014-15 *	2	10,410	28.49	\$198.75	\$5,662.79	\$176,916,800
2014-15 *	3	9,940	27.67	\$196.51	\$5,437.32	\$162,200,600
2014-15 *	4	8,000	23.66	\$191.16	\$4,523.52	\$108,541,900
2014-15 *	TOTAL	9,920	29.15	\$201.89	\$5,885.89	\$700,838,500
2015-16 **	1	7,760	31.79	\$203.45	\$6,467.90	\$150,533,100
2015-16 **	2	6,990	31.05	\$197.26	\$6,124.26	\$128,485,100
2015-16 **	3	6,260	29.53	\$196.81	\$5,811.82	\$109,213,200
2015-16 **	4	5,680	31.41	\$193.05	\$6,062.95	\$103,249,200
2015-16 **	TOTAL	6,670	30.98	\$198.10	\$6,137.78	\$491,480,700
2016-17 **	1	6,060	39.57	\$197.93	\$7,831.74	\$142,379,400
2016-17 **	2	5,920	33.50	\$196.91	\$6,595.93	\$117,173,100
2016-17 **	3	5,920	33.74	\$196.67	\$6,636.53	\$117,901,100
2016-17 **	4	5,470	29.65	\$193.29	\$5,730.45	\$93,990,400
2016-17 **	TOTAL	5,840	34.23	\$196.42	\$6,724.19	\$471,444,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

POV 250

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	49,380	2.34	\$137.86	\$322.89	\$47,834,500
2013-14 *	2	59,680	2.37	\$126.20	\$298.75	\$53,491,100
2013-14 *	3	65,090	2.29	\$154.20	\$352.57	\$68,845,800
2013-14 *	4	68,560	2.28	\$140.33	\$320.46	\$65,915,400
2013-14 *	TOTAL	60,680	2.32	\$139.94	\$324.23	\$236,086,800
2014-15 *	1	87,370	2.32	\$177.17	\$410.17	\$107,511,700
2014-15 *	2	85,490	2.13	\$155.79	\$332.55	\$85,284,300
2014-15 *	3	89,630	2.10	\$164.66	\$345.73	\$92,957,800
2014-15 *	4	81,180	2.15	\$156.95	\$337.44	\$82,178,100
2014-15 *	TOTAL	85,920	2.17	\$164.08	\$356.87	\$367,931,800
2015-16 **	1	100,120	2.33	\$156.36	\$364.75	\$109,550,700
2015-16 **	2	103,480	2.29	\$153.89	\$351.81	\$109,217,500
2015-16 **	3	85,090	2.29	\$159.52	\$365.28	\$93,248,500
2015-16 **	4	78,620	2.30	\$152.38	\$351.03	\$82,792,000
2015-16 **	TOTAL	91,830	2.30	\$155.55	\$358.29	\$394,808,700
2016-17 **	1	99,230	2.27	\$160.78	\$365.52	\$108,808,800
2016-17 **	2	105,260	2.26	\$153.43	\$347.00	\$109,579,500
2016-17 **	3	90,970	2.32	\$160.05	\$371.74	\$101,450,000
2016-17 **	4	80,550	2.27	\$151.82	\$344.98	\$83,363,800
2016-17 **	TOTAL	94,000	2.28	\$156.65	\$357.44	\$403,202,100

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MN-OAS

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	81,640	4.96	\$143.18	\$710.80	\$174,095,800
2013-14 *	2	76,440	4.56	\$132.48	\$604.46	\$138,616,900
2013-14 *	3	82,390	4.46	\$142.13	\$633.38	\$156,543,600
2013-14 *	4	76,310	4.51	\$141.18	\$637.27	\$145,889,400
2013-14 *	TOTAL	79,200	4.63	\$139.90	\$647.29	\$615,145,700
2014-15 *	1	93,580	4.98	\$150.56	\$749.21	\$210,338,200
2014-15 *	2	84,950	4.57	\$144.40	\$660.48	\$168,316,700
2014-15 *	3	81,580	4.70	\$156.93	\$737.90	\$180,602,400
2014-15 *	4	65,870	4.35	\$163.79	\$711.82	\$140,658,100
2014-15 *	TOTAL	81,500	4.68	\$153.08	\$715.70	\$699,915,300
2015-16 **	1	70,940	5.09	\$175.91	\$894.69	\$190,410,600
2015-16 **	2	66,780	4.61	\$161.34	\$743.02	\$148,852,000
2015-16 **	3	61,840	4.56	\$160.80	\$733.16	\$136,024,800
2015-16 **	4	58,940	4.69	\$162.38	\$761.95	\$134,724,900
2015-16 **	TOTAL	64,630	4.75	\$165.74	\$786.60	\$610,012,400
2016-17 **	1	64,960	5.29	\$168.62	\$891.83	\$173,787,500
2016-17 **	2	61,790	4.67	\$161.76	\$755.49	\$140,049,200
2016-17 **	3	64,010	4.75	\$161.59	\$767.02	\$147,290,900
2016-17 **	4	57,180	4.56	\$163.18	\$744.87	\$127,782,500
2016-17 **	TOTAL	61,990	4.83	\$163.99	\$791.74	\$588,910,100

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MN-ATD

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	68,830	6.23	\$253.80	\$1,581.80	\$326,604,400
2013-14 *	2	64,520	5.67	\$246.13	\$1,394.57	\$269,948,800
2013-14 *	3	67,620	5.57	\$259.56	\$1,445.91	\$293,323,600
2013-14 *	4	61,200	5.41	\$235.09	\$1,272.62	\$233,667,200
2013-14 *	TOTAL	65,540	5.73	\$249.25	\$1,428.49	\$1,123,544,000
2014-15 *	1	70,510	5.82	\$238.49	\$1,387.50	\$293,498,500
2014-15 *	2	62,490	5.02	\$214.53	\$1,076.04	\$201,720,300
2014-15 *	3	58,530	4.91	\$215.67	\$1,059.09	\$185,971,700
2014-15 *	4	49,090	4.56	\$212.48	\$968.07	\$142,561,900
2014-15 *	TOTAL	60,150	5.13	\$222.38	\$1,141.16	\$823,752,500
2015-16 **	1	49,300	5.63	\$215.30	\$1,212.16	\$179,279,800
2015-16 **	2	46,580	5.00	\$213.48	\$1,066.67	\$149,041,200
2015-16 **	3	42,270	5.00	\$210.21	\$1,051.14	\$133,294,900
2015-16 **	4	41,590	5.24	\$202.57	\$1,060.54	\$132,333,800
2015-16 **	TOTAL	44,930	5.23	\$210.75	\$1,101.51	\$593,949,600
2016-17 **	1	44,020	6.07	\$216.02	\$1,311.95	\$173,274,800
2016-17 **	2	42,310	5.20	\$207.18	\$1,077.76	\$136,799,100
2016-17 **	3	44,050	5.27	\$217.75	\$1,148.25	\$151,727,300
2016-17 **	4	41,280	5.11	\$204.45	\$1,043.82	\$129,266,500
2016-17 **	TOTAL	42,920	5.42	\$211.74	\$1,147.75	\$591,067,800

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MN-AFDC

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	500,460	2.88	\$188.84	\$543.08	\$815,371,900
2013-14 *	2	460,270	2.63	\$186.75	\$490.36	\$677,095,500
2013-14 *	3	454,470	2.54	\$206.83	\$525.38	\$716,309,600
2013-14 *	4	409,330	2.47	\$195.57	\$483.52	\$593,752,000
2013-14 *	TOTAL	456,130	2.64	\$194.04	\$512.01	\$2,802,529,000
2014-15 *	1	486,380	2.66	\$203.58	\$542.48	\$791,548,800
2014-15 *	2	461,350	2.45	\$192.67	\$471.20	\$652,159,100
2014-15 *	3	474,420	2.45	\$199.52	\$489.20	\$696,253,100
2014-15 *	4	422,810	2.44	\$183.93	\$448.83	\$569,298,400
2014-15 *	TOTAL	461,240	2.50	\$195.50	\$489.49	\$2,709,259,500
2015-16 **	1	499,520	2.71	\$189.16	\$512.17	\$767,518,700
2015-16 **	2	513,630	2.51	\$187.52	\$471.21	\$726,070,400
2015-16 **	3	487,430	2.42	\$188.73	\$456.18	\$667,076,400
2015-16 **	4	463,000	2.45	\$182.90	\$448.62	\$623,127,500
2015-16 **	TOTAL	490,890	2.52	\$187.20	\$472.57	\$2,783,793,000
2016-17 **	1	520,720	2.61	\$191.39	\$499.56	\$780,388,000
2016-17 **	2	510,870	2.44	\$188.66	\$460.01	\$705,025,200
2016-17 **	3	517,330	2.46	\$191.23	\$470.08	\$729,561,000
2016-17 **	4	452,880	2.39	\$183.43	\$438.04	\$595,135,800
2016-17 **	TOTAL	500,450	2.48	\$188.93	\$467.93	\$2,810,110,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MI-C

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	83,170	2.73	\$144.83	\$394.76	\$98,498,700
2013-14 *	2	77,500	2.64	\$140.69	\$370.74	\$86,195,000
2013-14 *	3	93,440	2.83	\$134.09	\$379.64	\$106,420,900
2013-14 *	4	83,510	2.76	\$140.26	\$386.43	\$96,809,200
2013-14 *	TOTAL	84,400	2.74	\$139.71	\$383.00	\$387,923,800
2014-15 *	1	88,300	2.75	\$141.98	\$390.49	\$103,443,000
2014-15 *	2	73,400	2.58	\$141.61	\$364.98	\$80,363,800
2014-15 *	3	78,920	2.75	\$149.10	\$410.08	\$97,088,100
2014-15 *	4	72,090	2.68	\$142.01	\$380.87	\$82,368,600
2014-15 *	TOTAL	78,180	2.69	\$143.74	\$387.23	\$363,263,500
2015-16 **	1	82,430	2.81	\$143.74	\$403.83	\$99,866,600
2015-16 **	2	76,920	2.57	\$138.11	\$355.40	\$82,011,100
2015-16 **	3	71,350	2.64	\$137.27	\$362.94	\$77,687,400
2015-16 **	4	66,850	2.72	\$138.90	\$378.33	\$75,872,700
2015-16 **	TOTAL	74,390	2.69	\$139.72	\$375.78	\$335,437,800
2016-17 **	1	76,400	2.80	\$139.85	\$391.84	\$89,805,300
2016-17 **	2	70,200	2.61	\$138.72	\$362.59	\$76,367,000
2016-17 **	3	70,090	2.85	\$140.07	\$398.99	\$83,899,800
2016-17 **	4	61,430	2.75	\$140.60	\$387.21	\$71,354,300
2016-17 **	TOTAL	69,530	2.76	\$139.80	\$385.24	\$321,426,400

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

MI-A

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	1,770	16.71	\$199.00	\$3,325.21	\$17,663,500
2013-14 *	2	1,710	11.88	\$190.40	\$2,262.63	\$11,614,100
2013-14 *	3	1,540	10.71	\$205.49	\$2,201.28	\$10,156,700
2013-14 *	4	1,150	13.98	\$200.25	\$2,799.61	\$9,689,500
2013-14 *	TOTAL	1,540	13.37	\$198.42	\$2,652.47	\$49,123,800
2014-15 *	1	930	14.09	\$230.79	\$3,251.01	\$9,070,300
2014-15 *	2	630	17.56	\$205.89	\$3,616.21	\$6,870,800
2014-15 *	3	530	20.55	\$223.80	\$4,599.55	\$7,304,100
2014-15 *	4	450	14.94	\$207.12	\$3,094.61	\$4,208,700
2014-15 *	TOTAL	640	16.45	\$218.53	\$3,594.38	\$27,453,900
2015-16 **	1	300	33.40	\$235.59	\$7,868.29	\$7,150,900
2015-16 **	2	230	38.36	\$225.21	\$8,639.78	\$6,001,300
2015-16 **	3	190	46.25	\$234.51	\$10,845.45	\$6,251,500
2015-16 **	4	280	27.13	\$224.05	\$6,077.53	\$5,126,100
2015-16 **	TOTAL	250	35.24	\$230.25	\$8,113.57	\$24,529,800
2016-17 **	1	200	50.69	\$235.66	\$11,946.47	\$7,111,400
2016-17 **	2	150	57.78	\$230.18	\$13,299.66	\$5,795,900
2016-17 **	3	200	45.52	\$232.25	\$10,570.74	\$6,459,100
2016-17 **	4	240	30.26	\$227.65	\$6,888.66	\$4,935,600
2016-17 **	TOTAL	200	44.45	\$231.78	\$10,303.63	\$24,302,100

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

REFUGEE

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	840	2.82	\$197.90	\$558.89	\$1,405,100
2013-14 *	2	630	2.78	\$145.04	\$402.95	\$764,800
2013-14 *	3	660	2.62	\$138.13	\$361.99	\$713,800
2013-14 *	4	640	2.83	\$137.20	\$388.72	\$750,600
2013-14 *	TOTAL	690	2.77	\$157.93	\$437.08	\$3,634,300
2014-15 *	1	630	2.80	\$118.88	\$332.45	\$629,300
2014-15 *	2	540	2.48	\$118.93	\$294.45	\$476,400
2014-15 *	3	460	2.57	\$145.46	\$373.21	\$511,300
2014-15 *	4	380	2.18	\$139.26	\$303.77	\$343,600
2014-15 *	TOTAL	500	2.54	\$128.30	\$326.12	\$1,960,600
2015-16 **	1	440	2.15	\$129.64	\$279.28	\$368,100
2015-16 **	2	410	2.21	\$143.36	\$316.71	\$394,100
2015-16 **	3	420	2.04	\$129.15	\$263.05	\$328,100
2015-16 **	4	420	2.26	\$155.56	\$351.25	\$437,500
2015-16 **	TOTAL	420	2.16	\$139.64	\$302.22	\$1,527,900
2016-17 **	1	490	2.12	\$124.70	\$264.71	\$386,800
2016-17 **	2	410	2.09	\$138.70	\$289.45	\$352,700
2016-17 **	3	440	2.15	\$137.00	\$294.48	\$386,500
2016-17 **	4	400	2.15	\$151.20	\$324.98	\$385,400
2016-17 **	TOTAL	430	2.13	\$137.21	\$291.88	\$1,511,400

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

OBRA

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	15,160	5.96	\$246.29	\$1,468.39	\$66,776,500
2013-14 *	2	14,610	5.66	\$244.88	\$1,385.79	\$60,734,900
2013-14 *	3	4,510	4.97	\$285.40	\$1,417.86	\$19,193,600
2013-14 *	4	4,840	4.47	\$250.35	\$1,118.72	\$16,256,100
2013-14 *	TOTAL	9,780	5.55	\$250.19	\$1,388.43	\$162,961,100
2014-15 *	1	6,910	4.92	\$220.82	\$1,087.02	\$22,534,000
2014-15 *	2	8,010	4.17	\$206.55	\$862.35	\$20,718,900
2014-15 *	3	9,330	4.01	\$216.28	\$866.51	\$24,244,000
2014-15 *	4	8,390	3.73	\$210.06	\$784.37	\$19,738,700
2014-15 *	TOTAL	8,160	4.17	\$213.60	\$891.07	\$87,235,600
2015-16 **	1	8,540	3.91	\$194.91	\$763.02	\$19,547,500
2015-16 **	2	7,780	3.36	\$212.81	\$714.11	\$16,673,200
2015-16 **	3	6,880	3.32	\$178.41	\$591.75	\$12,215,100
2015-16 **	4	6,810	3.47	\$194.01	\$673.09	\$13,753,100
2015-16 **	TOTAL	7,500	3.53	\$195.57	\$690.67	\$62,188,900
2016-17 **	1	7,830	3.82	\$175.05	\$668.22	\$15,687,400
2016-17 **	2	7,070	3.28	\$190.89	\$625.19	\$13,251,800
2016-17 **	3	6,920	3.60	\$184.58	\$664.14	\$13,796,900
2016-17 **	4	6,460	3.29	\$178.67	\$587.20	\$11,371,900
2016-17 **	TOTAL	7,070	3.51	\$181.92	\$637.97	\$54,108,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

POV 185

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	132,040	3.57	\$187.10	\$668.77	\$264,920,600
2013-14 *	2	126,050	3.41	\$183.48	\$625.09	\$236,381,300
2013-14 *	3	127,390	3.44	\$201.57	\$692.79	\$264,762,500
2013-14 *	4	114,620	3.24	\$197.54	\$640.25	\$220,149,300
2013-14 *	TOTAL	125,030	3.42	\$192.16	\$657.34	\$986,213,600
2014-15 *	1	151,620	3.34	\$205.49	\$685.53	\$311,811,300
2014-15 *	2	123,940	3.15	\$225.50	\$710.62	\$264,232,400
2014-15 *	3	135,170	3.06	\$225.06	\$688.06	\$279,015,600
2014-15 *	4	115,620	2.96	\$226.24	\$669.80	\$232,319,800
2014-15 *	TOTAL	131,590	3.14	\$219.41	\$688.63	\$1,087,379,100
2015-16 **	1	130,690	3.34	\$224.61	\$749.38	\$293,810,400
2015-16 **	2	129,010	3.14	\$214.18	\$672.96	\$260,458,400
2015-16 **	3	129,340	3.00	\$221.60	\$664.35	\$257,777,800
2015-16 **	4	122,440	3.00	\$227.10	\$682.41	\$250,657,900
2015-16 **	TOTAL	127,870	3.12	\$221.81	\$692.57	\$1,062,704,600
2016-17 **	1	140,370	3.24	\$218.60	\$708.89	\$298,513,900
2016-17 **	2	128,270	3.05	\$215.29	\$655.90	\$252,404,600
2016-17 **	3	137,690	3.08	\$221.51	\$681.67	\$281,575,400
2016-17 **	4	120,410	2.91	\$229.01	\$666.36	\$240,701,800
2016-17 **	TOTAL	131,680	3.08	\$220.81	\$679.15	\$1,073,195,700

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

POV 133

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	21,310	2.03	\$134.67	\$273.45	\$17,484,500
2013-14 *	2	19,930	1.95	\$131.99	\$257.54	\$15,394,500
2013-14 *	3	19,890	1.91	\$134.48	\$257.13	\$15,342,100
2013-14 *	4	19,910	1.97	\$127.32	\$251.06	\$14,993,400
2013-14 *	TOTAL	20,260	1.97	\$132.16	\$260.03	\$63,214,600
2014-15 *	1	27,730	1.96	\$147.80	\$289.51	\$24,086,200
2014-15 *	2	32,390	1.88	\$133.61	\$251.36	\$24,425,300
2014-15 *	3	42,540	1.87	\$152.60	\$285.95	\$36,488,400
2014-15 *	4	44,560	1.86	\$145.89	\$270.83	\$36,203,500
2014-15 *	TOTAL	36,800	1.89	\$145.50	\$274.43	\$121,203,300
2015-16 **	1	59,640	2.07	\$148.89	\$307.62	\$55,040,900
2015-16 **	2	58,350	1.82	\$158.30	\$287.82	\$50,380,300
2015-16 **	3	57,360	1.84	\$160.51	\$295.02	\$50,767,900
2015-16 **	4	58,060	1.76	\$150.03	\$264.27	\$46,028,600
2015-16 **	TOTAL	58,350	1.87	\$154.25	\$288.79	\$202,217,700
2016-17 **	1	63,090	1.77	\$159.60	\$282.44	\$53,460,900
2016-17 **	2	61,650	1.73	\$161.10	\$279.42	\$51,676,900
2016-17 **	3	61,600	1.83	\$164.69	\$301.77	\$55,762,800
2016-17 **	4	58,430	1.73	\$152.89	\$264.90	\$46,431,900
2016-17 **	TOTAL	61,190	1.77	\$159.73	\$282.36	\$207,332,600

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2015 BASE ESTIMATES)**

POV 100

AVERAGE MONTHLY

YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2013-14 *	1	21,580	2.37	\$151.37	\$358.87	\$23,236,000
2013-14 *	2	21,150	2.27	\$149.54	\$339.07	\$21,511,000
2013-14 *	3	20,680	2.18	\$147.25	\$320.52	\$19,881,600
2013-14 *	4	18,810	2.23	\$143.75	\$321.26	\$18,126,800
2013-14 *	TOTAL	20,550	2.26	\$148.18	\$335.53	\$82,755,400
2014-15 *	1	22,600	2.30	\$167.80	\$385.96	\$26,164,700
2014-15 *	2	24,120	2.09	\$156.77	\$327.43	\$23,694,900
2014-15 *	3	27,240	2.05	\$152.03	\$311.43	\$25,448,500
2014-15 *	4	25,490	2.09	\$152.94	\$318.94	\$24,384,200
2014-15 *	TOTAL	24,860	2.12	\$157.27	\$334.17	\$99,692,200
2015-16 **	1	31,000	2.19	\$163.97	\$358.45	\$33,333,300
2015-16 **	2	29,160	2.09	\$162.24	\$339.28	\$29,683,500
2015-16 **	3	27,760	2.06	\$157.20	\$324.43	\$27,017,500
2015-16 **	4	27,960	2.07	\$154.06	\$318.31	\$26,697,100
2015-16 **	TOTAL	28,970	2.10	\$159.60	\$335.79	\$116,731,300
2016-17 **	1	31,300	2.10	\$174.92	\$367.82	\$34,540,400
2016-17 **	2	29,630	2.07	\$168.67	\$349.44	\$31,057,100
2016-17 **	3	29,870	2.12	\$167.16	\$353.67	\$31,694,000
2016-17 **	4	28,330	2.05	\$160.08	\$328.32	\$27,903,600
2016-17 **	TOTAL	29,780	2.09	\$167.93	\$350.31	\$125,195,000

* ACTUAL

** ESTIMATED

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

Medi-Cal Base Policy Changes

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

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

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 14 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:

Two Plan Model
County Organized Health Systems
Geographic Managed Care
PHP & Other Managed Care (Other M/C)
Regional Model
Dental
Mental Health
Audits/Lawsuits
EPSDT Screens
Medicare Payments
State Hospital/Developmental Centers
Miscellaneous Services (Misc. Svcs.)
Recoveries
Drug Medi-Cal

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$67,673,000	\$48,581,000	\$19,092,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$12,715,000	\$10,018,960	\$2,696,040
	ELIGIBILITY SUBTOTAL	\$80,388,000	\$58,599,960	\$21,788,040
DRUG MEDI-CAL				
63	NARCOTIC TREATMENT PROGRAM	\$93,397,000	\$93,397,000	\$0
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$32,632,000	\$20,339,000	\$12,293,000
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,495,000	\$14,495,000	\$0
67	RESIDENTIAL TREATMENT SERVICES	\$5,162,000	\$5,162,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$145,686,000	\$133,393,000	\$12,293,000
MENTAL HEALTH				
70	SMHS FOR ADULTS	\$909,985,000	\$839,574,000	\$70,411,000
71	SMHS FOR CHILDREN	\$1,016,690,000	\$974,791,000	\$41,899,000
	MENTAL HEALTH SUBTOTAL	\$1,926,675,000	\$1,814,365,000	\$112,310,000
MANAGED CARE				
105	TWO PLAN MODEL	\$20,052,924,000	\$14,829,759,030	\$5,223,164,970
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,353,031,000	\$6,197,000,560	\$2,156,030,440
107	GEOGRAPHIC MANAGED CARE	\$3,441,331,000	\$2,538,499,740	\$902,831,260
110	REGIONAL MODEL	\$1,309,989,000	\$969,629,560	\$340,359,440
114	PACE (Other M/C)	\$294,166,000	\$147,083,000	\$147,083,000
116	DENTAL MANAGED CARE (Other M/C)	\$144,027,000	\$87,601,860	\$56,425,140
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$60,948,000	\$30,474,000	\$30,474,000
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$3,702,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$456,500
	MANAGED CARE SUBTOTAL	\$33,664,734,000	\$24,804,206,750	\$8,860,527,250
OTHER				
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,649,830,000	\$1,218,687,000	\$1,431,143,000
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,661,965,000	\$0	\$1,661,965,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,708,743,000	\$1,708,743,000	\$0
167	DENTAL SERVICES	\$1,014,022,000	\$660,641,610	\$353,380,390
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,086,867,000	\$1,086,867,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,129,000	\$206,129,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$188,380,000	\$188,380,000	\$0
175	MEDI-CAL TCM PROGRAM	\$43,872,000	\$43,872,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,250,000	\$20,125,000	\$20,125,000
177	EPSDT SCREENS	\$38,271,000	\$19,523,850	\$18,747,150
183	LAWSUITS/CLAIMS	\$3,370,000	\$1,663,000	\$1,707,000
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,216,000	\$1,108,000	\$1,108,000

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	OTHER			
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,537,000	\$1,537,000	\$0
197	BASE RECOVERIES	<u>-\$306,727,000</u>	<u>-\$146,274,000</u>	<u>-\$160,453,000</u>
	OTHER SUBTOTAL	\$8,338,725,000	\$5,011,002,460	\$3,327,722,540
	GRAND TOTAL	<u><u>\$44,156,208,000</u></u>	<u><u>\$31,821,567,170</u></u>	<u><u>\$12,334,640,830</u></u>

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2016-17

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$62,379,000	\$50,094,000	\$12,285,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$11,701,000	\$10,296,880	\$1,404,120
	ELIGIBILITY SUBTOTAL	\$74,080,000	\$60,390,880	\$13,689,120
DRUG MEDI-CAL				
63	NARCOTIC TREATMENT PROGRAM	\$96,629,000	\$96,207,700	\$421,300
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$29,194,000	\$16,550,100	\$12,643,900
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,617,000	\$14,495,900	\$121,100
67	RESIDENTIAL TREATMENT SERVICES	\$5,745,000	\$5,745,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$146,185,000	\$132,998,700	\$13,186,300
MENTAL HEALTH				
70	SMHS FOR ADULTS	\$897,363,000	\$820,307,200	\$77,055,800
71	SMHS FOR CHILDREN	\$1,090,478,000	\$1,046,311,000	\$44,167,000
	MENTAL HEALTH SUBTOTAL	\$1,987,841,000	\$1,866,618,200	\$121,222,800
MANAGED CARE				
105	TWO PLAN MODEL	\$18,469,452,000	\$12,909,667,440	\$5,559,784,560
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$7,458,135,000	\$5,302,771,040	\$2,155,363,960
107	GEOGRAPHIC MANAGED CARE	\$3,408,128,000	\$2,439,562,240	\$968,565,760
110	REGIONAL MODEL	\$1,231,722,000	\$878,197,200	\$353,524,800
114	PACE (Other M/C)	\$322,812,000	\$161,406,000	\$161,406,000
116	DENTAL MANAGED CARE (Other M/C)	\$147,449,000	\$89,215,010	\$58,233,990
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$74,169,000	\$37,084,500	\$37,084,500
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$3,702,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$456,500
	MANAGED CARE SUBTOTAL	\$31,120,185,000	\$21,822,062,430	\$9,298,122,570
OTHER				
164	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,703,855,000	\$1,243,870,500	\$1,459,984,500
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,871,377,000	\$0	\$1,871,377,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,535,667,000	\$1,535,667,000	\$0
167	DENTAL SERVICES	\$1,140,954,000	\$741,058,830	\$399,895,170
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,493,950,000	\$1,493,950,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$207,330,000	\$207,330,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$161,949,000	\$161,949,000	\$0
175	MEDI-CAL TCM PROGRAM	\$39,634,000	\$39,634,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$41,545,000	\$20,772,500	\$20,772,500
177	EPSDT SCREENS	\$38,271,000	\$19,523,850	\$18,747,150
183	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$932,500
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,283,000	\$1,141,500	\$1,141,500

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2016-17**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	OTHER			
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$1,028,000	\$0
197	BASE RECOVERIES	-\$289,203,000	-\$137,917,000	-\$151,286,000
	OTHER SUBTOTAL	\$8,950,505,000	\$5,328,940,680	\$3,621,564,320
	GRAND TOTAL	\$42,278,796,000	\$29,211,010,890	\$13,067,785,110

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

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPI	\$93,271,000	\$38,806,000	\$67,673,000	\$19,092,000	-\$25,598,000	-\$19,714,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$16,482,000	\$5,768,700	\$12,715,000	\$2,696,040	-\$3,767,000	-\$3,072,660
	ELIGIBILITY SUBTOTAL	\$109,753,000	\$44,574,700	\$80,388,000	\$21,788,040	-\$29,365,000	-\$22,786,660
DRUG MEDI-CAL							
63	NARCOTIC TREATMENT PROGRAM	\$85,534,000	\$0	\$93,397,000	\$0	\$7,863,000	\$0
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$40,057,000	\$12,424,000	\$32,632,000	\$12,293,000	-\$7,425,000	-\$131,000
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$20,779,000	\$0	\$14,495,000	\$0	-\$6,284,000	\$0
67	RESIDENTIAL TREATMENT SERVICES	\$33,618,000	\$9,832,000	\$5,162,000	\$0	-\$28,456,000	-\$9,832,000
	DRUG MEDI-CAL SUBTOTAL	\$179,988,000	\$22,256,000	\$145,686,000	\$12,293,000	-\$34,302,000	-\$9,963,000
MENTAL HEALTH							
70	SMHS FOR ADULTS	\$1,149,581,000	\$68,885,000	\$909,985,000	\$70,411,000	-\$239,596,000	\$1,526,000
71	SMHS FOR CHILDREN	\$992,419,000	\$43,095,000	\$1,016,690,000	\$41,899,000	\$24,271,000	-\$1,196,000
	MENTAL HEALTH SUBTOTAL	\$2,142,000,000	\$111,980,000	\$1,926,675,000	\$112,310,000	-\$215,325,000	\$330,000
MANAGED CARE							
105	TWO PLAN MODEL	\$10,518,318,000	\$5,119,314,000	\$20,052,924,000	\$5,223,164,970	\$9,534,606,000	\$103,850,970
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,589,386,000	\$2,221,705,300	\$8,353,031,000	\$2,156,030,440	\$3,763,645,000	-\$65,674,860
107	GEOGRAPHIC MANAGED CARE	\$2,050,257,000	\$994,887,900	\$3,441,331,000	\$902,831,260	\$1,391,074,000	-\$92,056,640
110	REGIONAL MODEL	\$750,730,000	\$365,171,550	\$1,309,989,000	\$340,359,440	\$559,259,000	-\$24,812,110
114	PACE (Other M/C)	\$295,935,000	\$147,967,500	\$294,166,000	\$147,083,000	-\$1,769,000	-\$884,500
116	DENTAL MANAGED CARE (Other M/C)	\$146,820,000	\$60,779,700	\$144,027,000	\$56,425,140	-\$2,793,000	-\$4,354,560
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$47,202,000	\$23,601,000	\$60,948,000	\$30,474,000	\$13,746,000	\$6,873,000
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,003,000	\$3,501,500	\$7,405,000	\$3,702,500	\$402,000	\$201,000
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$976,000	\$488,000	\$913,000	\$456,500	-\$63,000	-\$31,500
	MANAGED CARE SUBTOTAL	\$18,406,627,000	\$8,937,416,450	\$33,664,734,000	\$8,860,527,250	\$15,258,107,000	-\$76,889,200
OTHER							
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,618,021,000	\$1,408,764,500	\$2,649,830,000	\$1,431,143,000	\$31,809,000	\$22,378,500
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,636,699,000	\$1,636,699,000	\$1,661,965,000	\$1,661,965,000	\$25,266,000	\$25,266,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,541,478,000	\$0	\$1,708,743,000	\$0	\$167,265,000	\$0

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

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER							
167	DENTAL SERVICES	\$1,101,822,000	\$428,145,500	\$1,014,022,000	\$353,380,390	-\$87,800,000	-\$74,765,110
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$845,295,000	\$0	\$1,086,867,000	\$0	\$241,572,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,500,000	\$0	\$206,129,000	\$0	-\$371,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$162,286,000	\$0	\$188,380,000	\$0	\$26,094,000	\$0
175	MEDI-CAL TCM PROGRAM	\$47,090,000	\$0	\$43,872,000	\$0	-\$3,218,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$44,659,000	\$22,329,500	\$40,250,000	\$20,125,000	-\$4,409,000	-\$2,204,500
177	EPSDT SCREENS	\$38,736,000	\$18,901,500	\$38,271,000	\$18,747,150	-\$465,000	-\$154,350
183	LAWSUITS/CLAIMS	\$3,690,000	\$1,845,000	\$3,370,000	\$1,707,000	-\$320,000	-\$138,000
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,152,000	\$1,076,000	\$2,216,000	\$1,108,000	\$64,000	\$32,000
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$0	\$1,537,000	\$0	\$252,000	\$0
197	BASE RECOVERIES	-\$277,433,000	-\$139,644,000	-\$306,727,000	-\$160,453,000	-\$29,294,000	-\$20,809,000
	OTHER SUBTOTAL	\$7,972,280,000	\$3,378,117,000	\$8,338,725,000	\$3,327,722,540	\$366,445,000	-\$50,394,460
	GRAND TOTAL	\$28,810,648,000	\$12,494,344,150	\$44,156,208,000	\$12,334,640,830	\$15,345,560,000	-\$159,703,320

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% F	\$67,673,000	\$19,092,000	\$62,379,000	\$12,285,000	-\$5,294,000	-\$6,807,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$12,715,000	\$2,696,040	\$11,701,000	\$1,404,120	-\$1,014,000	-\$1,291,920
	ELIGIBILITY SUBTOTAL	\$80,388,000	\$21,788,040	\$74,080,000	\$13,689,120	-\$6,308,000	-\$8,098,920
DRUG MEDI-CAL							
63	NARCOTIC TREATMENT PROGRAM	\$93,397,000	\$0	\$96,629,000	\$421,300	\$3,232,000	\$421,300
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$32,632,000	\$12,293,000	\$29,194,000	\$12,643,900	-\$3,438,000	\$350,900
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,495,000	\$0	\$14,617,000	\$121,100	\$122,000	\$121,100
67	RESIDENTIAL TREATMENT SERVICES	\$5,162,000	\$0	\$5,745,000	\$0	\$583,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$145,686,000	\$12,293,000	\$146,185,000	\$13,186,300	\$499,000	\$893,300
MENTAL HEALTH							
70	SMHS FOR ADULTS	\$909,985,000	\$70,411,000	\$897,363,000	\$77,055,800	-\$12,622,000	\$6,644,800
71	SMHS FOR CHILDREN	\$1,016,690,000	\$41,899,000	\$1,090,478,000	\$44,167,000	\$73,788,000	\$2,268,000
	MENTAL HEALTH SUBTOTAL	\$1,926,675,000	\$112,310,000	\$1,987,841,000	\$121,222,800	\$61,166,000	\$8,912,800
MANAGED CARE							
105	TWO PLAN MODEL	\$20,052,924,000	\$5,223,164,970	\$18,469,452,000	\$5,559,784,560	-\$1,583,472,000	\$336,619,590
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,353,031,000	\$2,156,030,440	\$7,458,135,000	\$2,155,363,960	-\$894,896,000	-\$666,480
107	GEOGRAPHIC MANAGED CARE	\$3,441,331,000	\$902,831,260	\$3,408,128,000	\$968,565,760	-\$33,203,000	\$65,734,500
110	REGIONAL MODEL	\$1,309,989,000	\$340,359,440	\$1,231,722,000	\$353,524,800	-\$78,267,000	\$13,165,360
114	PACE (Other M/C)	\$294,166,000	\$147,083,000	\$322,812,000	\$161,406,000	\$28,646,000	\$14,323,000
116	DENTAL MANAGED CARE (Other M/C)	\$144,027,000	\$56,425,140	\$147,449,000	\$58,233,990	\$3,422,000	\$1,808,850
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$60,948,000	\$30,474,000	\$74,169,000	\$37,084,500	\$13,221,000	\$6,610,500
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$7,405,000	\$3,702,500	\$0	\$0
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$913,000	\$456,500	\$0	\$0
	MANAGED CARE SUBTOTAL	\$33,664,734,000	\$8,860,527,250	\$31,120,185,000	\$9,298,122,570	-\$2,544,549,000	\$437,595,320
OTHER							
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,649,830,000	\$1,431,143,000	\$2,703,855,000	\$1,459,984,500	\$54,025,000	\$28,841,500

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

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER							
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,661,965,000	\$1,661,965,000	\$1,871,377,000	\$1,871,377,000	\$209,412,000	\$209,412,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,708,743,000	\$0	\$1,535,667,000	\$0	-\$173,076,000	\$0
167	DENTAL SERVICES	\$1,014,022,000	\$353,380,390	\$1,140,954,000	\$399,895,170	\$126,932,000	\$46,514,780
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,086,867,000	\$0	\$1,493,950,000	\$0	\$407,083,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,129,000	\$0	\$207,330,000	\$0	\$1,201,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$188,380,000	\$0	\$161,949,000	\$0	-\$26,431,000	\$0
175	MEDI-CAL TCM PROGRAM	\$43,872,000	\$0	\$39,634,000	\$0	-\$4,238,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,250,000	\$20,125,000	\$41,545,000	\$20,772,500	\$1,295,000	\$647,500
177	EPSDT SCREENS	\$38,271,000	\$18,747,150	\$38,271,000	\$18,747,150	\$0	\$0
183	LAWSUITS/CLAIMS	\$3,370,000	\$1,707,000	\$1,865,000	\$932,500	-\$1,505,000	-\$774,500
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,216,000	\$1,108,000	\$2,283,000	\$1,141,500	\$67,000	\$33,500
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,537,000	\$0	\$1,028,000	\$0	-\$509,000	\$0
197	BASE RECOVERIES	-\$306,727,000	-\$160,453,000	-\$289,203,000	-\$151,286,000	\$17,524,000	\$9,167,000
	OTHER SUBTOTAL	\$8,338,725,000	\$3,327,722,540	\$8,950,505,000	\$3,621,564,320	\$611,780,000	\$293,841,780
	GRAND TOTAL	\$44,156,208,000	\$12,334,640,830	\$42,278,796,000	\$13,067,785,110	-\$1,877,412,000	\$733,144,280

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

MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<u>ELIGIBILITY</u>	
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
<u>DRUG MEDI-CAL</u>	
63	NARCOTIC TREATMENT PROGRAM
64	INTENSIVE OUTPATIENT TREATMENT SERVICES
66	OUTPATIENT DRUG FREE TREATMENT SERVICES
67	RESIDENTIAL TREATMENT SERVICES
<u>MENTAL HEALTH</u>	
70	SMHS FOR ADULTS
71	SMHS FOR CHILDREN
<u>MANAGED CARE</u>	
105	TWO PLAN MODEL
106	COUNTY ORGANIZED HEALTH SYSTEMS
107	GEOGRAPHIC MANAGED CARE
110	REGIONAL MODEL
114	PACE (Other M/C)
116	DENTAL MANAGED CARE (Other M/C)
117	SENIOR CARE ACTION NETWORK (Other M/C)
120	AIDS HEALTHCARE CENTERS (Other M/C)
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
<u>OTHER</u>	
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
165	MEDICARE PAYMENTS - PART D PHASED-DOWN
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
167	DENTAL SERVICES
168	PERSONAL CARE SERVICES (Misc. Svcs.)
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
175	MEDI-CAL TCM PROGRAM

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

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
177	EPSDT SCREENS
183	LAWSUITS/CLAIMS
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)
197	BASE RECOVERIES

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/2014
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1837

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$67,673,000	\$62,379,000
- STATE FUNDS	\$19,092,000	\$12,285,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$67,673,000	\$62,379,000
STATE FUNDS	\$19,092,000	\$12,285,000
FEDERAL FUNDS	\$48,581,000	\$50,094,000

DESCRIPTION

Purpose:

This policy change estimates the benefits cost for the Medi-Cal Access Program (MCAP) mothers with incomes between 213-322% of the federal poverty level (FPL).

Authority:

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

Interdependent Policy Changes:

PC 8 Medi-Cal Access Program Infants 266-322% FPL

Background:

Effective July 1, 2014, the Access for Infants and Mothers Program (AIM) was transitioned and renamed MCAP. The MCAP covers pregnant women in families with incomes between 213-322% FPL. These pregnant women are subject to premiums fixed at 1.5% of their adjusted annual income.

Reason for Change from Prior Estimate:

- The May 2015 estimate assumed a monthly average of 3,774 pregnant women for FY 2015-16. Based on actual enrollment data through June 2015, the November 2015 estimate assumes a monthly average of 3,534 pregnant women for FY 2015-16 and 3,085 for FY 2016-17.
- June 2016 estimated capitation payments moved to FY 2016-17.
- Due to the timing of when June 2017 estimated capitation payments are received, they are assumed to be paid in FY 2017-18.

Methodology:

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

	FY 2015-16	FY 2016-17
Average monthly caseload	3,534	3,085
Deliveries	431	382

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

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

	FY 2015-16	FY 2016-17
PMPM: July-Sept 2014	\$493.37	
PMPM: Oct-Sept 2015	\$495.83	\$495.83
PMPD: July-Sept 2014	\$10,204.10	
PMPD: Oct-Sept 2015	\$11,582.93	\$11,582.93

- 3) Medi-Cal Access Program subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total \$3,639,000 in both FY 2015-16 and FY 2015-16.
- 4) The Department assumes 10% of the monthly subscribers have a maternity only deductible exceeding \$500 and are ineligible for FFP.
- 5) The total estimated costs for the Medi-Cal Access Program mothers in FY 2015-16 and FY 2016-17 are:

(Dollars in Thousands)

FY 2015-16	TF	SF	FF
65% Title XXI FFP/35% Perinatal Insurance Fund	\$24,777	\$8,672	\$16,105
88% Title XXI FFP/12% Perinatal Insurance Fund	\$39,324	\$4,719	\$34,605
100% Perinatal Insurance Fund	\$7,211	\$7,211	\$0
Premiums	(\$3,639)	(\$1,510)	(\$2,129)
Total	\$67,673	\$19,092	\$48,581

(Dollars in Thousands)

FY 2016-17	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	\$59,344	\$7,121	\$52,223
100% Perinatal Insurance Fund	\$6,674	\$6,674	\$0
Premiums	(\$3,639)	(\$1,510)	(\$2,129)
Total	\$62,379	\$12,285	\$50,094

Funding:

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL

BASE POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 11/2013
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1797

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$12,715,000	\$11,701,000
- STATE FUNDS	\$2,696,040	\$1,404,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,715,000	\$11,701,000
STATE FUNDS	\$2,696,040	\$1,404,120
FEDERAL FUNDS	\$10,018,960	\$10,296,880

DESCRIPTION

Purpose:

This policy change estimates the benefits cost for the Medi-Cal Access Program (MCAP) linked infants with incomes between 266-322% of the federal poverty level (FPL).

Authority:

AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Updated enrollment projections reflect a 41% decrease of 1st and 2nd year infants in FY 2015-16. This is based upon updated enrollment projections from PC 4 MCAP Mothers 213-322% FPL.

Methodology:

1. The Department estimates 3,349 average monthly infants with family income between 266% and 322% FPL will enroll in FY 2015-16 and 2,594 in FY 2016-17.
2. The Department estimates the weighted average monthly per-member-per-month (PMPM) cost in FY 2015-16 is \$342.39 and \$388.83 in FY 2016-17. The increase from FY 2015-16 to FY 2016-17 is due to an increase in the number of infants calculated at the first two-month infant rate.
3. MCAP subscribers are subject to monthly premiums. Premiums are estimated to total \$522,000 in FY 2015-16 and \$405,000 in FY 2016-17.

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL**BASE POLICY CHANGE NUMBER: 8**

4. The increased number of enrolled pregnant mothers will also have direct correlation to the increased number of enrolled linked infants into the Medi-Cal Infant Access Program and OTLICP.
5. The total estimated costs for the MCAP linked infants in FY 2015-16 and FY 2016-17 are:

(Dollars in thousands)	FY 2015-16		FY 2016-17	
	TF	GF	TF	GF
Benefits	\$13,237	\$2,807	\$12,105	\$1,453
Premiums	(\$522)	(\$111)	(\$405)	(\$49)
Net	\$12,715	\$2,696	\$11,701	\$1,404

Funding:

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

88% Title XXI FFP/12% GF (4260-113-0890/0001)

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1728

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$93,397,000	\$96,629,000
- STATE FUNDS	\$0	\$421,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$93,397,000	\$96,629,000
STATE FUNDS	\$0	\$421,300
FEDERAL FUNDS	\$93,397,000	\$96,207,700

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is 50% CF and 50% Title XIX federal funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. ACA Optional Expansion population is eligible for Title XIX federal reimbursement at 100% until December 2016 and 95% beginning January 2017.

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the regular and perinatal populations.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through March 2015.
2. The UOS is based on the total approved units divided by the caseload. Complete data from July

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

2013 through June 2014 was used to calculate the average UOS.

3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
4. The cost estimate is developed by the following: UOS x Rates x Caseload.

FY 2015-16	UOS	Rates	Caseload	Total
Regular				
Dosing	210.4	\$11.44	43,075	\$103,681,000
Individual	92.9	\$13.39	43,075	\$53,583,000
Group	0.3	\$3.02	43,075	\$39,000
EPSDT				
Dosing	116.0	\$11.44	406	\$539,000
Individual	58.5	\$13.39	406	\$318,000
Group	0.1	\$3.02	406	\$0
ACA Optional				
Dosing	210.4	\$11.44	4,600	\$11,071,000
Individual	92.9	\$13.39	4,600	\$5,722,000
Group	0.3	\$3.02	4,600	\$4,000
Total				\$174,957,000
Perinatal				
Dosing	101.1	\$13.72	204	\$282,000
Individual	41.2	\$21.40	204	\$180,000
Group	0.2	\$5.79	204	\$0
ACA Optional				
Dosing	101.1	\$13.72	22	\$31,000
Individual	41.2	\$21.40	22	\$20,000
Group	0.2	\$5.79	22	\$0
Total				\$513,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

FY 2016-17	UOS	Rates	Caseload	Total
Regular				
Dosing	210.4	\$11.44	43,075	\$103,681,000
Individual	92.9	\$13.39	43,075	\$53,583,000
Group	0.3	\$3.02	43,075	\$39,000
EPSDT				
Dosing	116.0	\$11.44	423	\$561,000
Individual	58.5	\$13.39	423	\$331,000
Group	0.1	\$3.02	423	\$0
ACA Optional				
Dosing	210.4	\$11.44	4,600	\$11,071,000
Individual	92.9	\$13.39	4,600	\$5,722,000
Group	0.3	\$3.02	4,600	\$4,000
Total				\$174,992,000
Perinatal				
Dosing	101.1	\$13.72	219	\$304,000
Individual	41.2	\$21.40	219	\$193,000
Group	0.2	\$5.79	219	\$0
ACA Optional				
Dosing	101.1	\$13.72	24	\$33,000
Individual	41.2	\$21.40	24	\$21,000
Group	0.2	\$5.79	24	\$0
Total				\$551,000

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

	Accrual	FY 2015-16	FY 2016-17
FY 2014-15			
Regular	\$152,457,000	\$38,114,000	\$0
Perinatal	\$472,000	\$118,000	\$0
FY 2015-16			
Regular	\$174,957,000	\$131,218,000	\$43,739,000
Perinatal	\$513,000	\$385,000	\$128,000
FY 2016-17			
Regular	\$174,992,000	\$0	\$131,245,000
Perinatal	\$551,000	\$0	\$414,000
		\$169,835,000	\$175,526,000

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

6. Total estimated federal reimbursements for NTP services are:

FY 2015-16	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Regular	\$153,133,000	\$76,100,000	\$753,000	\$76,280,000	\$0
Regular - ACA Optional 100%	\$16,201,000	\$16,201,000	\$0	\$0	\$0
Perinatal	\$452,000	\$0	\$294,000	\$158,000	\$0
Perinatal - ACA Optional 100%	\$49,000	\$49,000	\$0	\$0	\$0
Total	\$169,835,000	\$92,350,000	\$1,047,000	\$76,438,000	\$0

FY 2016-17	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Regular	\$158,186,000	\$78,683,000	\$778,000	\$78,725,000	\$0
Regular - ACA Optional 100%	\$8,399,000	\$8,399,000	\$0	\$0	\$0
Regular - ACA Optional 95/5%	\$8,399,000	\$7,979,000	\$0	\$0	\$420,000
Perinatal	\$488,000	\$0	\$317,000	\$171,000	\$0
Perinatal - ACA Optional 100%	\$27,000	\$27,000	\$0	\$0	\$0
Perinatal - ACA Optional 95/5%	\$27,000	\$25,000	\$0	\$0	\$1,000
Total	\$175,526,000	\$95,113,000	\$1,095,000	\$78,896,000	\$421,000

Funding:

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

100% Title XXI FF (4260-113-0890)

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

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

*Totals may differ due to rounding

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1726

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$32,632,000	\$29,194,000
- STATE FUNDS	\$12,293,000	\$12,643,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$32,632,000	\$29,194,000
STATE FUNDS	\$12,293,000	\$12,643,900
FEDERAL FUNDS	\$20,339,000	\$16,550,100

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. This service was limited to Early and Periodic Screening Diagnosis and Treatment (EPSDT), pregnant and postpartum women.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

With the provisions of the Affordable Care Act (ACA) starting January 1, 2014, the expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured and are considered part of the ACA mandatory expansion. The populations are described below:

ACA Population	Description	Funding
Expanded	Medi-Cal eligible and enrolled, but not receiving services: Non-EPSDT, non-pregnant/postpartum	50% GF/50% FF Title XIX; Certain aid codes 65% FF Title XXI
Mandatory	Medi-Cal eligible, but not enrolled in Medi-Cal	50% GF/50% FFP Title XIX Certain aid codes 65% and 88% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX (CY 2014-2016); 95% FFP Title XIX/5% GF (CY 2017)

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the regular, EPSDT and perinatal populations.

Methodology:

1. The DMC eligible clients are categorized into three groups: Regular, EPSDT, and Perinatal.
2. The caseload projections are based on complete caseload data from January 2010 through March 2015.
3. The UOS is based on the approved units divided by the caseload. Complete data from July 2013 through June 2014 was used to calculate the average UOS.
4. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
5. The cost estimate is developed by the following: UOS x Rate x Caseload.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

6. Amounts may differ due to rounding.

			FY 2015-16		FY 2016-17	
	UOS	Rates	Caseload	Total	Caseload	Total
Current						
Regular	18.7	\$58.30	1,964	\$2,142,000	1,839	\$2,005,000
EPSDT	38.5	\$58.30	832	\$1,867,000	779	\$1,748,000
Perinatal	32.9	\$82.10	214	\$578,000	200	\$541,000
Subtotal			3,010	\$4,587,000	2,818	\$4,294,000
Expanded						
Regular	18.7	\$58.30	22,578	\$24,615,000	22,582	\$24,619,000
EPSDT	38.5	\$58.30	-	\$0	-	\$0
Perinatal	32.9	\$82.10	-	\$0	-	\$0
Subtotal			22,578	\$24,615,000	22,582	\$24,619,000
Mandatory						
Regular	18.7	\$58.30	17	\$19,000	22	\$24,000
EPSDT	38.5	\$58.30	238	\$533,000	302	\$678,000
Perinatal	32.9	\$82.10	25	\$69,000	32	\$87,000
Subtotal			280	\$621,000	356	\$789,000
Optional						
Regular	18.7	\$58.30	305	\$333,000	357	\$389,000
EPSDT	38.5	\$58.30	-	\$0	-	\$0
Perinatal	32.9	\$82.10	388	\$1,049,000	453	\$1,225,000
Subtotal			694	\$1,382,000	810	\$1,614,000
Total				\$31,205,000		\$31,316,000

INTENSIVE OUTPATIENT TREATMENT SERVICES**BASE POLICY CHANGE NUMBER: 64**

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

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
Regular	\$34,821,000	\$8,705,250	\$0
Perinatal	\$8,922,000	\$2,230,500	\$0
FY 2014-15	\$43,743,000	\$10,935,750	\$0
Regular	\$29,509,000	\$22,131,750	\$7,377,250
Perinatal	\$1,696,000	\$1,272,000	\$424,000
FY 2015-16	\$31,205,000	\$23,403,750	\$7,801,250
Regular	\$29,463,000	\$0	\$22,097,250
Perinatal	\$1,853,000	\$0	\$1,389,750
FY 2016-17	\$31,316,000	\$0	\$23,487,000
Total		\$34,339,500	\$31,288,250

8. Funding for current beneficiaries is 50% CF and 50% FF. Beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% FF. Minor consent costs are funded 100% by the counties. Beneficiaries in the optional category are funded 100% FF (95% FF and 5% GF starting January 2017). A portion of children are funded 65% FF and 35% GF (88% FF and 12% GF starting October 2015) and the remaining children population at 50% FF and 50% GF.

FY 2015-16	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	\$4,963,000	\$914,000	\$2,580,000	\$1,469,000	\$0
Perinatal	\$682,000	\$5,000	\$438,000	\$239,000	\$0
Expanded					
Regular	\$24,141,000	\$11,986,000	\$139,000	\$0	\$12,016,000
Perinatal	\$0	\$0	\$0	\$0	\$0
Mandatory					
Regular	\$1,193,000	\$19,000	\$950,000	\$0	\$224,000
Perinatal	\$151,000	\$1,000	\$97,000	\$0	\$53,000
Optional					
Regular	\$1,902,000	\$1,902,000	\$0	\$0	\$0
Perinatal	\$1,308,000	\$1,308,000	\$0	\$0	\$0
Total	\$34,340,000	\$16,135,000	\$4,204,000	\$1,708,000	\$12,293,000

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

FY 2016-17	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	\$3,815,000	\$1,901,000	\$13,000	\$1,901,000	\$0
Perinatal	\$551,000	\$4,000	\$354,000	\$193,000	\$0
Expanded					
Regular	\$24,618,000	\$12,222,000	\$152,000	\$0	\$12,244,000
Perinatal	\$0	\$0	\$0	\$0	\$0
Mandatory					
Regular	\$664,000	\$332,000	\$0	\$0	\$332,000
Perinatal	\$83,000	\$1,000	\$53,000	\$0	\$29,000
Optional					
Regular 100% FF	\$188,000	\$188,000	\$0	\$0	\$0
Regular 95% FF / 5% GF	\$187,000	\$178,000	\$0	\$0	\$9,000
Perinatal 100% FF	\$591,000	\$591,000	\$0	\$0	\$0
Perinatal 95% FF / 5% GF	\$591,000	\$561,000	\$0	\$0	\$30,000
Total	\$31,288,000	\$15,978,000	\$572,000	\$2,094,000	\$12,644,000

Funding:

100% General Fund (4260-101-0001)

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

100% Title XXI FF (4260-113-0890)

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

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

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1727

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$14,495,000	\$14,617,000
- STATE FUNDS	\$0	\$121,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,495,000	\$14,617,000
STATE FUNDS	\$0	\$121,100
FEDERAL FUNDS	\$14,495,000	\$14,495,900

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is generally 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. ACA Optional population is eligible for Title XIX federal reimbursement at 100% until December 2016 and 95% beginning January 2017.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

Reason for Change from Prior Estimate:

The change is due to updated caseload, rates, and units of service (UOS).

Methodology:

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent (MC), and Perinatal.
2. The caseload projections are based on complete caseload data from January 2010 through March 2015.
3. The Units of Service (UOS) data is based on the most recent complete data, July 2013-June 2014, to calculate an average UOS.
4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance (DOF), whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 required rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
6. The cost estimate is developed by the following: UOS x Rate x Caseload.
7. Amounts may contain rounding differences.

	UOS	Rates	FY 2015-16		FY 2016-17	
			Caseload	Total	Caseload	Total
Current Population						
Regular						
Individual	2.9	\$66.93	19,402	\$3,766,000	16,774	\$3,256,000
Group	23	\$27.14	19,402	\$12,111,000	16,774	\$10,471,000
Subtotal				\$15,877,000		\$13,727,000
EPSDT						
Individual	4.8	\$66.93	4,153	\$1,334,000	3,591	\$1,154,000
Group	24.1	\$27.14	4,153	\$2,717,000	3,591	\$2,349,000
Subtotal				\$4,051,000		\$3,503,000
Minor Consent						
Individual	4.8	\$66.93	1,108	\$356,000	958	\$308,000
Group	21.1	\$27.14	1,108	\$635,000	958	\$549,000
Subtotal				\$991,000		\$857,000
Perinatal						
Individual	2.2	\$107.04	259	\$61,000	224	\$53,000
Group	13.8	\$52.11	259	\$186,000	224	\$161,000
Subtotal				\$247,000	-	\$214,000
Mandatory						
Regular						
Individual	2.9	\$66.93	585	\$113,000	1,184	\$230,000
Group	23	\$27.14	585	\$365,000	1,184	\$739,000
Subtotal				\$478,000		\$969,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

			FY 2015-16		FY 2016-17	
EPSDT						
Individual	4.8	\$66.93	219	\$70,000	444	\$143,000
Group	24.1	\$27.14	219	\$143,000	444	\$290,000
Subtotal				\$213,000		\$433,000
Minor Consent						
Individual	4.8	\$66.93	101	\$32,000	205	\$66,000
Group	21.1	\$27.14	101	\$58,000	205	\$117,000
Subtotal				\$90,000		\$183,000
Perinatal						
Individual	2.2	\$107.04	12	\$3,000	25	\$6,000
Group	13.8	\$52.11	12	\$9,000	25	\$18,000
Subtotal				\$12,000		\$24,000
Optional						
Regular						
Individual	2.9	\$66.93	3,997	\$776,000	6,387	\$1,240,000
Group	23	\$27.14	3,997	\$2,495,000	6,387	\$3,987,000
Subtotal				\$3,271,000		\$5,227,000
EPSDT						
Individual	4.8	\$66.93	-	\$0	-	\$0
Group	24.1	\$27.14	-	\$0	-	\$0
Subtotal				\$0		\$0
Perinatal						
Individual	2.2	\$107.04	75	\$18,000	121	\$28,000
Group	13.8	\$52.11	75	\$54,000	121	\$87,000
Subtotal				\$72,000		\$115,000
Total				\$25,302,000		\$ 25,252,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

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

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
Regular	\$32,083,000	\$7,938,250	\$0
Minor Consent	\$2,281,000	\$645,500	\$0
Perinatal	\$733,000	\$163,000	\$0
FY 2014-15	\$35,097,000	\$8,746,750	\$0
Current			
Regular	\$19,928,000	\$14,946,000	\$4,982,000
Minor Consent	\$991,000	\$743,250	\$247,750
Perinatal	\$247,000	\$185,250	\$61,750
Mandatory			
Regular	\$691,000	\$518,250	\$172,750
Minor Consent	\$90,000	\$67,500	\$22,500
Perinatal	\$12,000	\$9,000	\$3,000
Optional			
Regular	\$3,271,000	\$2,453,250	\$817,750
Perinatal	\$72,000	\$54,000	\$18,000
FY 2015-16	\$25,302,000	\$18,976,500	\$6,325,500
Current			
Regular	\$17,230,000	\$0	\$12,922,500
Minor Consent	\$857,000	\$0	\$642,750
Perinatal	\$214,000	\$0	\$160,500
Mandatory			
Regular	\$1,402,000	\$0	\$1,051,500
Minor Consent	\$183,000	\$0	\$137,250
Perinatal	\$24,000	\$0	\$18,000
Optional			
Regular	\$5,227,000	\$0	\$3,920,250
Perinatal	\$115,000	\$0	\$86,250
FY 2016-17	\$25,252,000	\$0	\$18,939,000
Total		\$27,723,250	\$25,264,500

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

9. Total estimated federal reimbursements for ODF treatment services are:

FY 2015-16	TF	FF	FF	GF	County
		(Title XIX)	(Title XXI)		
Current					
Regular	\$22,881,000	\$11,362,000	\$132,000	\$0	\$11,387,000
Minor Consent	\$1,389,000	\$0	\$0	\$0	\$1,389,000
Perinatal	\$348,000	\$2,000	\$224,000	\$0	\$122,000
Mandatory					
Regular	\$521,000	\$259,000	\$3,000	\$0	\$259,000
Minor Consent	\$68,000	\$0	\$0	\$0	\$68,000
Perinatal	\$9,000	\$0	\$6,000	\$0	\$3,000
Optional					
Regular	\$2,453,000	\$2,453,000	\$0	\$0	\$0
Perinatal	\$54,000	\$54,000	\$0	\$0	\$0
Total	\$27,723,000	\$14,130,000	\$365,000	\$0	\$13,228,000

FY 2016-17	TF	FF	FF	GF	County
		(Title XIX)	(Title XXI)		
Current					
Regular	\$17,903,000	\$8,890,000	\$110,000	\$0	\$8,903,000
Minor Consent	\$891,000	\$0	\$0	\$0	\$891,000
Perinatal	\$223,000	\$2,000	\$143,000	\$0	\$78,000
Mandatory					
Regular	\$1,225,000	\$608,000	\$8,000	\$0	\$609,000
Minor Consent	\$160,000	\$0	\$0	\$0	\$160,000
Perinatal	\$20,000	\$0	\$13,000	\$0	\$7,000
Optional					
Regular – 100% FF	\$2,369,000	\$2,369,000	\$0	\$0	\$0
Regular - 95% FF	\$2,369,000	\$2,251,000	\$0	\$118,000	\$0
Perinatal - 100% FF	\$52,000	\$52,000	\$0	\$0	\$0
Perinatal - 95% FF	\$53,000	\$50,000	\$0	\$3,000	\$0
Total	\$25,265,000	\$14,222,000	\$ 274,000	\$121,000	\$10,648,000

Funding:

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

100% Title XXI FF (4260-113-0890)

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

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

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1725

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$5,162,000	\$5,745,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,162,000	\$5,745,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,162,000	\$5,745,000

DESCRIPTION

Purpose:

This policy change estimates the reimbursement for the Drug Medi-Cal (DMC) Residential Treatment services.

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

The DMC program provides certain medically necessary substance use treatment services. These services are provided by certified providers under contract with the counties or with the State. Perinatal services are reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67

RTS funding for both current and ACA mandatory expansion populations is 50% CF and 50% Title XIX Federal Funds (FF) with certain aid codes eligible for Title XXI federal reimbursement at 65%. Non-federal share of cost is budgeted by County Funds (CF).

Effective September 1, 2015, the Drug Medi-Cal Organized Delivery System (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. Cost for the non-perinatal expansion population is budgeted in policy change titled Residential Treatment Services Expansion.

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the perinatal population. In addition, costs for the RTS expansion to non-perinatal population is now budgeted in policy change titled Residential Treatment Services Expansion.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through March 2015.
2. The UOS is based on the most recent complete data, July 2013-June 2014 to calculate an average UOS for existing caseload.
3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about FY 2016-17 rates, see the Annual Rate Adjustment policy change.
4. The cost estimate is developed by the following: Caseload x UOS x Rates

	Caseload	UOS	Rates	Total*
FY 2015-16	1,661	61.5	\$101.05	\$10,320,000
FY 2016-17	1,891	61.5	\$101.05	\$11,753,000

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

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
FY 2014-15	\$10,038,000	\$2,510,000	\$0
FY 2015-16	\$10,320,000	\$7,740,000	\$2,580,000
FY 2016-17	\$11,753,000	\$0	\$8,815,000
Total		\$10,250,000	\$11,395,000

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67

Funding:

FY 2015-16	TF	FFP	CF
100% Title XIX FFP (4260-101-0890)	\$10,137,000	\$5,069,000	\$5,068,000
100% Title XXI FFP (4260-113-0890)	\$113,000	\$93,000	\$20,000
Total	\$10,250,000	\$5,162,000	\$5,088,000

FY 2016-17	TF	FFP	CF
100% Title XIX FFP (4260-101-0890)	\$11,270,000	\$5,635,000	\$5,635,000
100% Title XXI FFP (4260-113-0890)	\$125,000	\$110,000	\$15,000
Total	\$11,395,000	\$5,745,000	\$5,650,000

*Totals may differ due to rounding

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1780

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$909,985,000	\$897,363,000
- STATE FUNDS	\$70,411,000	\$77,055,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$909,985,000	\$897,363,000
STATE FUNDS	\$70,411,000	\$77,055,800
FEDERAL FUNDS	\$839,574,000	\$820,307,200

DESCRIPTION

Purpose:

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

Authority

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

The following Medi-Cal SMHS are available for adults:

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

Reason for Change from Prior Estimate:

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

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months of FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2015, with dates of service from June 2009 through March 2015. The FFS data is current as of June 30, 2015, with dates of service from April 2009 through January 2015.
2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2013-14	\$1,124,291	\$990,165	\$134,126
FY 2014-15	\$1,181,903	\$1,044,001	\$137,902
FY 2015-16	\$1,240,248	\$1,098,174	\$142,074
FY 2016-17	\$1,298,592	\$1,152,347	\$146,245

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

5. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2013-14 claims, 28% of FY 2013-14 claims, and 71% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2013-14	\$11,243	\$9,902	\$1,341
FY 2014-15	\$258,089	\$219,336	\$38,753
FY 2015-16	\$957,203	\$856,475	\$100,728
Total FY 2015-16	\$1,226,535	\$1,085,713	\$140,822

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 21% of FY 2015-16 claims, and 78% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2014-15 claims, 28% of FY 2015-16 claims, and 71% of FY 2016-17 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2014-15	\$11,819	\$10,440	\$1,379
FY 2015-16	\$270,642	\$230,717	\$39,925
FY 2016-17	\$1,002,412	\$898,727	\$103,685
Total FY 2016-17	\$1,284,873	\$1,139,884	\$144,989

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

(Dollars In Thousands)

Cash Estimate	TF	FF	County	GF Reimbursement
Total FY 2015-16	\$1,226,535	\$613,268	\$542,856	\$70,411
Total FY 2016-17	\$1,284,873	\$642,437	\$569,941	\$72,495

8. Assume ACA impact to SMHS for Adults is \$226,306,000 in FY 2015-16, funded by 100% federal funds (FF), and \$182,431,000 in FY 2016-17 funded by 95% FF and 5% GF beginning January 1, 2017.

(Dollars in Thousands)

Cash Estimate	TF	FF	County	GF	GF Reimbursement
Total FY 2015-16	\$1,452,841	\$839,574	\$542,856	\$0	\$70,411
Total FY 2016-17	\$1,467,304	\$820,307	\$569,941	\$4,561	\$72,495

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

9. This table shows the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services in FY 2015-16 and FY 2016-17.

	FY 2015-16 Utilization	FY 2016-17 Utilization
SD/MC	378,558	403,059
FFS	27,749	29,851
TOTAL	406,307	432,910

Funding:

100% Title XIX FFP (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Title XIX ACA FFP (4260-101-0890)
95% Title XIX FF / 5% GF (4260-101-0001/0890)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1779

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,016,690,000	\$1,090,478,000
- STATE FUNDS	\$41,899,000	\$44,167,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,016,690,000	\$1,090,478,000
STATE FUNDS	\$41,899,000	\$44,167,000
FEDERAL FUNDS	\$974,791,000	\$1,046,311,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

The following Medi-Cal SMHS are available for children:

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

*Children - Age 18 through 20

Reason for Change from Prior Estimate:

Expenditures increased due to the inclusion of additional approved claims data as of June 30, 2015. Also, there are enhanced federal funds of 88% beginning October 1, 2015, for CHIP expenditures.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) and 70 months Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2015, with dates of service from June 2009 through March 2015. The FFS data is current as of June 30, 2015, with dates of service from April 2009 through January 2015.
2. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent six months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.
3. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

	FY 2015-16 Utilization	FY 2016-17 Utilization
SD/MC	280,569	292,284
FFS	14,040	14,944
TOTAL	294,609	307,228

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

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

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2013-14	\$1,671,870	\$1,596,255	\$75,615
FY 2014-15	\$1,749,995	\$1,665,538	\$84,457
FY 2015-16	\$1,849,625	\$1,759,003	\$90,622
FY 2016-17	\$1,949,254	\$1,852,467	\$96,787

5. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2013-14 claims, 28% of FY 2014-15 claims, and 71% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2013-14	\$16,719	\$15,963	\$756
FY 2014-15	\$373,649	\$349,915	\$23,734
FY 2015-16	\$1,436,111	\$1,371,861	\$64,250
Total FY 2015-16	\$1,826,479	\$1,737,739	\$88,740

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 21% of FY 2015-16 claims, and 78% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2014-15 claims, 28% of FY 2015-16 claims, and 71% of FY 2016-17 claims. Amounts may contain rounding differences. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2014-15	\$17,500	\$16,655	\$845
FY 2015-16	\$395,017	\$369,551	\$25,466
FY 2016-17	\$1,513,377	\$1,444,756	\$68,621
Total FY 2016-17	\$1,925,894	\$1,830,962	\$94,932

7. Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement at 65% and 88% (beginning October 1, 2015). Medi-Cal claims are eligible for 50% federal reimbursement. GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars In Thousands)

	TF	FF	M-CHIP*	County	GF Reimbursement
FY 2015-16	\$1,826,480	\$817,811	\$156,980	\$809,790	\$41,899
FY 2016-17	\$1,925,894	\$853,259	\$193,052	\$835,416	\$44,167

Funding:

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

100% Title XXI FFP (4260-113-0890)*

100% Reimbursement (4260-601-0995)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 56

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$20,052,924,000	\$18,469,452,000
- STATE FUNDS	\$5,223,164,970	\$5,559,784,560
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,052,924,000	\$18,469,452,000
STATE FUNDS	\$5,223,164,970	\$5,559,784,560
FEDERAL FUNDS	\$14,829,759,030	\$12,909,667,440

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 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:

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

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

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

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 105

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs. The base IGT capitation payments for Alameda County are budgeted in this policy change.
3. Rates have been redetermined for FY 2015-16.
4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$270,550,000 for FY 2015-16 and \$421,030,000 for FY 2016-17 were included in the rates.
5. The savings from AB 97 are included in the rates. Savings of \$120,343,000 for FY 2015-16 and \$158,543,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care physicians effective January 1, 2015.
6. Services provided through the LA Mobile Vision Pilot Project are included in the rates. These were previously budgeted in PC 53 Pediatric Mobile Vision Project.
7. Capitation rate increases due to the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
8. The Department receives federal reimbursement of 90% for family planning services.
9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP of 88/12 will be budgeted for OTLICP.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alameda	3,649,980	\$1,138,796
Contra Costa	2,295,486	\$666,338
Kern	3,447,579	\$768,389
Los Angeles	32,415,865	\$8,852,095
Riverside	7,496,627	\$1,821,627
San Bernardino	7,619,222	\$1,816,674
San Francisco	1,769,721	\$641,472
San Joaquin	2,801,979	\$649,019
Santa Clara	3,692,969	\$1,011,253
Stanislaus	2,179,213	\$631,833
Tulare	2,264,851	\$478,680
Fresno	4,424,466	\$1,100,435
Kings	522,411	\$122,651
Madera	634,169	\$148,500
Total	75,214,536	\$19,847,762
Hepatitis C Adjustment		\$205,162
Total FY 2015-16		\$20,052,924

(Dollars in Thousands)

Included in the Above Dollars	FY 2015-16
Mental Health	\$270,550
Blood Factor	(\$10,715)
AB 97	(\$120,343)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alameda	3,691,420	\$1,003,984
Contra Costa	2,320,352	\$624,606
Kern	3,459,345	\$770,050
Los Angeles	32,666,939	\$7,990,580
Riverside	7,595,694	\$1,703,458
San Bernardino	7,712,085	\$1,721,316
San Francisco	1,785,937	\$560,935
San Joaquin	2,819,528	\$624,569
Santa Clara	3,717,047	\$928,191
Stanislaus	2,190,703	\$598,066
Tulare	2,275,315	\$445,309
Fresno	4,462,434	\$1,054,741
Kings	524,688	\$108,422
Madera	636,524	\$139,704
Total	75,858,011	\$18,273,931
Heptatitis C Adjustment		\$195,521
Total FY 2016-17		\$18,469,452

(Dollars in Thousands)

Included in the Above Dollars	FY 2016-17
Mental Health	\$287,903
Blood Factor	(\$14,612)
AB 97	(\$158,543)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$10,118,704	\$5,059,352	\$5,059,352
State GF	\$32,227	\$32,227	\$0
ACA 100%FFP	\$9,108,189	\$0	\$9,108,189
Family Planning 90/10 GF	\$120,183	\$12,018	\$108,165
Title XXI 65/35 GF	\$168,405	\$58,942	\$109,463
Title XXI 88/12 GF	\$505,216	\$60,626	\$444,590
Total	\$20,052,924	\$5,223,165	\$14,829,759

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$10,515,121	\$5,257,561	\$5,257,561
State GF	\$32,230	\$32,230	\$0
ACA 95/5 GF	\$3,569,760	\$178,488	\$3,391,272
ACA 100%FFP	\$3,569,760	\$0	\$3,569,760
Family Planning 90/10 GF	\$120,183	\$12,018	\$108,165
Title XXI 88/12 GF	\$662,398	\$79,488	\$582,910
Total	\$18,469,452	\$5,559,784	\$12,909,668

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 12/1987
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 57

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$8,353,031,000	\$7,458,135,000
- STATE FUNDS	\$2,156,030,440	\$2,155,363,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,353,031,000	\$7,458,135,000
STATE FUNDS	\$2,156,030,440	\$2,155,363,960
FEDERAL FUNDS	\$6,197,000,560	\$5,302,771,040

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 124 Managed Care Expansion to Rural Counties
 PC 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:

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

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

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

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 115 Managed Care Rate Range IGTs. The base IGT capitation payments for San Mateo County are budgeted in this policy change.
3. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA).
4. Rates have been redetermined for FY 2015-16.
5. Capitation rate increases due to the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy change.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$71,332,000 for FY 2015-16 and \$91,328,000 for FY 2016-17 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$37,043,000 for FY 2015-16 and \$42,563,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
8. The Department receives federal reimbursement of 90% for family planning services.
9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
501- San Luis Obispo	636,941	\$198,711
502- SantaBarbara	1,343,786	\$410,526
503- San Mateo	1,280,993	\$494,990
504- Solano	1,277,138	\$475,732
505- Santa Cruz	792,169	\$272,899
506- Orange	8,924,325	\$2,952,164
507- Napa	331,174	\$124,357
508- Monterey	1,732,456	\$534,128
509- Yolo	607,200	\$217,517
513- Sonoma	1,298,687	\$484,001
514- Merced	1,471,596	\$366,956
510 - Marin	425,135	\$194,196
512 - Mendocino	424,808	\$143,121
515 - Ventura	2,296,514	\$726,080
523 - Del Norte	129,942	\$40,822
517 - Humboldt	568,953	\$182,296
511 - Lake	333,886	\$103,644
518 - Lassen	82,794	\$26,273
519 - Modoc	35,097	\$12,319
520 - Shasta	731,787	\$242,258
521 - Siskiyou	191,714	\$63,421
522 - Trinity	54,858	\$18,014
Total FY 2015-16	24,971,954	\$8,284,425
Hepatitis C Adjustmt		\$68,606
Total with Adjustments		\$8,353,031

(Dollars in Thousands)

Included in Above Dollars	FY 2015-16
Mental Health	\$71,332
Blood Factor	(\$18,839)
AB 97	(\$37,043)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
501- San Luis Obispo	641,967	\$190,183
502- SantaBarbara	1,351,011	\$404,041
503- San Mateo	1,287,419	\$408,641
504- Solano	1,284,972	\$415,497
505- Santa Cruz	793,545	\$232,654
506-Orange	8,971,661	\$2,498,801
507- Napa	335,466	\$122,387
508- Monterey	1,747,984	\$478,114
509- Yolo	610,457	\$198,523
513- Sonoma	1,311,536	\$439,186
514- Merced	1,480,598	\$356,810
510 - Marin	427,303	\$164,038
512 - Mendocino	425,783	\$130,121
515 -Ventura	2,302,405	\$637,687
523 - DelNorte	130,014	\$42,183
517 -Humboldt	570,853	\$191,242
511 -Lake	334,893	\$107,626
518 -Lassen	82,992	\$27,158
519 -Modoc	35,327	\$12,688
520 - Shasta	734,023	\$250,894
521 - Siskiyou	192,153	\$65,697
522 - Trinity	55,039	\$18,814
Total FY 2016-17	25,107,401	\$7,392,985
Hepatitis C Adjustment		\$65,150
Total with Adjustments		\$7,458,135

(Dollars in Thousands)

Included in Above Dollars	FY 2016-17
Mental Health	\$91,328
Blood Factor	(\$31,252)
AB 97	(\$42,563)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$4,144,889	\$2,072,445	\$2,072,445
State GF	\$14,303	\$14,303	\$0
Family Planning 90/10 GF	\$42,596	\$4,260	\$38,336
Title XXI 65/35 GF	\$91,582	\$32,054	\$59,528
Title XXI 88/12 GF	\$274,747	\$32,970	\$241,777
ACA 100%FFP	\$3,784,914	\$0	\$3,784,914
Total	\$8,353,031	\$2,156,032	\$6,196,999

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$4,037,655	\$2,018,828	\$2,018,828
State GF	\$14,319	\$14,319	\$0
Family Planning 90/10 GF	\$42,596	\$4,260	\$38,336
Title XXI 88/12 GF	\$356,518	\$42,782	\$313,736
ACA 100%FFP	\$1,503,524	\$0	\$1,503,524
ACA 95/5 GF	\$1,503,524	\$75,177	\$1,428,347
Total	\$7,458,135	\$2,155,365	\$5,302,771

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 4/1994
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 58

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$3,441,331,000	\$3,408,128,000
- STATE FUNDS	\$902,831,260	\$968,565,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,441,331,000	\$3,408,128,000
STATE FUNDS	\$902,831,260	\$968,565,760
FEDERAL FUNDS	\$2,538,499,740	\$2,439,562,240

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 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:

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

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

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

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs.
3. Rates have been redetermined for FY 2015-16.
4. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$45,275,000 for FY 2015-16 and \$47,816,000 for FY 2016-17 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$22,939,000 for FY 2015-16 and \$29,463,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
7. The FY 2015-16 and FY 2016-17 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.
8. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Sacramento	4,902,131	\$1,243,599
San Diego	7,564,490	\$2,164,576
Total	12,466,621	\$3,408,175
Hepatitis C Adjustment		\$33,156
Total FY 2015-16		\$3,441,331

(Dollars in Thousands)

Included in Dollars Above	FY 2015-16
Mental Health	\$45,275
Blood Factor	(\$1,953)
AB 97	(\$22,939)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Sacramento	4,918,161	\$1,202,157
San Diego	7,619,157	\$2,174,468
Total	12,537,318	\$3,376,625
Hepatitis C Adjustment		\$31,503
Total FY 2016-17		\$3,408,128

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	\$47,816
Blood Factor	(\$4,648)
AB 97	(\$29,463)

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$1,737,667	\$868,833	\$868,833
State GF	\$5,544	\$5,544	\$0
Family Planning 90/10 GF	\$21,737	\$2,174	\$19,563
Title XXI 65/35 GF	\$37,014	\$12,955	\$24,059
Title XXI 88/12 GF	\$111,043	\$13,325	\$97,718
ACA Optional Expansion 100% FF	\$1,528,326	\$0	\$1,528,326
Total	\$3,441,331	\$902,831	\$2,538,500

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$1,814,940	\$907,470	\$907,470
State GF	\$5,546	\$5,546	\$0
Family Planning 90/10 GF	\$21,737	\$2,174	\$19,563
Title XXI 88/12 GF	\$149,778	\$17,973	\$131,805
ACA Optional Expansion 100% FF	\$708,064	\$0	\$708,064
ACA Optional Expansion 95/5 GF	\$708,064	\$35,403	\$672,661
Total	\$3,408,128	\$968,566	\$2,439,563

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110
 IMPLEMENTATION DATE: 11/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1842

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,309,989,000	\$1,231,722,000
- STATE FUNDS	\$340,359,440	\$353,524,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,309,989,000	\$1,231,722,000
STATE FUNDS	\$340,359,440	\$353,524,800
FEDERAL FUNDS	\$969,629,560	\$878,197,200

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 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:

Managed care was previously in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the state. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinated their care and leads to better health outcomes and lower costs.

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

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110

Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rebasing process includes refreshed data and adjustments to trends.
2. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
3. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs.
4. Rates have been redetermined for FY 2015-16.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$15,219,000 for FY 2015-16 and \$17,134,000 for FY 2016-17 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$3,981,000 for FY 2015-16 and \$5,228,000 for FY 2016-17 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.
7. The FY 2015-16 and FY 2016-17 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.
8. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.
9. Effective December 1, 2014, all non-dual Seniors and Persons with Disabilities (SPDs) were required to enroll.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alpine	2,889	\$1,024
Amador	73,380	\$23,012
Butte	776,095	\$259,906
Calaveras	110,548	\$34,919
Colusa	76,441	\$17,511
El Dorado	338,178	\$107,350
Glenn	108,079	\$29,578
Inyo	46,473	\$13,262
Mariposa	44,309	\$13,779
Mono	29,959	\$8,183
Nevada	217,451	\$67,684
Placer	525,893	\$156,312
Plumas	50,844	\$17,317
Sierra	6,778	\$2,285
Sutter	370,694	\$102,011
Tehama	243,026	\$73,993
Tuolumne	133,394	\$43,385
Yuba	284,709	\$85,914
Imperial	638,559	\$218,500
San Benito	69,165	\$22,106
Total FY 2015-16	4,146,863	\$1,298,031
Hepatitis C Adjustment		\$11,958
Total with Adjustments		\$1,309,989

(Dollars in Thousands)

Included in Dollars Above	FY 2015-16
Mental Health	\$15,219
Blood Factor	(\$3,828)
AB 97	(\$3,981)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alpine	2,884	\$936
Amador	73,361	\$21,355
Butte	776,789	\$247,318
Calaveras	110,527	\$32,539
Colusa	76,372	\$16,323
El Dorado	338,448	\$100,071
Glenn	107,976	\$27,932
Inyo	46,453	\$12,351
Mariposa	44,319	\$12,753
Mono	29,932	\$7,426
Nevada	217,343	\$62,861
Placer	526,087	\$145,404
Plumas	50,804	\$16,268
Sierra	6,777	\$2,110
Sutter	370,570	\$95,778
Tehama	243,144	\$70,791
Tuolumne	133,380	\$40,744
Yuba	284,730	\$82,031
Imperial	639,169	\$206,163
San Benito	70,335	\$19,270
Total FY 2016-17	4,149,401	\$1,220,424
Hepatitis C Adjustment		\$11,298
Total with Adjustments		\$1,231,722

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	\$17,134
Blood Factor	(\$5,796)
AB 97	(\$5,228)

Funding:

(Dollars in Thousands)

FY 2015-16		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$653,309	\$326,654	\$326,654
State GF	4260-101-0001	\$3,886	\$3,886	\$0
ACA 100% FFP	4260-101-0890	\$593,673	\$0	\$593,673
Family Planning 90/10 GF	4260-101-0001/0890	\$8,706	\$871	\$7,835
Title XXI FF 65/35 GF	4260-113-0001/0890	\$12,604	\$4,411	\$8,193
Title XXI FF 88/12 GF	4260-113-0001/0890	\$37,812	\$4,537	\$33,275
Total		\$1,309,990	\$340,359	\$969,631

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2016-17		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$660,574	\$330,287	\$330,287
State GF	4260-101-0001	\$3,888	\$3,888	\$0
ACA 95/5 GF	4260-101-0890	\$255,512	\$12,776	\$242,736
ACA 100%FFP	4260-101-0890	\$255,512	\$0	\$255,512
Family Planning 90/10 GF	4260-101-0001/0890	\$8,706	\$871	\$7,835
Title XXI FF 88/12 GF	4260-113-0001/0890	\$47,530	\$5,704	\$41,826
Total		\$1,231,722	\$353,526	\$878,196

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 114
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 62

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$294,166,000	\$322,812,000
- STATE FUNDS	\$147,083,000	\$161,406,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$294,166,000	\$322,812,000
STATE FUNDS	\$147,083,000	\$161,406,000
FEDERAL FUNDS	\$147,083,000	\$161,406,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

The Department currently has eleven contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. The Department is finalizing an application for a new PACE organization and is expected to begin operations in April 2017. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits (UPL), pursuant to SB 870. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 114

Below is a list of PACE organizations:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco	November 1, 1983
	Alameda	July 1, 2002
	Santa Clara	January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
	Contra Costa	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Central Valley Medical Svs.	Fresno	August 1, 2014
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	April 1, 2015
Hope Through Housing	San Bernardino	April 1, 2017
	Riverside	April 1, 2017

Reason for Change from Prior Estimate:

Estimated enrollment projections decreased by 2% in FY 2015-16 and increased 13% in FY 2016-17. A delay in implementation of 2015 PACE rates for all plans and 2014 rates for three plans increased costs for FY 2015-16.

Methodology:

1. Assume the 2014 and 2015 rates are calculated using the UPL for each year. The 2016 and 2017 rates will be calculated using the existing comparable population FFS UPL methodology.
2. FY 2015-16 and FY 2016-17 estimated funding is based on approved calendar year (CY) 2015 rates and projected CY 2016 rates and CY 2017 rates.
3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and impact of the CCI demonstration as experienced to date.
4. The Department is working with PACE organizations and proposing changes to current law to transition from a UPL-based methodology to an actuarially sound experienced-based methodology. The Department anticipates restructuring the methodology to determine the rates effective January 2017.
5. The Department is still processing three contract amendments to implement 2014 PACE rates for three PACE organizations currently paid at 2013 PACE rates. The Department anticipates receiving CMS approval and implementation of these contract amendments in September 2015. This will result in repayments of approximately \$113,000 and is expected to occur in FY 2015-16.
6. The Department will also recoup approximately \$169,000 due to a required shift to rates set at

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 114

95% of the UPL to rates set at 90% of the UPL for two of the PACE organizations that finished their first year of enrollment operations during 2014. This recoupment is expected to occur in FY 2015-16.

7. The Department anticipates receiving CMS approval of contract amendments implementing 2015 rates in October 2015, retroactive to January 2015. This results in a repayment of \$17,800,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2014 PACE rates from January to June 2015. The repayment is expected to occur in FY 2015-16.

FY 2015-16	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$37,505,000	7,799	650
Sutter SeniorCare	\$12,761,000	2,967	247
AltaMed Senior BuenaCare	\$87,069,000	20,970	1,747
OnLok (SF, Alameda and Santa Clara)	\$81,482,000	16,419	1,368
St. Paul's PACE	\$26,140,000	6,063	505
Los Angeles Jewish Homes	\$6,716,000	1,650	137
CalOptima PACE	\$3,813,000	990	83
InnovAge (San Bernardino and Riverside)	\$11,199,000	2,710	226
Redwood Coast	\$3,003,000	897	75
Central Valley Medical Services	\$10,357,000	2,136	178
San Ysidro San Diego	\$3,497,000	827	69
Total Capitation Payments	\$283,542,000	63,428	5,285
2014 Rate Repayment	\$113,000		
2014 Rate Recoupment	(\$169,000)		
2015 Rate Repayment	\$10,680,000		
Total FY 2015-16	\$294,166,000		

*Totals may differ due to rounding.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 114

FY 2016-17	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$39,942,000	8,140	678
Sutter SeniorCare	\$12,939,000	2,967	247
AltaMed Senior BuenaCare	\$93,232,000	22,053	1,838
OnLok (SF, Alameda and Santa Clara)	\$87,001,000	17,232	1,436
St. Paul's PACE	\$30,863,000	7,024	585
Los Angeles Jewish Homes	\$8,588,000	2,070	172
CalOptima PACE	\$5,597,000	1,389	116
InnovAge (San Bernardino and Riverside)	\$20,186,000	4,785	399
Redwood Coast	\$5,284,000	1,527	127
Central Valley Medical Services	\$14,678,000	3,000	250
San Ysidro San Diego	\$4,192,000	935	78
Hope (San Bernardino and Riverside)	\$310,000	68	23
Total Capitation Payments	\$322,812,000	71,189	5,949
Total FY 2016-17	\$322,812,000		

*Totals may differ due to rounding.

Funding:

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116
 IMPLEMENTATION DATE: 7/2004
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1029

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$144,027,000	\$147,449,000
- STATE FUNDS	\$56,425,140	\$58,233,990
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$144,027,000	\$147,449,000
STATE FUNDS	\$56,425,140	\$58,233,990
FEDERAL FUNDS	\$87,601,860	\$89,215,010

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116

Reason for Change from Prior Estimate:

The changes are due to updated monthly eligibles and dental rates for FY 2015-16 and FY 2016-17.

Methodology:

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates for FY 2013-14 and FY 2014-15 are shown in the Dental Retroactive Rate Changes policy change.
3. Rate adjustments have been included for FY 2014-15. These approved rates have been used for FY 2015-16. Proposed FY 2015-16 capitated rates have been used for FY 2016-17. FY 2015-16 rates include the exemption from AB 97.
4. The impact of the Restoration of Adult Dental Benefits is \$23,865,000 for FY 2015-16 and \$17,247,000 for FY 2016-17.
5. The impact of the Health Insurance Provider Fund (HIPF) is \$850,000 for FY 2016-17.

(Dollars in Thousands)

FY 2015-16	Capitation Rate	Average Monthly Eligibles	Total Funds
GMC			
<21	\$11.45	228,283	\$31,366
21+	\$8.42	157,776	\$15,942
PHP			
<21	\$12.95	318,631	\$49,515
21+	\$7.80	166,008	\$15,538
ACA Optional Dental			
GMC	\$8.42	353,817	\$2,979
PHP	\$7.80	3,603,835	\$28,110
ACA Mandatory Dental			
GMC 21+	\$8.42	1,143	\$9
GMC <21	\$11.45	3,324	\$38
PHP 21+	\$7.80	11,642	\$91
PHP <21	\$12.95	33,861	\$439
		Total FY 2015-16	\$144,027

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116

(Dollars in Thousands)

FY 2016-17	Capitation Rate	Average Monthly Eligible	Total Funds
GMC			
<21	\$11.45	232,076	\$31,887
21+	\$8.42	160,398	\$16,207
PHP			
<21	\$12.95	319,770	\$49,692
21+	\$7.80	166,602	\$15,594
ACA Optional Dental			
GMC	\$8.42	366,943	\$3,090
PHP	\$7.80	3,737,529	\$29,153
ACA Mandatory Dental			
GMC 21+	\$8.42	1,934	\$16
GMC <21	\$11.45	5,625	\$64
PHP 21+	\$7.80	19,699	\$154
PHP <21	\$12.95	57,294	\$742
HIPF			\$850
Total FY 2016-17			\$147,449

Funding:

	TF	GF	FF
FY 2015-16			
65% Title XIX / 35% GF 4260-101-0001/0890	\$34,000	\$12,000	\$22,000
88% Title XIX / 12% GF 4260-101-0001/0890	\$102,000	\$12,000	\$90,000
50% Title XIX / 50% GF 4260-101-0001/0890	\$112,802,000	\$56,401,000	\$56,401,000
100% Title XIX ACA FF 4260-101-0890	\$31,089,000	\$0	\$31,089,000
Total	\$144,027,000	\$56,425,000	\$87,602,000
FY 2016-17			
88% Title XIX / 12% GF 4260-101-0001/0890	\$232,000	\$28,000	\$204,000
50% Title XIX / 50% GF 4260-101-0001/0890	\$114,791,000	\$57,395,000	\$57,396,000
100% Title XIX ACA FF 4260-101-0890	\$16,213,000	\$0	\$16,213,000
95% Title XIX ACA FF / 5% GF 4260-101-0001/0890	\$16,213,000	\$811,000	\$15,402,000
Total	\$147,449,000	\$58,234,000	\$89,215,000

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 117
 IMPLEMENTATION DATE: 2/1985
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 61

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$60,948,000	\$74,169,000
- STATE FUNDS	\$30,474,000	\$37,084,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$60,948,000	\$74,169,000
STATE FUNDS	\$30,474,000	\$37,084,500
FEDERAL FUNDS	\$30,474,000	\$37,084,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14200

Interdependent Policy Changes:

PC 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:

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

Reason for Change from Prior Estimate:

Eligible months were updated with actuals from January 2015 through July 2015 and increased by 34% for FY 2015-16 and 21% for FY 2016-17. The changes are also due to delayed implementation of 2015 SCAN rates and calendar year (CY) 2014 rate update to incorporate adult dental benefit restoration for the period of May through December 2014.

Methodology:

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

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 117

2. Total enrollment is projected to be 12,915 in December 2015 and 14,064 by June 2016 based on Medi-Cal enrollment projections submitted by SCAN.
3. The CY 2014 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for CY 2015 and 2016 have not been finalized. The Department is finalizing CY 2015 rates using SCAN actuals. CY 2016 rates are projected by trending forward from preliminary CY 2015 rates. Rates in development will be based on SCAN plans' actual experience.
4. The Department anticipates receiving CMS approval in September 2015 for contract amendments implementing recalculated SCAN 2014 rates for the period of May 2014 through December 2014, reflecting the restoration of the adult dental benefit. This will result in a repayment to SCAN of approximately \$445,000 for capitation payments made from May 2014 through December 2014 using updated SCAN CY 2014 rates. The repayment is expected to occur during the October 2015 capitation cycle.
5. The Department anticipates receiving CMS approval of contract amendments implementing 2015 SCAN rates, retroactive from January 1, 2015, in November 2015. This will result in an estimated repayment of approximately \$3,820,000 for the increase in rates for SCAN health plans. The repayment is expected to occur during the December 2015 capitation cycle. This will also result in an estimated recoupment of approximately \$1,240,000 for the decrease to the rates set for SCAN health plans. The recoupment is expected to occur during the December 2015 capitation cycle.

FY 2015-16	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$38,873,000	103,665	8,639
Riverside	\$12,365,000	29,240	2,437
San Bernardino	\$7,857,000	19,571	1,631
Total	\$59,095,000	152,476	12,707
2014 Rate Repayment	\$445,000		
2015 Rate Repayment	\$2,084,000		
2015 Rate Recoupment	(\$676,000)		
Total FY 2015-16	\$60,948,000		
FY 2016-17	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$48,789,000	125,179	10,432
Riverside	\$15,520,000	35,310	2,943
San Bernardino	\$9,860,000	23,630	1,969
Total FY 2016-17	\$74,169,000	184,119	15,344

*Totals may differ due to rounding.

Funding:

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 120
 IMPLEMENTATION DATE: 5/1985
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 63

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$7,405,000	\$7,405,000
- STATE FUNDS	\$3,702,500	\$3,702,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,405,000	\$7,405,000
STATE FUNDS	\$3,702,500	\$3,702,500
FEDERAL FUNDS	\$3,702,500	\$3,702,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14088.85

Interdependent Policy Changes:

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

Currently, the PCCM is receiving capitation payments at the 2011 capitation rate level through 2016. This has resulted in an overpayment to the PCCM given a reduction in capitation rates in 2012. The Department has a contractual option to recoup the overpayments on a monthly basis, retroactive to January 2012. Recoupment is expected to begin FY 2015-16.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 120

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

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

Reason for Change from Prior Estimate:

Recoupment of retroactive rate adjustments has been delayed from FY 2014-15 to FY 2015-16. Projected eligibles for FY 2015-16 and FY 2016-17 increased.

Methodology:

- 1) Assume dual eligible months will be 4,404 in FY 2015-16 and FY 2016-17.
- 2) Assume dual eligible monthly capitation rates are \$292.07 in FY 2015-16 and FY 2016-17.

Duals: FY 2015-16 and FY 2016-17: 4,404 x \$292.07 = **\$1,286,000 TF**

- 3) Assume Medi-Cal only eligible months will be 5,628 in FY 2015-16 and FY 2016-17.
- 4) Assume Medi-Cal only monthly capitation rates are \$1,502.07 in FY 2015-16 and FY 2016-17.

Medi-Cal Only: FY 2015-16 and FY 2016-17: 5,628 x \$1,502.07 = **\$8,454,000 TF**

- 5) The total recoupment for calendar years 2012 and 2013 is estimated to be **\$2,335,000 TF** in FY 2015-16 and FY 2016-17.

FY 2015-16	TF	GF	FF
Dual	\$1,286,000	\$643,000	\$643,000
Medi-Cal Only	\$8,454,000	\$4,227,000	\$4,227,000
Recoupment	(\$2,335,000)	(\$1,167,500)	(\$1,167,500)
Total	\$7,405,000	\$3,702,500	\$3,702,500

FY 2016-17	TF	GF	FF
Dual	\$1,286,000	\$643,000	\$643,000
Medi-Cal Only	\$8,454,000	\$4,227,000	\$4,227,000
Recoupment	(\$2,335,000)	(\$1,167,500)	(\$1,167,500)
Total	\$7,405,000	\$3,702,500	\$3,702,500

Funding:

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

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

BASE POLICY CHANGE NUMBER: 122
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 66

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$913,000	\$913,000
- STATE FUNDS	\$456,500	\$456,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$913,000	\$913,000
STATE FUNDS	\$456,500	\$456,500
FEDERAL FUNDS	\$456,500	\$456,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 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's contract with the Family Mosaic Project was effective January 1, 2008. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out-of-home placement. The contract with the Family Mosaic project has been extended through June 30, 2016. The Department anticipates continuing this agreement with Family Mosaic.

Reason for Change from Previous Estimate:

Based on actual 2015 enrollment, the estimated number of member months decreased from 535 to 494 in FY 2015-16 and FY 2016-17.

Methodology:

- 1) Assume the total member months will be 494 in FY 2015-16 and FY 2016-17.
- 2) The Family Mosaic capitation rates are assumed to be \$1,848.75 in FY 2015-16 and FY 2016-17.
- 3) The costs for the Family Mosaic Project are expected to be:
 FY 2015-16 and FY 2016-17: $494 \times \$1,848.75 = \mathbf{\$913,000 \text{ TF } (\$456,500 \text{ GF})}$

Funding:

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

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

BASE POLICY CHANGE NUMBER: 164
 IMPLEMENTATION DATE: 7/1988
 ANALYST: Humei Wang
 FISCAL REFERENCE NUMBER: 76

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$2,649,830,000	\$2,703,855,000
- STATE FUNDS	\$1,431,143,000	\$1,459,984,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,649,830,000	\$2,703,855,000
STATE FUNDS	\$1,431,143,000	\$1,459,984,500
FEDERAL FUNDS	\$1,218,687,000	\$1,243,870,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 134 Medicare Part B Premium Increase

Background:

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

Reason for Change from Prior Estimate:

Increase is due to changes in estimated eligibles and the updated Part A premium. Projected Part B premium increase is in the Medicare Part B Premium Increase Policy Change.

	2015	2016		2017
		May 2015 Estimate	November 2015 Estimate	November 2015 Estimate
	Actual			
	Premiums			
Part A	\$407.00	\$ 407.00	\$411.00	\$ 415.04
Part B	\$104.90	\$ 104.90	\$104.90	\$ 104.90
	Average Monthly Eligibles			
Part A		178,700	178,400	181,200
Part B		1,325,400	1,338,100	1,367,800

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

BASE POLICY CHANGE NUMBER: 164

Methodology:

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the 2015 Medicare Part A premium at \$407.00 and the Medicare Part B premium at \$104.90.
3. The Centers for Medicare and Medicaid set the 2016 Medicare Part A premium at \$411.00 and the Medicare Part B premium is budgeted at \$104.90.
4. For 2017, the Medicare Part A premium is estimated to increase by \$4.04 to \$415.04 based on its 2016 growth rate 0.0098, and the Medicare Part B premium is budgeted at \$104.90.
5. Medicare Part B premium is expected to increase in 2017 and is estimated in the Regular Policy Change – Medicare Part B Premium Increase.

FY 2015-16	Part A	Part B
Average Monthly Eligibles	178,400	1,338,100
Rate 07/2015-12/2015	\$407.00	\$104.90
Rate 01/2016-06/2016	\$411.00	\$104.90
FY 2016-17		
Average Monthly Eligibles	181,200	1,367,800
Rate 07/2016-12/2016	\$411.00	\$104.90
Rate 01/2017-06/2017	\$415.04	\$104.90

Funding:

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

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 165
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Peter Bjorkman
 FISCAL REFERENCE NUMBER: 1019

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,661,965,000	\$1,871,377,000
- STATE FUNDS	\$1,661,965,000	\$1,871,377,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,661,965,000	\$1,871,377,000
STATE FUNDS	\$1,661,965,000	\$1,871,377,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 ²/₃% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2013	\$103.70
2014	\$97.40
2015	\$98.76
2016	\$110.23
2017	\$117.25 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 165

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

Fiscal Year	Total Payment	Ave. Monthly Beneficiaries
FY 2012-13	\$1,454,929,918	1,176,313
FY 2013-14	\$1,479,580,071	1,213,682
FY 2014-15	\$1,522,511,847	1,296,510

Reason for Change from Prior Estimate:

- The projected average monthly eligibles have increased since the May Estimate.

Methodology:

- The 2015 growth increased 3.64% over 2014 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2015 is \$98.76.
- The 2016 growth increased 11.61% over 2015 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2016 is \$110.23.
- The 2017 growth is estimated to increase 6.37% based on the Part D 2015 annual percentage increase from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2017 is \$117.25.
- Phase-down payments have a two-month lag (i.e., bills submitted in January are received in February and due in March).
- The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from July 2010 – August 2015.
- The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
FY 2015-16	12	1,349,649	\$138,497,059	\$1,661,965,000
FY 2016-17	12	1,385,101	\$155,948,066	\$1,871,377,000

Funding:

100% GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER: 166
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 23

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,708,743,000	\$1,535,667,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,708,743,000	\$1,535,667,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,708,743,000	\$1,535,667,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement 01-15834

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

The estimated amounts for FY 2015-16 have increased from the 2015 Budget Act to include retroactive payments from prior years. There are fewer retroactive payments in FY 2016-17.

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

BASE POLICY CHANGE NUMBER: 166

Methodology:

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

(Dollars in Thousands)	Total	CDDS	DHCS
	Funds	GF	FFP
FY 2015-16	\$3,417,486	\$1,708,743	\$1,708,743
FY 2016-17	\$3,071,333	\$1,535,666	\$1,535,667

Funding:

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167
 IMPLEMENTATION DATE: 7/1988
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 135

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,014,022,000	\$1,140,954,000
- STATE FUNDS	\$353,380,390	\$399,895,170
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,014,022,000	\$1,140,954,000
STATE FUNDS	\$353,380,390	\$399,895,170
FEDERAL FUNDS	\$660,641,610	\$741,058,830

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167

Reason for Change from Prior Estimate:

The changes are due to updated monthly eligibles and dental rates for FY 2015-16 and FY 2016-17.

Methodology:

1. The approved FY 2014-15 capitation rates used for FY 2015-16 are \$7.81 for regular eligibles and \$5.81 for refugees.
2. The proposed FY 2015-16 capitation rates have been used for FY 2016-17 and now includes one rate for regular eligibles and refugees. FY 2015-16 rates include the exemption from AB 97.
3. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ending June 30, 2014 resulted in an underwriting gain of \$57.7 million. According to the contract distribution provisions, the Department will receive \$53 million and Delta will retain \$4.7 million in FY 2015-16.
4. The impact of the Restoration of Adult Dental Benefits is \$189,459,000 for FY 2015-16 and \$351,958,000 for FY 2016-17.
5. The impact of the Health Insurance Provider Fund (HIPF) is \$4,000,000 for FY 2016-17.

(Dollars in Thousands)

FY 2015-16	Rate	Average Monthly Eligibles	Total Funds
Regular 7/15 – 6/16	\$7.81	7,973,847	\$747,309
Refugee 7/15 – 6/16	\$5.81	1,339	\$93
Other FFS	Non-Capitated		\$84,788
		Subtotal	\$832,190
Underwriting Gain			(\$53,057)
		Total	\$779,133
ACA			
ACA Optional Dental	\$7.81	2,475,042	\$231,961
ACA Mandatory Dental	\$7.81	31,251	\$2,928
ACA Subtotal			\$234,889
		Total FY 2015-16	\$1,014,022

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167

(Dollars in Thousands)

FY 2016-17	Rate	Average Monthly Eligibles	Total Funds
Regular 7/15 – 6/16	\$8.18	8,057,643	790,938
Other FFS	Non-Capitated		\$88,863
		Subtotal	\$879,801
HIPF			\$4,000
ACA			
ACA Optional Dental	\$8.18	2,566,860	\$251,963
ACA Mandatory Dental	\$8.18	52,877	\$5,190
ACA Subtotal (included in dollars above)			\$257,153
Restoration of AB97			\$105,065
		Total FY 2016-17	\$1,140,954

Funding:

FY 2015-16	TF	GF	FF
65% Title XXI / 35% GF (4260-113-0001/0890)	\$29,111,000	\$10,189,000	\$18,922,000
88% Title XXI / 12% GF (4260-113-0001/0890)	\$87,332,000	\$10,480,000	\$76,852,000
65% Title XIX / 35% GF (4260-101-0001/0890)	\$682,000	\$239,000	\$443,000
100% GF (4260-101-0001)	\$10,000	\$10,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$664,926,000	\$332,463,000	\$332,463,000
100% Title XIX ACA (4260-101-0890)	\$231,961,000	\$0	\$231,961,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	\$0	\$0	\$0
Total	\$1,014,022,000	\$353,381,000	\$660,641,000
FY 2016-17	TF	GF	FF
88% Title XXI / 12% GF (4260-113-0001/0890)	\$132,546,000	\$15,905,000	\$116,640,000
65% Title XIX / 35% GF (4260-101-0001/0890)	\$682,000	\$239,000	\$443,000
100% GF (4260-101-0001)	\$10,000	\$10,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$754,838,000	\$377,419,000	\$377,419,000
100% Title XIX ACA (4260-101-0890)	\$126,439,000	\$0	\$126,439,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	\$126,439,000	\$6,322,000	\$120,117,000
Total	\$1,140,954,000	\$399,895,000	\$741,059,000

*Totals may differ due to rounding.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 168
 IMPLEMENTATION DATE: 4/1993
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 22

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,086,867,000	\$1,493,950,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,086,867,000	\$1,493,950,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,086,867,000	\$1,493,950,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreements:

03-75676 (PCSP)

09-86307 (IPO)

SB 1036 (Chapter 45, Statutes of 2012)

SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 168

Reason for Change from Prior Estimate:

Revised expenditure data is provided by CDSS.

Methodology:

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

(Dollars in Thousands)

	TF	FFP	CDSS GF/ County Share
FY 2015-16	\$2,173,734	\$1,086,867	\$1,086,867
FY 2016-17	\$2,987,900	\$1,493,950	\$1,493,950

Funding:

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 169
 IMPLEMENTATION DATE: 7/1997
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 77

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$206,129,000	\$207,330,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$206,129,000	\$207,330,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$206,129,000	\$207,330,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement (IA) 03-75282
 IA 03-75283

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOCFs. There are four DCs and one SOCF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOCFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

The General Fund (GF) is included in the CDDS budget on an accrual basis and the federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The changes are due to updated expenditures.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 169

Methodology:

1. The following estimates have been provided by CDDS.

(Dollars in Thousands)

CASH BASIS	Total Funds	CDDS GF	FFP Regular
FY 2015-16	\$412,258	\$206,129	\$206,129
FY 2016-17	\$414,660	\$207,330	\$207,330

Funding:

100% Title XIX (4260-101-0890)

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 171
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 26

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$188,380,000	\$161,949,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$188,380,000	\$161,949,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$188,380,000	\$161,949,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:

Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:

Not Applicable

Background:

Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

The General Fund is in the CDDS budget on an accrual basis. The federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The caseload has been updated.

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 171

Methodology:

1. The following estimates have been provided by CDDS:

(Dollars in Thousands)

CASH BASIS	Total Fund	CDDS GF	DHCS FFP
FY 2015-16	\$376,761	\$188,381	\$188,380
FY 2016-17	\$323,898	\$161,949	\$161,949

Funding:

100% Title XIX (4260-101-0890)

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175
 IMPLEMENTATION DATE: 6/1995
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 27

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$43,872,000	\$39,634,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,872,000	\$39,634,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$43,872,000	\$39,634,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:

SB 910 (Chapter 1179, Statutes of 1991), Welfare & Institutions Code 14132.44

Interdependent Policy Changes:

Not Applicable

Background:

The TCM program provides funding to LGAs for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP). The TCM program, per the approved State Plan Amendment (SPA) #10-010, serves children under 21, medically fragile individuals 18 and over, individuals at risk of institutionalization, individuals at risk of negative health or psycho-social outcomes, and individuals with communicable diseases.

Reason for Change from Prior Estimate:

The change is due to:

- A lower FY 2015-16 baseline estimate for claims,
- A lower annual percentage increase assumption from 2% to 1%,
- A lower estimate of the increased claims resulting from the SPA#10-010 removal of the capitated amount,
- A lower than previously estimated ACA encounter cost,
- Addition of FY 2014-15 remaining payments to be paid in FY 2015-16, and
- The inclusion of the FY 2010-11 reconciliation recoupment.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175

Methodology:

1. SPA #10-010, approved on December 19, 2013, also lifted the annual capitated amount (CAP removal), effective October 16, 2010. The annual capitated amount is the maximum amount of dollars an LGA could claim for reimbursement within a target population.
2. The projected payment amount of \$38.721 million for FY 2015-16 and FY 2016-17 is based on average expenditures from FY 2013-14 through FY 2014-15.
3. Assume a 1% cost increase each year.
4. In FY 2015-16, \$1,315,000 will be paid for ACA encounters retro to January 1, 2014. In FY 2016-17, ACA encounters are estimated to be \$526,000.
5. In FY 2015-16, additional SPA cap removal claims will be paid for FY 2010-11 and FY 2012-13. Additionally, FY 2014-15 claims not paid in FY 2014-15 will be paid in FY 2015-16.
6. In FY 2015-16, the FY 2010-11 reconciliation will be completed and the Department will recoup \$3,609,000 and pay \$55,000, for a savings of \$3,554,000.
7. Assume the FY 2016-17 payment is the same as FY 2015-16 with an adjustment that includes an ACA Federal Medicaid Assistance Percentage decrease to 95% effective January 1, 2017.

FY 2015-16	FF
FY 2015-16 Base (Average Expenditures)	\$38,721,000
1% Program cost increase	\$387,000
SPA#10-010 increase (CAP removal)	
FY 2010-11	\$270,000
FY 2012-13	\$29,000
ACA encounters	
FY 2013-14	\$263,000
FY 2014-15	\$526,000
FY 2015-16	\$526,000
Additional claims	
FY 2014-15	\$6,704,000
Reconciliation	
FY 2010-11	(\$3,554,000)
Total FY 2015-16	\$43,872,000

FY 2016-17	FF
FY 2016-17 Base (Average Expenditures)	\$38,721,000
1% Program cost increase	\$387,000
ACA encounters	
FY 2016-17	\$526,000
Total FY 2016-17	\$39,634,000

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175

Funding:

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

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

95% Title XIX ACA (4260-101-0890)

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176
 IMPLEMENTATION DATE: 4/2000
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 32

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$40,250,000	\$41,545,000
- STATE FUNDS	\$20,125,000	\$20,772,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,250,000	\$41,545,000
STATE FUNDS	\$20,125,000	\$20,772,500
FEDERAL FUNDS	\$20,125,000	\$20,772,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 39 California Community Transitions (CCT) Costs

Background:

AB 668 authorized additional hours on behalf of eligible PCS program recipients if they needed more than the monthly hours allowed under the In-Home Supportive Services Program (IHSS) and qualified for the Medi-Cal Skilled NF Level of Care Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (SA), and In-Home Medical Care Waivers were merged into two waivers called the Nursing Facility/Acute Hospital (NF/AH) Waiver and the In-Home Operations (IHO) Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific Level Of Care (LOC) criteria. Waiver Personal Care Services (WPCS) under these two waivers include services that differ from those in the State Plan which allow beneficiaries to remain at home. Although there is no longer a requirement that waiver consumers receive a maximum of 283 hours of IHSS prior to receiving WPCS, waiver consumers must first utilize authorized State Plan IHSS hours prior to accessing this waiver service. These services are provided by the counties' IHSS program providers and paid via an IA with the Department or will be provided by home health agencies and other qualified HCBS waiver provider types paid via the Medi-Cal fiscal intermediary.

Reason for Change from Prior Estimate:

The total hours were revised from the prior estimate, which were projected higher than usual. The FY 2015-16 rate has increased due to an increase in WPCS participants and all counties with provider rates under \$10/hour will increase to the \$10 minimum wage, effective January 1, 2016.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176

Methodology:

1. Assume the number of current NF A/B LOC Waiver beneficiaries using WPCS is estimated to increase by an average of 6 per month in FY 2015-16 and FY 2016-17.
2. Assume the number of current NF SA LOC beneficiaries using Waiver PCS is estimated to stay the same in FY 2015-16 and FY 2016-17.
3. The Department's CCT Demonstration Project expects to transition 528 beneficiaries out of inpatient extended health care facilities in FY 2015-16, and 540 beneficiaries in FY 2016-17. Based on actual data from July 2014 through June 2015, 6% of the beneficiaries are expected to use WPCS.
4. The average cost/hour is \$10.63 for FY 2015-16 and \$10.70 FY 2016-17.
5. The chart below displays the estimate on an accrual basis.

FY 2015-16	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,400,118	\$10.63	\$25,513,249	\$12,756,625	\$12,756,625
NF S/A	1,240,197	\$10.63	\$13,183,293	\$6,591,646	\$6,591,646
IHOWaiver					
NF A/B	143,760	\$10.63	\$1,528,172	\$764,086	\$764,086
NF S/A	26,503	\$10.63	\$281,725	\$140,862	\$140,862
Total			\$40,506,438	\$20,253,219	\$20,253,219
FY 2016-17	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,470,379	\$10.70	\$26,433,059	\$13,216,529	\$13,216,529
NF S/A	1,261,427	\$10.70	\$13,497,264	\$6,748,632	\$6,748,632
IHOWaiver					
NF A/B	143,760	\$10.70	\$1,538,235	\$769,118	\$769,118
NF S/A	26,503	\$10.70	\$283,580	\$141,790	\$141,790
Total			\$41,752,138	\$20,876,069	\$20,876,069

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

(Dollars in Thousands)	TF	GF	FF
FY 2015-16	\$40,250	\$20,125	\$20,125
FY 2016-17	\$41,545	\$20,773	\$20,773

Funding:

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

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 177
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Peter Bjorkman
 FISCAL REFERENCE NUMBER: 136

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$38,271,000	\$38,271,000
- STATE FUNDS	\$18,747,150	\$18,747,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$38,271,000	\$38,271,000
STATE FUNDS	\$18,747,150	\$18,747,150
FEDERAL FUNDS	\$19,523,850	\$19,523,850

DESCRIPTION

Purpose:

This policy change estimates the screening costs for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Authority:

Title 22, California Code of Regulations 51340(a)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Nearly offsetting changes in the estimated number of screens and cost per screen result in a slightly lower projection of estimated expenditures.

Methodology:

Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2015-16 and FY 2016-17, based on historical trends from July 2010 to April 2015.

FY 2015-16

Screens 642,990 x \$59.52 (weighted average) = **\$38,271,000** (rounded)

FY 2016-17

Screens 642,990 x \$59.52 (weighted average) = **\$38,271,000** (rounded)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 177

Funding:

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

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 183
 IMPLEMENTATION DATE: 7/1989
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 93

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$3,370,000	\$1,865,000
- STATE FUNDS	\$1,707,000	\$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,370,000	\$1,865,000
STATE FUNDS	\$1,707,000	\$932,500
FEDERAL FUNDS	\$1,663,000	\$932,500

DESCRIPTION

Purpose:

This policy change estimates the cost of Medi-Cal lawsuit judgments, settlements, and attorney fees that are not shown in other policy changes.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

State Legislature appropriates State dollars to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all lawsuit settlements approved by the Legislature and the Governor.

Reason for Change from Prior Estimate:

Lawsuits were updated.

Methodology:

1. Attorney Fees

1. Shreve v. Kent	\$2,500
2. Terry L. Hibbs v. DHCS, et al.	\$5,000
Total for FY 2015-16	\$7,500

2. Provider Settlements of \$75,000 or Less Payments

1. Catholic HealthcareWest	\$5,406
2. CPH Hospital Management	\$1,265
3. CHA Hollywood Medical Center	\$24,552
4. Farrow Evan	\$536

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 183

5. Ramona Care v. L.A. Care and DHCS	\$75,000
6. LA County – Minor Consent Disallowance (100% GF)	<u>\$43,693</u>
Total for FY 2015-16	\$150,452
3. <u>Beneficiary</u>	
1. Shreve v. Kent	<u>\$452</u>
Total for FY 2015-16	\$452
4. <u>Other Attorney Fees Payments</u>	
1. California Association of Rural Health Clinics	\$325,000
2. Saavedra	\$475,000
3. ILC of Southern California v. Maxwell-Jolly	\$180,000
4. Desert Valley Hospital v. Toby Douglas, DHCS	<u>\$500,000</u>
Total for FY 2015-16	\$1,480,000
5. <u>Other Beneficiary Settlements</u>	
1. Victim's Compensation and Government Claims Board Claims	<u>\$25,000</u>
Total for FY 2015-16	\$25,000

	Committed	Balance	Budgeted	Budgeted
	2015-16	2015-16	2015-16	2016-17
Attorney Fees <\$5,000	\$7,500	\$42,500	\$50,000 *	\$50,000 *
Provider Settlements <\$75,000	\$150,452	\$1,449,548	\$1,600,000 *	\$1,600,000 *
Beneficiary Settlements <\$2,000	\$452	\$14,548	\$15,000 *	\$15,000 *
Small Claims Court	\$0	\$200,000	\$200,000 *	\$200,000 *
Other Attorney Fees	\$1,480,000	N/A	\$1,480,000	\$0
Other Provider Settlements	\$0	N/A	\$0	\$0
Other Beneficiary Settlements	\$25,000	N/A	\$25,000	\$0
	\$1,663,404	\$1,706,596	\$3,370,000	\$1,865,000

* Represents potential totals.

Funding:

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

100% GF (4260-101-0001)

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 184
 IMPLEMENTATION DATE: 1/1993
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 91

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$2,216,000	\$2,283,000
- STATE FUNDS	\$1,108,000	\$1,141,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,216,000	\$2,283,000
STATE FUNDS	\$1,108,000	\$1,141,500
FEDERAL FUNDS	\$1,108,000	\$1,141,500

DESCRIPTION

Purpose:

This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:

Welfare & Institutions Code 14124.91
 Social Security Act 1916(e)
 Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Based on updated data, HIPP program expenditures increased and enrollment decreased resulting in higher average costs.

Methodology:

1. Premium costs are determined by the prior year's average premium expense and include ancillary costs as incurred.
2. In FY 2015-16 and FY 2016-17, it is estimated that there will be a decrease in enrollment and the insurance premiums will increase by 5% over the previous year.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 184

3. The average monthly premium cost including ancillary costs is estimated to be \$686.47 in FY 2015-16 and \$720.79 in FY 2016-17.
4. The average monthly HIPP enrollment is estimated to be 269 in FY 2015-16 and 264 in FY 2016-17.
5. Costs for FY 2015-16 and FY 2016-17 are estimated to be:

FY2015-16: $\$686.47 \times 269 \times 12 \text{ Months} = \$2,216,000 \text{ TF } (\$1,108,000 \text{ GF})$

FY2016-17: $\$720.79 \times 264 \times 12 \text{ Months} = \$2,283,000 \text{ TF } (\$1,141,000 \text{ GF})$

Funding:

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

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185
 IMPLEMENTATION DATE: 7/1997
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1083

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,537,000	\$1,028,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,537,000	\$1,028,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,537,000	\$1,028,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement (IA) #07-65689

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

There are still costs to be incurred in the current year due to delay in local jurisdictions invoicing to the State.

Methodology:

1. Annual expenditures on the accrual basis are \$2,056,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

(Dollars in Thousands)

FY 2015-16	DHCS FFP	CDPH CLPP Fee Funds
Benefits Costs	\$1,537	\$1,537

FY 2016-17	DHCS FFP	CDPH CLPP Fee Funds
Benefits Costs	\$1,028	\$1,028

Funding:

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 197
 IMPLEMENTATION DATE: 7/1987
 ANALYST: Stephanie Hockman
 FISCAL REFERENCE NUMBER: 127

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	-\$306,727,000	-\$289,203,000
- STATE FUNDS	-\$160,453,000	-\$151,286,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$306,727,000	-\$289,203,000
STATE FUNDS	-\$160,453,000	-\$151,286,000
FEDERAL FUNDS	-\$146,274,000	-\$137,917,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from estates, personal injury settlements, judgements or awards, provider/beneficiary overpayments, and other health insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Reason for Change from Prior Estimate:

July 2015 provider audits were higher than average resulting in additional overpayment collections.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 197

(Dollars in Thousands)

	FY 2015-16	FY 2016-17
Personal Injury Collections	(\$57,510)	(\$56,228)
Workers' Comp. Contract	(\$1,788)	(\$1,788)
H.I. Contingency Contract	(\$73,500)	(\$73,500)
General Collections	(\$173,928)	(\$157,686)
TOTAL	(\$306,727)	(\$289,203)

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2012 – July 2015.
2. The General Fund ratio for collections is estimated to be 52.31% in FY 2015-16 and FY 2016-17.

Funding:

100% GF (4260-101-0001)

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

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

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<u>ELIGIBILITY</u>	
1	FAMILY PACT PROGRAM
2	MEDI-CAL ADULT INMATE PROGRAMS
3	BREAST AND CERVICAL CANCER TREATMENT
5	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES
6	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%
7	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION
9	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	NEW QUALIFIED IMMIGRANTS
14	SCHIP FUNDING FOR PRENATAL CARE
15	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
16	INCARCERATION VERIFICATION PROGRAM
17	PARIS-VETERANS
18	TLICP PREMIUMS
<u>AFFORDABLE CARE ACT</u>	
19	COMMUNITY FIRST CHOICE OPTION
20	ACA OPTIONAL EXPANSION
21	HEALTH INSURER FEE
22	ACA MANDATORY EXPANSION
23	PAYMENTS TO PRIMARY CARE PHYSICIANS
24	1% FMAP INCREASE FOR PREVENTIVE SERVICES
25	STATE-ONLY FORMER FOSTER CARE PROGRAM
26	ACA MAGI SAVINGS
27	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY
29	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS
30	RECOVERY AUDIT CONTRACTOR SAVINGS
31	ACA REDETERMINATIONS
32	MANAGED CARE DRUG REBATES
<u>BENEFITS</u>	
33	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
34	LOCAL EDUCATION AGENCY (LEA) PROVIDERS

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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35	BEHAVIORAL HEALTH TREATMENT
36	CCS DEMONSTRATION PROJECT PILOTS
37	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA
38	DENTAL CHILDREN'S OUTREACH AGES 0-3
39	CALIFORNIA COMMUNITY TRANSITIONS COSTS
40	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT
41	YOUTH REGIONAL TREATMENT CENTERS
42	CCT FUND TRANSFER TO CDSS AND CDDS
43	ALLIED DENTAL PROFESSIONALS ENROLLMENT
44	PEDIATRIC PALLIATIVE CARE WAIVER
45	CHDP PROGRAM DENTAL REFERRAL
46	BENEFICIARY OUTREACH AND EDUCATION PROGRAM
47	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER
48	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS
49	WOMEN'S HEALTH SERVICES
50	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS
199	END OF LIFE SERVICES
203	SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES
PHARMACY	
52	ORKAMBI BENEFIT
53	ADAP RYAN WHITE MEDS DATA MATCH
54	HEPATITIS C REVISED CLINICAL GUIDELINES
55	NON FFP DRUGS
56	BCCTP DRUG REBATES
57	MEDICAL SUPPLY REBATES
58	LITIGATION SETTLEMENTS
59	FAMILY PACT DRUG REBATES
60	STATE SUPPLEMENTAL DRUG REBATES
61	AGED AND DISPUTED DRUG REBATES
62	FEDERAL DRUG REBATE PROGRAM
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65	RESIDENTIAL TREATMENT SERVICES EXPANSION

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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69	ANNUAL RATE ADJUSTMENT
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72	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
73	ELIMINATION OF STATE MAXIMUM RATES
74	TRANSITION OF HFP - SMH SERVICES
75	KATIE A. V. DIANA BONTA
76	INVESTMENT IN MENTAL HEALTH WELLNESS
77	HEALTHY FAMILIES - SED
78	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
79	IMD ANCILLARY SERVICES
80	CHART REVIEW
81	INTERIM AND FINAL COST SETTLEMENTS - SMHS
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<u>WAIVER--MH/UCD & BTR</u>	
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
85	MH/UCD & BTR—DPH INTERIM & FINAL RECONS
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
87	BTR—SAFETY NET CARE POOL
88	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
89	BTR - LIHP - MCE
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
92	MH/UCD & BTR—DPH INTERIM RATE GROWTH
93	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
94	BTR—DESIGNATED STATE HEALTH PROGRAMS
95	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
96	MH/UCD—SAFETY NET CARE POOL
97	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
98	MH/UCD—STABILIZATION FUNDING

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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100	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
101	MH/UCD & BTR—BCCTP
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205	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
206	GLOBAL PAYMENT PROGRAM
207	WAIVER 2020 DESIGNATED STATE HEALTH PROGRAM
208	WAIVER 2020 WHOLE PERSON CARE PILOTS
209	WAIVER 2020 DENTAL TRANSFORMATION INITIATIVE
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108	CCI-MANAGED CARE PAYMENTS
109	CCI-TRANSFER OF IHSS COSTS TO CDSS
111	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES
112	MANAGED CARE RATE RANGE IGTS
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115	HQAF RATE RANGE INCREASES
118	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS
119	INLAND EMPIRE HEALTH PLAN SETTLEMENT
121	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES
124	EXTEND GROSS PREMIUM TAX
125	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
126	MANAGED CARE IGT ADMIN. & PROCESSING FEE
127	GENERAL FUND REIMBURSEMENTS FROM DPHS
129	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
130	MCO TAX MANAGED CARE PLANS
131	FORMER AGNEWS' BENEFICIARIES RECOUPMENT
132	CCI-SAVINGS AND DEFERRAL
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MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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135	DENTAL RETROACTIVE RATE CHANGES
136	FQHC/RHC/CBRC RECONCILIATION PROCESS
137	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
138	LTC RATE ADJUSTMENT
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
141	ANNUAL MEI INCREASE FOR FQHCS/RHCS
142	HOSPICE RATE INCREASES
143	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE
144	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
145	10% PAYMENT REDUCTION FOR LTC FACILITIES
146	NON-AB 1629 LTC RATE FREEZE
147	LABORATORY RATE METHODOLOGY CHANGE
148	10% PROVIDER PAYMENT REDUCTION
149	REDUCTION TO RADIOLOGY RATES
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150	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
151	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
152	HOSPITAL QAF - HOSPITAL PAYMENTS
153	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
154	NDPH IGT SUPPLEMENTAL PAYMENTS
155	CERTIFICATION PAYMENTS FOR DP-NFS
156	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
157	FFP FOR LOCAL TRAUMA CENTERS
158	CAPITAL PROJECT DEBT REIMBURSEMENT
159	GEMT SUPPLEMENTAL PAYMENT PROGRAM
160	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
161	IGT PAYMENTS FOR HOSPITAL SERVICES
162	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
163	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
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POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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170	ARRA HITECH - PROVIDER PAYMENTS
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
173	CCI IHSS RECONCILIATION
174	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
179	INDIAN HEALTH SERVICES
180	WPCS WORKERS' COMPENSATION
181	OVERTIME FOR WPCS PROVIDERS
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS
186	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS
188	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER
189	FUNDING ADJUST.—ACA OPT. EXPANSION
190	FUNDING ADJUST.—OTLICP
191	CIGARETTE AND TOBACCO SURTAX FUNDS
192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS
194	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
195	IHSS REDUCTION IN SERVICE HOURS
196	COUNTY SHARE OF OTLICP-CCS COSTS
210	FFP REPAYMENT FOR CDDS COSTS

FAMILY PACT PROGRAM

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

Service Category	FY 2015-16		FY 2016-17	
	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: $320 \times 90\% \times 10\% = 29$ monthly Non-ACA State inmates
 - Adults ACA Optional Expansion: $320 \times 90\% \times 90\% = 259$ 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: $80,000 \times 2\% \times 20\% \times 20\% = 64$ monthly Non-ACA county inmates
 - County ACA: $80,000 \times 2\% \times 20\% \times 80\% = 256$ 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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: $460 \times \$146.61 \times 12 \text{ months} = \$809,000^* \text{ TF } (\$809,000 \text{ GF})$ *Rounded

FY 2016-17: $460 \times \$146.61 \times 12 \text{ months} = \$809,000^* \text{ TF } (\$809,000 \text{ GF})$ *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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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			
	TF	GF	SF	FF
Medi-Cal Access Program:				
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			
	TF	GF	SF	FF
Medi-Cal Access Program:				
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, Statutes 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):

$$\begin{aligned} 0-18 \text{ year olds: } & \$11,222,000 \text{ TF} \times 32.1\% \text{ non-emergency} = \$3,602,000 \text{ TF} \\ 19-20 \text{ year olds: } & \$1,429,000 \text{ TF} \times 32.1\% \text{ non-emergency} = \$459,000 \text{ TF} \end{aligned}$$

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:

$$\begin{aligned} 0-18 \text{ year olds: } & 169,141 \text{ eligible months} \times \$116.77 \times 39.87\% = \$7,875,000 \text{ TF} \\ 19-20 \text{ year olds: } & 18,807 \text{ eligible months} \times \$116.77 \times 39.87\% = \$876,000 \text{ TF} \end{aligned}$$

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:

$$\$29,909,000 \text{ TF} \times 6.64\% = \$1,986,000 \text{ TF}$$

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.

$$\text{Non-pregnancy services} = 69,887 \text{ eligible months} \times \$116.77 \times 6.64\% = \$542,000 \text{ TF}$$

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 fundingtype:

(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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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:

- 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.
- 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

$$38,714,725 \text{ Californians} \times 11.8\% \times 28\% \times 25\% \text{ take-up} = 319,784 \text{ as of June 2016}$$

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:

- Effective January 1, 2014, the ACA will simplify eligibility for several coverage groups (Children, Pregnant Women, and 1931(b)).
- 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 <i>Sneede v. Kizer</i>	(\$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)

- 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

- o Parents and caretaker relatives;
- o Pregnant Women;
- o 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	
	TF	GF	TF	GF
Newly Eligible NQI Childless Adults:				
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)
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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.

$$\$1,100,000,000 \text{ TF} \times 0.5\% \text{ recovery rate} = \$5,500,000 \text{ TF potential annual savings}$$

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.

$$\$5,500,000 \text{ TF} \times .25 = \$1,375,000 \text{ TF}$$

4. Assume 75% of findings are appealed.

$$\$5,500,000 \text{ TF} \times 0.75 = \$4,125,000 \text{ TF}$$

5. Assume 50% of appealed findings are upheld.

$$\$4,125,000 \text{ TF} \times 0.5 = \$2,062,500 \text{ TF}$$

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

$$\$2,062,500 \text{ TF} \div 16 \text{ months} = \$128,906 \text{ TF per month}$$

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

$$\text{FY 2015-16 savings: } \$1,375,000 \text{ TF} + (\$128,906 \text{ TF} \times 4 \text{ mos}) = \mathbf{\$1,891,000 \text{ TF} (\$945,000 \text{ GF})}$$

$$\text{FY 2016-17 savings: } \$128,906 \times 12 \text{ months} = \mathbf{\$1,547,000 \text{ TF} (\$773,500 \text{ GF})}$$

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:

- 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

$$\text{FY 2014-15: } 7,790 \times \$1,640.24 = \$12,777,500 \text{ TF}$$

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

$$\text{FY 2015-16: } 4,650 \times \$19,683 = \$91,526,000 \text{ TF}$$

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.

$$\text{FY 2016-17: } 9,979 \times \$20,667 = \$206,236,000$$

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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:

- 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.
- 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

- 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:
 $\$3,085,000 \times 70\% = \$2,160,000$ TF (monthly \$180,000 TF)

- HPSM received capitation payments beginning May 2013.
- Assume the June capitation payment will be deferred to the following fiscal year.
- Assume the CCS pilot program is budget neutral.
- 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 January 2015.

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: $77,985 \times \$272.51 = \mathbf{\$21,252,000 \text{ TF}}$

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: $\$21,252,000 \times 20\% = \mathbf{\$4,250,000 \text{ TF}}$

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.

$$\$38,799,000 - (\$38,799,000 \times 25\%) = \$29,100,000$$

2. Assume reduction for utilization and FFS caseload decline of 40% due to additional shifts to managed care.

$$\$29,100,000 - (\$29,100,000 \times 40\%) = \$17,460,000$$

3. Increase in periodicity from 15 lifetime screens to 29 lifetime screens.

$$\$17,460,000 / 15 \text{ screens} = \$1,164,000 \text{ per screen}$$

$$\$1,164,000 \times 14 \text{ additional screens} = \$16,296,000 \text{ for additional screens}$$

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.

$$\$38,799,000 \times 5\% = \$1,940,000$$

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

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.

$$\text{FY 2015-16: } \$18,236,000 \div 12 \text{ months} \times 6 \text{ months} = \mathbf{\$9,118,000 \text{ TF}}$$

$$\text{FY 2016-17: } \mathbf{\$18,236,000 \text{ TF}}$$

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 (YRTC).

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)

$$1,800 \text{ MM} \times \$300 \text{ PMPM} = \$540,000 \text{ TF}$$

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

$$524 \text{ MM} \times \$300 \text{ PMPM} = \$157,000 \text{ (caseload expansion)}$$

$$\$540,000 + \$157,000 = \$697,000 \text{ TF}$$

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

$$3,240 \text{ MM} \times \$300 \text{ PMPM} = \$972,000 \text{ TF}$$

Funding:

FY2015-16:		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

FY2016-17:		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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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%.

$318,179 \times 2.76\% = 8,782$ (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:

FY2015-16:

4,233 referrals \div 12 months \times 9 months = 3,175 \times \$190.96 = **\$606,000 TF**

FY2016-17:

4,233 referrals \times \$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
OTLIP 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
OTLIP 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 the following situations:

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

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

Reason for Change from Prior Estimate:

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 DDFFP	\$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:

- 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

- 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 of \$5,788 for FY 2015-16 and FY 2016-17 for NF-B beneficiaries.
$$\text{\$190.30 NF-B daily rate} \times 365 \text{ days} / 12 \text{ months} = \text{\$5,788 per month}$$
7. Assume a savings of \$12,414,000 TF for FY 2015-16 and \$22,518,000 TF for FY 2016-17.
$$\text{FY 2015-16: } 3,201 \text{ non-DD enrollment months} \times \text{\$5,788} \times 0.670 \text{ payment lag} = \text{\$12,414,000 TF savings}$$

$$\text{FY 2016-17: } 3,990 \text{ non-DD enrollment months} \times \text{\$5,788} \times 0.975 \text{ payment lag} = \text{\$22,518,000 TF savings}$$
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 DDFFP	\$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 DDFFP	\$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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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: $\$259,000 \times 34 = \$8,806,000$ per year

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

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

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

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

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

GHPP Medi-Cal: $\$259,000 \times 105 = \$27,195,000$ 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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)
BioMed	(\$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 Amt s	(\$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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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:

- 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	\$21.82	\$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

- 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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:

- 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

- 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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 (OTLICIP). OTLICIP 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

	<u>TF</u>	<u>FFP</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 82

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

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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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

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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:

- 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.
- 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

- 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
DY2011-12	\$56,753	\$56,753
DY2012-13	\$41,028	\$41,028
DY2013-14	\$28,598	\$28,598
Total FY 2015-16	\$126,379	\$126,379

(Dollars in Thousands)

FY 2016-17	TF	FF
DY2010-11	(\$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:

- 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

- 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)
<ul style="list-style-type: none"> · 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 ABX35 (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 encountersX	\$350 =	\$1,171,800 FF
New Waiver (2 Mo.)	1,332 encountersX	\$350 =	\$466,200 FF
CY 2016	4,200 encountersX	\$350 =	\$1,470,000 FF
CY 2017	4,200 encountersX	\$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 (DY2014-15)	\$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 (DY2014-15)	\$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 FY2015-16.
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 (DY2014-15)	\$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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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 careplans.

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 policy change.
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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 Fairgrievs
 FISCAL REFERENCE NUMBER: 1939

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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. $\$118.80 \times 1.0435 = \$123.96 + \$3.00$ 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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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**
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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:

- Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.
- 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

- 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.
- 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.
- The QASP will continue at FY 2014-15 levels, \$90 million total funds, instead of setting aside a portion of the annual increase.
- 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**
REGULAR POLICY CHANGE NUMBER: 137

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

REGULAR POLICY CHANGE NUMBER: 138

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

REGULAR POLICY CHANGE NUMBER: 138

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

REGULAR POLICY CHANGE NUMBER: 138

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 reimbursement rates.

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 2014-15Retro	\$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 2015-16Retro	\$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.

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 \times (1+0.8\%) = \151.09
2015	12,645,852	\$151.09	$\$151.09 \times (1+0.8\%) = \152.30
2016	12,953,368	\$152.30	$\$152.30 \times (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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

$$497,083 \times 45\% \times 98\% \times \$11 = \$2,411,000 \text{ TF (rounded)}$$

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

<u>Provider Type</u>	<u>Payment Reduction Effective Date</u>	<u>Payment Reduction Implementation Date</u>	<u>Total Months of Retroactive Period</u>	<u>Recoupment Start Date</u>	<u>Total Months to Recoup</u>
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:

$\$21,549,000 \div 12 \text{ months} = \$1,796,000.$

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:

$\$21,549,000 \div 12 \text{ months} \times 34 \text{ months} = \$61,055,500$

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 SPA09-004.
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:
 - FY 2013-14 and FY 2014-15 payments shifted from FY 2014-15 to FY 2015-16,
 - 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 toNDPHs (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 toNDPHs	\$1,176	\$0	\$588	\$588	\$0
FY 2014-15 Payments toNDPHs (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 toNDPHs	\$93,000	\$0	\$46,500	\$46,500	\$0
FY 2015-16 Payments toNDPHs (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 toNDPHs	\$93,000	\$0	\$46,500	\$46,500	\$0
FY 2016-17 Payments toNDPHs (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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

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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.

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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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.

July 2015 – December 2015:

824 beneficiaries x 420 units x \$0.3125 rate per unit = \$108,000 TF

January 2016 – June 2016:

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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.—OTLIP

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.—OTLCP
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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:

- One-year claims are based on actual claims received from the counties.
- 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:

$$\text{FY 2015-16: } \$8,466,000 - \$4,868,000 = (\$3,598,000)$$

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:

$$\text{FY 2016-17: } (\$3,598,000) \times 1.018 = (\$3,663,000)$$

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: $90\% \times 17,595 \text{ beneficiaries} = 15,835$
SRP services performed by Dentists: $79\% \times 968 \text{ beneficiaries} = 765$

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 $\$198 \times 15,835 = \$3,136,000$
12. The estimated annual expenditure for non-RDHAPS in FY 2013-14 is $\$198 \times 765 = \$151,000$
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 $\times 1.018 = \$3,250,000$

FY 2016-17: $\$3,250,000$ projected expenditure for FY 2015-16 $\times 1.018 = \$3,308,000$

Dentists:

FY 2015-16: $\$154,000$ projected expenditure for FY 2014-15 $\times 1.018 = \$157,000$

FY 2016-17: $\$157,000$ projected expenditure for FY 2015-16 $\times 1.018 = \$160,000$

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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
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 firstDY.

(Dollars in Thousands)

FY 2015-16	TF	IGT*	FF
DY2015-16	\$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
DY2015-16	\$258,096	\$129,048	\$129,048
DY2016-17	\$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 (OSHDP)
<ul style="list-style-type: none"> • 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.

Increase Preventative Services Utilization for Children

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.

Caries Risk Assessment and Management

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 to 12 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:

$$393 \times \$226.20 \times 2 = \$177,793$$

Placement Assessments

1. Assume it will take mental health staff four hours per client to complete a mental health assessment.

$$393 \times \$226.20 \times 4 = \$355,586$$

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)

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGE	TOTAL STATE FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
OTHER							
1	COUNTY ADMINISTRATION BASE	\$0	\$0	\$1,302,683,000	\$0	\$1,302,683,000	\$651,341,500
2	IMPLEMENTATION OF ACA	\$0	\$485,385,000	\$0	\$0	\$485,385,000	\$242,692,500
3	SAWS	\$166,805,000	\$0	\$0	\$0	\$166,805,000	\$10,176,000
4	CalWORKS APPLICATIONS	\$0	\$0	\$71,944,000	\$0	\$71,944,000	\$35,972,000
5	CASE MANAGEMENT FOR TLICP	\$0	\$0	\$0	\$49,019,000	\$49,019,000	\$17,156,650
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$26,646,000	\$26,646,000	\$1,976,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	-\$327,797,000
8	SAVE	\$0	\$0	\$0	\$0	\$0	-\$3,500,000
9	PRIOR YEAR RECONCILIATIONS	-\$2,309,000	\$0	\$0	\$0	-\$2,309,000	-\$1,057,500
	OTHER SUBTOTAL	\$164,496,000	\$485,385,000	\$1,374,627,000	\$75,665,000	\$2,100,173,000	\$626,960,650
	GRAND TOTAL	\$164,496,000	\$485,385,000	\$1,374,627,000	\$75,665,000	\$2,100,173,000	\$626,960,650

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2016-17**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGE	TOTAL STATE FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
OTHER							
1	COUNTY ADMINISTRATION BASE	\$0	\$0	\$1,302,683,000	\$0	\$1,302,683,000	\$651,341,500
2	IMPLEMENTATION OF ACA	\$0	\$655,310,000	\$0	\$0	\$655,310,000	\$327,655,000
3	SAWS	\$137,293,000	\$0	\$0	\$0	\$137,293,000	\$7,879,500
4	CalWORKS APPLICATIONS	\$0	\$0	\$65,223,000	\$0	\$65,223,000	\$32,611,500
5	CASE MANAGEMENT FOR TLICP	\$0	\$0	\$0	\$49,657,000	\$49,657,000	\$17,379,950
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$26,646,000	\$26,646,000	\$1,976,500
7	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	-\$359,003,000
8	SAVE	\$0	\$0	\$0	\$0	\$0	-\$3,500,000
9	PRIOR YEAR RECONCILIATIONS	-\$2,309,000	\$0	\$0	\$0	-\$2,309,000	-\$765,000
	OTHER SUBTOTAL	\$134,984,000	\$655,310,000	\$1,367,906,000	\$76,303,000	\$2,234,503,000	\$675,575,950
	GRAND TOTAL	\$134,984,000	\$655,310,000	\$1,367,906,000	\$76,303,000	\$2,234,503,000	\$675,575,950

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION BASE	\$1,302,683,000	\$651,341,500	\$1,302,683,000	\$651,341,500	\$0	\$0
2	2	IMPLEMENTATION OF ACA	\$485,385,000	\$242,692,500	\$485,385,000	\$242,692,500	\$0	\$0
3	3	SAWS	\$162,822,000	\$12,416,000	\$166,805,000	\$10,176,000	\$3,983,000	-\$2,240,000
5	4	CalWORKS APPLICATIONS	\$71,944,000	\$35,972,000	\$71,944,000	\$35,972,000	\$0	\$0
6	5	CASE MANAGEMENT FOR TLICP	\$49,019,000	\$17,156,650	\$49,019,000	\$17,156,650	\$0	\$0
7	6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$26,646,000	\$1,976,500	\$26,646,000	\$1,976,500	\$0	\$0
8	7	ENHANCED FEDERAL FUNDING	\$0	-\$324,487,000	\$0	-\$327,797,000	\$0	-\$3,310,000
9	8	SAVE	\$0	-\$3,500,000	\$0	-\$3,500,000	\$0	\$0
10	9	PRIOR YEAR RECONCILIATIONS	-\$2,309,000	-\$1,154,500	-\$2,309,000	-\$1,057,500	\$0	\$97,000
		OTHER SUBTOTAL	\$2,096,190,000	\$632,413,650	\$2,100,173,000	\$626,960,650	\$3,983,000	-\$5,453,000
		COUNTY ADMINISTRATION GRAND TOTAL	\$2,096,190,000	\$632,413,650	\$2,100,173,000	\$626,960,650	\$3,983,000	-\$5,453,000

Costs shown do not include percent reflected in base calculation.

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
1	COUNTY ADMINISTRATION BASE	\$1,302,683,000	\$651,341,500	\$1,302,683,000	\$651,341,500	\$0	\$0
2	IMPLEMENTATION OF ACA	\$485,385,000	\$242,692,500	\$655,310,000	\$327,655,000	\$169,925,000	\$84,962,500
3	SAWS	\$166,805,000	\$10,176,000	\$137,293,000	\$7,879,500	-\$29,512,000	-\$2,296,500
4	CalWORKS APPLICATIONS	\$71,944,000	\$35,972,000	\$65,223,000	\$32,611,500	-\$6,721,000	-\$3,360,500
5	CASE MANAGEMENT FOR TLICP	\$49,019,000	\$17,156,650	\$49,657,000	\$17,379,950	\$638,000	\$223,300
6	LOS ANGELES COUNTY HOSPITAL INTAKES	\$26,646,000	\$1,976,500	\$26,646,000	\$1,976,500	\$0	\$0
7	ENHANCED FEDERAL FUNDING	\$0	-\$327,797,000	\$0	-\$359,003,000	\$0	-\$31,206,000
8	SAVE	\$0	-\$3,500,000	\$0	-\$3,500,000	\$0	\$0
9	PRIOR YEAR RECONCILIATIONS	-\$2,309,000	-\$1,057,500	-\$2,309,000	-\$765,000	\$0	\$292,500
	OTHER SUBTOTAL	\$2,100,173,000	\$626,960,650	\$2,234,503,000	\$675,575,950	\$134,330,000	\$48,615,300
	COUNTY ADMINISTRATION GRAND TOTAL	\$2,100,173,000	\$626,960,650	\$2,234,503,000	\$675,575,950	\$134,330,000	\$48,615,300

Costs shown do not include percent reflected in base calculation.

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>OTHER</u>
1	COUNTY ADMINISTRATION BASE
2	IMPLEMENTATION OF ACA
3	SAWS
4	CalWORKS APPLICATIONS
5	CASE MANAGEMENT FOR TLICP
6	LOS ANGELES COUNTY HOSPITAL INTAKES
7	ENHANCED FEDERAL FUNDING
8	SAVE
9	PRIOR YEAR RECONCILIATIONS

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1704

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$1,302,683,000	\$0	\$1,302,683,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$1,302,683,000	\$0	\$1,302,683,000
STATE FUNDS	\$0	\$651,341,500	\$0	\$651,341,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$1,302,683,000	\$0	\$1,302,683,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$1,302,683,000	\$0	\$1,302,683,000
STATE FUNDS	\$0	\$651,341,500	\$0	\$651,341,500

DESCRIPTION

Purpose:

This policy change reflects the base allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

PC 7 Enhanced Federal Funding

Background:

The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. The base estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

The base estimate consists of the costs identified for three sub-categories: (1) staff costs (2) support costs, and (3) staff development costs.

1. Staff Costs

This amount includes the estimated costs for staff in three staff categories: eligibility workers and supervisors, clerical support staff, and administrative staff. The staff costs for each of the three categories will be allocated to individual counties to fund all Medi-Cal eligibility determination activities.

COUNTY ADMINISTRATION BASE**COUNTY ADMIN. POLICY CHANGE NUMBER: 1****2. Support Costs**

Support costs are a combination of two types of expenditures: operating support costs and electronic data processing costs. These two types of expenditures are further divided into allocated costs and direct costs.

- a. Allocated costs are those that are shared across all programs and distributed to individual programs based on a ratio developed from the total expenditures for each program.
- b. Direct costs are specific to the Medi-Cal program only.

3. Staff Development Costs

Staff development costs are the costs of training Medi-Cal eligibility workers. The amount in this item includes:

- a. Trainers' salaries and benefits,
- b. Operating costs related to training,
- c. Trainees' salaries and benefits,
- d. Travel, per diem, supplies and tuition,
- e. Purchase of contracted training services.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1) The total rounded estimated FY 2015-16 and FY 2016-17 county administration costs are:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Staff Salary Costs	\$909,622	\$454,811	\$454,811
Support Staff Costs	\$373,643	\$186,821	\$186,821
Staff Development Costs	\$19,416	\$9,708	\$9,708
Total Base Allocation	\$1,302,683	\$651,341	\$651,342
FY 2016-17	TF	GF	FF
Staff Salary Costs	\$909,622	\$454,811	\$454,811
Support Staff Costs	\$373,643	\$186,821	\$186,821
Staff Development Costs	\$19,416	\$9,708	\$9,708
Total Base Allocation	\$1,302,683	\$651,341	\$651,342

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Medi-Cal County Administration				
FY 2015-16 and FY 2016-17				
County	Total Staff Salary Costs	Support Staff	Staff Development Costs	Base Allocation
Alameda	\$32,542,588	\$11,615,145	\$1,385,854	\$45,543,587
Alpine	\$41,700	\$0	\$0	\$41,700
Amador	\$681,637	\$366,187	\$10,341	\$1,058,165
Butte	\$5,379,540	\$2,399,702	\$25,500	\$7,804,742
Calaveras	\$694,063	\$441,347	\$6,910	\$1,142,320
Colusa	\$635,448	\$291,552	\$21,716	\$948,716
Contra Costa	\$23,315,114	\$12,617,981	\$304,333	\$36,237,428
Del Norte	\$558,190	\$259,284	\$11,200	\$828,674
El Dorado	\$2,652,217	\$1,101,127	\$90,000	\$3,843,344
Fresno	\$28,892,408	\$16,305,175	\$657,347	\$45,854,930
Glenn	\$1,059,460	\$342,764	\$18,000	\$1,420,224
Humboldt	\$3,875,219	\$1,057,846	\$119,300	\$5,052,365
Imperial	\$5,074,973	\$1,872,353	\$115,220	\$7,062,546
Inyo	\$554,240	\$212,327	\$11,000	\$777,567
Kern	\$17,115,100	\$7,278,489	\$196,890	\$24,590,479
Kings	\$2,702,453	\$955,428	\$144,250	\$3,802,131
Lake	\$1,631,990	\$568,477	\$51,706	\$2,252,173
Lassen	\$492,642	\$218,634	\$23,468	\$734,744
Los Angeles	\$273,758,990	\$119,782,655	\$2,103,000	\$395,644,645
Madera	\$3,292,642	\$1,697,142	\$4,465	\$4,994,249
Marin	\$3,206,326	\$1,600,478	\$103,412	\$4,910,216
Mariposa	\$417,966	\$539,071	\$0	\$957,037
Mendocino	\$3,488,586	\$1,469,968	\$15,718	\$4,974,272
Merced	\$9,075,836	\$1,956,051	\$144,064	\$11,175,951
Modoc	\$387,012	\$332,812	\$15,000	\$734,824
Mono	\$207,098	\$110,669	\$20,000	\$337,767
Monterey	\$11,136,422	\$5,713,668	\$475,000	\$17,325,090
Napa	\$2,072,297	\$1,160,104	\$43,563	\$3,275,964
Nevada	\$1,527,574	\$732,652	\$25,631	\$2,285,857
Orange	\$77,886,813	\$20,747,854	\$2,000,674	\$100,635,341
Placer	\$4,215,254	\$1,860,122	\$91,206	\$6,166,582
Plumas	\$373,319	\$197,689	\$5,171	\$576,179

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

Medi-Cal County Administration				
FY 2015-16 and FY 2016-17				
County	Total Staff Salary Costs	Support Staff	Staff Development Costs	Base Allocation
Riverside	\$42,122,663	\$23,700,136	\$750,977	\$66,573,776
Sacramento	\$30,420,717	\$12,121,920	\$885,878	\$43,428,515
San Benito	\$1,150,098	\$389,751	\$64,103	\$1,603,952
San Bernardino	\$42,437,752	\$17,141,455	\$861,000	\$60,440,207
San Diego	\$54,194,098	\$24,937,737	\$2,311,253	\$81,443,088
San Francisco	\$21,609,931	\$4,737,695	\$206,824	\$26,554,450
San Joaquin	\$16,284,780	\$4,472,548	\$434,329	\$21,191,657
San Luis Obispo	\$5,329,928	\$3,862,538	\$149,947	\$9,342,413
San Mateo	\$15,595,364	\$5,437,955	\$551,844	\$21,585,163
Santa Barbara	\$14,576,928	\$6,200,380	\$881,375	\$21,658,683
Santa Clara	\$53,322,942	\$15,373,238	\$1,500,000	\$70,196,180
Santa Cruz	\$7,550,308	\$3,000,456	\$422,880	\$10,973,644
Shasta	\$4,145,591	\$2,114,811	\$200,000	\$6,460,402
Sierra	\$113,167	\$173,930	\$1,500	\$288,597
Siskiyou	\$1,013,009	\$258,380	\$128,037	\$1,399,426
Solano	\$9,405,955	\$4,679,039	\$500,000	\$14,584,994
Sonoma	\$11,267,525	\$2,945,891	\$237,048	\$14,450,464
Stanislaus	\$15,194,676	\$3,970,500	\$160,184	\$19,325,360
Sutter	\$2,950,607	\$1,943,224	\$50,000	\$4,943,831
Tehama	\$1,468,661	\$679,223	\$5,500	\$2,153,384
Trinity	\$353,544	\$128,062	\$11,500	\$493,106
Tulare	\$16,162,830	\$4,855,829	\$459,400	\$21,478,059
Tuolumne	\$1,153,800	\$800,054	\$8,928	\$1,962,782
Ventura	\$17,008,190	\$8,607,859	\$265,114	\$25,881,163
Yolo	\$3,821,963	\$3,233,330	\$71,160	\$7,126,453
Yuba	\$2,022,731	\$2,072,590	\$58,121	\$4,153,442
Total	\$909,622,876	\$373,643,283	\$19,416,841	\$1,302,683,000

Funding:

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

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1796

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$485,385,000	\$0	\$655,310,000	\$0
TOTAL FUNDS	\$485,385,000	\$0	\$655,310,000	\$0
STATE FUNDS	\$242,692,500	\$0	\$327,655,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$485,385,000	\$0	\$655,310,000	\$0
TOTAL FUNDS	\$485,385,000	\$0	\$655,310,000	\$0
STATE FUNDS	\$242,692,500	\$0	\$327,655,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the county administrative costs for implementing required provisions of the Affordable Care Act (ACA).

Authority:

Not Applicable

Interdependent Policy Changes:

PC 7 Enhanced Federal Funding

Background:

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

Additionally, the ACA established online health insurance exchanges. Covered California, California's online health insurance exchange, provides competitive health care coverage for individuals and small employers. As required by ACA, Covered California determines an applicant's eligibility for subsidized coverage. The ACA also requires states to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs.

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Covered California offers applicants the option to file online, in person, by mail, by telephone with the exchange, or with the county welfare departments (CWD). To meet this requirement, the Department and Covered California formed a partnership to develop the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). CalHEERS allows for the one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

Reason for Change from Prior Estimate:

The Medi-Cal program continues to experience ACA related caseload growth, and the Administration continues to work towards systemic improvement of CalHEERS.

Methodology:

- 1) Effective January 1, 2014, the ACA simplifies eligibility for several coverage groups (Children, Pregnant Women, and 1931b).
- 2) Since January 2014, the Medi-Cal program has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and ACA mandatory expansions.
- 3) The CalHEERS was developed to automate the eligibility work for a large portion of new and existing Medi-Cal beneficiaries. However, currently the system isn't completely functional. This requires counties to manually process some eligibility determinations and renewals. These manual workarounds performed by the counties require additional resources.
- 4) The total county administrative costs estimated for implementing required provisions of the ACA are:

(Dollars in thousands)	TF	GF	FF
FY 2015-16	\$ 485,385	\$ 242,693	\$ 242,693
FY 2016-17	\$ 655,310	\$ 327,655	\$ 327,655

Funding:

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

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/1987
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 214

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$166,805,000	\$0	\$137,293,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$166,805,000	\$0	\$137,293,000	\$0
STATE FUNDS	\$10,176,000	\$0	\$7,879,500	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$166,805,000	\$0	\$137,293,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$166,805,000	\$0	\$137,293,000	\$0
STATE FUNDS	\$10,176,000	\$0	\$7,879,500	\$0

DESCRIPTION

Purpose:

This policy change estimates and reimburses the California Department of Social Services (CDSS) 100% Federal Financial Participation (FFP) for automated Eligibility Determination and Automated Benefit Computation. This policy change also estimates the funds for the Los Angeles Eligibility Automated Determination Evaluation and Reposting System (LEADER) that is paid by the Department.

Authority:

Welfare & Institutions Code 14154
 Interagency Agreement # 04-35639
 Interagency Agreement CalHEERS # 14-90510
 Interagency Agreement ACMS # 14-90518
 Affordable Care Act (ACA)

Interdependent Policy Changes:

Not Applicable

Background:

The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LEADER, the Consortium-IV (C-IV), and the CalWORKs Information Network (CalWIN). SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

LEADER is the automated system for Los Angeles County and is currently in the maintenance and operation phase. Los Angeles County began the process to replace the LEADER system and has

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

entered the development phase of the process with the contractor Accenture. The Centers for Medicare and Medicaid Services (CMS), OSI and the Los Angeles County Board of Supervisors have reviewed and approved the LEADER Replacement System (LRS) development contract. While the replacement system is being developed, Los Angeles County received state and federal approval to extend the existing LEADER maintenance and operations contract for an additional two years, through April 2015. On November 12, 2014, an additional two-year sole source extension of the current LEADER M&O services contract was approved by the Los Angeles County Board of Supervisors. The contract has been extended through April 2017. This extension allows for the ongoing maintenance and operations of the LEADER system, until full implementation of LRS in Los Angeles County. The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase. The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. LRS is being developed using the C-IV system as the baseline. The process of migrating the C-IV system to the LRS codebase will begin following implementation and stabilization of LRS in Los Angeles County. The pilot for operational readiness is scheduled to conclude by November 2015; countywide implementation is planned to begin in March 2016. The C-IV Migration will result in a new consortium to replace the LEADER and C-IV consortia.

Counties in all three of the SAWS have upgraded and expanded the current county call center infrastructure to interface with Covered California's service center. This expansion is required to meet the increase in call volume and the increase in services provided to beneficiaries.

Reason for Change from Prior Estimate:

Funding for CalHEERS Development has been added to the CY estimate.

Methodology:

1) The following estimate was provided by CDSS on a cash basis.

(Dollars in Thousands)	FY 2015-16	FY 2016-17
Statewide Project Management	\$1,910	\$1,889
CalHEERS Interface Development	\$1,818	\$0
SB 1341 Medi-Cal/SAWS	\$7,845	\$13,712
SAWS Customer Service Centers	\$1,253	\$0
LEADER - Replacement	\$59,015	\$32,711
LA County LEADER M&O*	\$20,352	\$15,760
WCDS-CalWIN	\$39,879	\$39,061
Consortium IV	\$34,432	\$33,604
State Client Index	\$70	\$68
Appeals Case Management System (ACMS)	\$231	\$488
Total	\$166,805	\$137,293

Funding:

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

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

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 217

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$71,944,000	\$0	\$65,223,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$71,944,000	\$0	\$65,223,000
STATE FUNDS	\$0	\$35,972,000	\$0	\$32,611,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$71,944,000	\$0	\$65,223,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$71,944,000	\$0	\$65,223,000
STATE FUNDS	\$0	\$35,972,000	\$0	\$32,611,500

DESCRIPTION

Purpose:

This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Since 1998, the Department shares in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1) The estimated costs for FY 2015-16 were provided on a cash basis from CDSS.

CaIWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in thousands)

	TF	GF	FF
FY 2015-16	\$71,944	\$35,972	\$35,972
FY 2016-17	\$65,223	\$32,611	\$32,612

Funding:

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

CASE MANAGEMENT FOR TLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1598

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$49,019,000	\$0	\$49,657,000
TOTAL FUNDS	\$0	\$49,019,000	\$0	\$49,657,000
STATE FUNDS	\$0	\$17,156,650	\$0	\$17,379,950
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$49,019,000	\$0	\$49,657,000
TOTAL FUNDS	\$0	\$49,019,000	\$0	\$49,657,000
STATE FUNDS	\$0	\$17,156,650	\$0	\$17,379,950

DESCRIPTION

Purpose:

This policy change budgets the county administration costs associated with the ongoing costs for case management and redetermination of Targeted Low Income Children's Program (TLICP) beneficiaries.

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent current subscribers' applications and information to the counties. The final group transitioned November 1, 2013. The program has since been renamed as the TLICP.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The Department currently estimates the case management and redetermination for the former TLICP beneficiaries at \$4.00 PMPM.

CASE MANAGEMENT FOR TLICP
COUNTY ADMIN. POLICY CHANGE NUMBER: 5

2. Estimated costs:

(Dollars In Thousands)

FY	TF	GF
FY 2015-16	\$49,019	\$17,157
FY 2016-17	\$49,657	\$17,380

Funding:

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

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 7/1994
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 213

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$26,646,000	\$0	\$26,646,000
TOTAL FUNDS	\$0	\$26,646,000	\$0	\$26,646,000
STATE FUNDS	\$0	\$1,976,500	\$0	\$1,976,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$26,646,000	\$0	\$26,646,000
TOTAL FUNDS	\$0	\$26,646,000	\$0	\$26,646,000
STATE FUNDS	\$0	\$1,976,500	\$0	\$1,976,500

DESCRIPTION

Purpose:

The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. The applications processed by the PFSWs are sent to the Los Angeles County Human Services Agency for final eligibility determination. Welfare & Institutions Code Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The federal share for any costs not covered by the DPSS rate is passed through to the county.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Based on actual data, the average reimbursement rate is estimated at \$268 for both current year and budget year. Assume in FY 2015-16 and FY 2016-17, PFSWs will continue processing at 2,215 per month.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

FY 2015-16: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,561,500 GF)

FY 2016-17: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,561,500 GF)

2. The Department will complete the FY 2013-14 Los Angeles County Hospital Intakes reconciliation in FY 2015-16.
3. The Department will complete the FY 2014-15 Los Angeles County Hospital Intakes reconciliation in FY 2016-17.

(Dollars in Thousands)	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2013-14 Recon.	\$8,176	(\$1,585)	\$9,761	\$0	\$0	\$0
FY 2013-14 Pass.	\$11,347	\$0	\$11,347	\$0	\$0	\$0
FY 2014-15 Recon.	\$0	\$0	\$0	\$8,176	(\$1,585)	\$9,761
FY 2014-15 Pass.	\$0	\$0	\$0	\$11,347	0	\$11,347
Total	\$26,646	\$1,976	\$24,670	\$26,646	\$1,976	\$24,670

Funding:

(Dollars in Thousands)

FY 2015-16		TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$21,108	\$0	\$21,108
100% GF	4260-101-0001	(\$1,585)	(\$1,585)	\$0
Total		\$26,646	\$1,976	\$24,670
FY 2016-17		TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$21,108	\$0	\$21,108
100% GF	4260-101-0001	(\$1,585)	(\$1,585)	\$0
Total		\$26,646	\$1,976	\$24,670

Funding:

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

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

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 1/2015
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1835

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$327,797,000	\$0	-\$359,003,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$327,797,000	\$0	-\$359,003,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare and Medicaid Services (CMS) published guidance that allows for federal funding at 75% for some of these activities. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance, and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

In order to secure the enhanced funding, there are various conditions required of a MMIS. Also, there are minimum critical success factors for accepting the new applications, making modified adjusted gross income (MAGI) determinations and coordination with Covered California. In January 2014 the Department submitted an Advanced Planning Document (APD) to secure CMS approval. CMS approved the APD on September 29, 2014.

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

Reason for Change from Prior Estimate:

The FY 2015-16 and FY 2016-17 estimated County Administrative costs were updated, which increased the overall amount eligible for enhanced 75/25 funding.

Methodology:

1. The effective date for the approval for the Department's APD is September 29, 2014, with retroactivity for April-September 2014. In addition, both FY 2015-16 and FY 2016-17 contain additional funding related to the implementation of the Affordable Care Act (ACA).
2. Assume that 67.5% of county administration forecasted expenditure costs are eligible for the enhanced funding because they are application, on-going case maintenance, and redetermination costs.
3. The savings are estimated to be:
(Dollars in Thousands)

FY 2015-16	TF	GF	FF
FY 2015-16 at 50% FFP	\$ 1,311,188	\$ 655,594	\$ 655,594
FY 2015-16 at 75% FFP	\$ 1,311,188	\$ 327,797	\$ 983,391
Total FY 2015-16 Difference	\$ -	\$ (327,797)	\$ 327,797

FY 2016-17	TF	GF	FF
FY 2016-17 at 50% FFP	\$ 1,436,010	\$ 718,005	\$ 718,005
FY 2016-17 at 75% FFP	\$ 1,436,010	\$ 359,003	\$ 1,177,008
Total FY 2016-17 Difference	\$ -	\$ (359,003)	\$ 359,003

Funding:

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

75% Title XIX GF/ 25% GF (4260-101-0001/0890)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 10/1988
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 215

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$3,500,000	\$0	-\$3,500,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$3,500,000	\$0	-\$3,500,000	\$0

DESCRIPTION**Purpose:**

The policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

The Immigration Reform and Control Act (IRCA) of 1986 required states to use the SAVE system to verify alien status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications.

Reason for Change from Prior Estimate:

There is no change.

SAVE**COUNTY ADMIN. POLICY CHANGE NUMBER: 8****Methodology:**

1. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Reported	Fiscal Year	Estimated
FY 2011-12*	\$6,418,702	FY 2014-15**	\$7,000,000
FY 2012-13*	\$6,348,795	FY 2015-16**	\$7,000,000
FY 2013-14*	\$6,261,572	FY 2016-17**	\$7,000,000

* Actual

** Preliminary

2. Based on claims through June 2015, federal funds will be:

(Dollars in Thousands)

FY 2015-16		TF	GF	FF
50% Title XIX/50% GF	4260-101-0001/0890	(\$7,000)	(\$3,500)	(\$3,500)
100 % Title XIX SAVE	4260-113-0890	\$7,000	\$0	\$7,000
Net Impact		\$0	(\$3,500)	\$3,500
FY 2016-17		TF	GF	FF
50% Title XIX/50% GF	4260-101-0001/0890	(\$7,000)	(\$3,500)	(\$3,500)
100% Title XIX SAVE	4260-113-0890	\$7,000	\$0	\$7,000
Net Impact		\$0	(\$3,500)	\$3,500

Funding:

100% GF (4260-101-0001)

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

PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1191

	FY 2015-16		FY 2016-17	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	-\$2,309,000	\$0	-\$2,309,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	-\$2,309,000	\$0	-\$2,309,000	\$0
STATE FUNDS	-\$1,057,500	\$0	-\$765,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	-\$2,309,000	\$0	-\$2,309,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	-\$2,309,000	\$0	-\$2,309,000	\$0
STATE FUNDS	-\$1,057,500	\$0	-\$765,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the reconciliation of county administration expenditures to the county administration allocation.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Two years following the end of a fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quarterly administrative claim which is used by the Department for the county administration reconciliation process.

Reason for Change from Prior Estimate:

The Department updated the general fund and federal fund amounts assuming it received enhanced FFP for County Admin expenditures in FY 2014-15 and Q4 of FY 2013-14.

Methodology:

- 1) In FY 2015-16, the Department will complete the final reconciliation for FY 2013-14. The table reflects the estimated reconciliation dollars for FY 2015-16 and FY 2016-17 based on the previous year's final reconciliation.

PRIOR YEAR RECONCILIATIONS
COUNTY ADMIN. POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Q1-Q3 FY 2013-14 Reconciliation	(\$1,732,000)	(\$866,000)	(\$866,000)
Q4 FY 2013-14 Reconciliation	(\$577,000)	(\$191,000)	(\$386,000)
Total FY 2015-16	(\$2,309,000)	(\$1,057,000)	(\$1,252,000)
FY 2016-17	TF	GF	FF
FY 2014-15 Final Reconciliation	(\$2,309,000)	(\$765,000)	(\$1,544,000)
Total FY 2016-17	(\$2,309,000)	(\$765,000)	(\$1,544,000)

Funding:

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

75% Title XIX FF/ 25% GF (4260-101-0001/0890)

November 2015 Medi-Cal Estimate

**OTHER ADMINISTRATION
FUNDING SUMMARY**

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The Fiscal Intermediary Tab of the Medi-Cal Estimate has been moved to the Other Administration Tab. These items continue to be budgeted in the Medi-Cal's Fiscal Intermediary component. The policy changes related to the Fiscal Intermediary can be found under the following subsections: DHCS-MEDICAL FI, DHCS-HEALTH CARE OPTIONS, AND DHCS-DENTAL FI.

<u>FY 2015-2016 ESTIMATE:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>State Funds</u>
OTHER ADMINISTRATION			
County Administration	\$1,873,713,000	\$1,682,974,000	\$190,739,000
Fiscal Intermediary	\$485,532,000	\$319,744,000	\$165,788,000
Total Other Administration Tab	\$2,359,245,000	\$2,002,718,000	\$356,527,000

Management Summary:

COUNTY ADMINISTRATION	\$3,973,886,000	\$3,156,186,000	\$817,700,000
Shown in Other Administration Tab	\$1,873,713,000	\$1,682,974,000	\$190,739,000
Shown in County Administration Tab	\$2,100,173,000	\$1,473,212,000	\$626,961,000
FISCAL INTERMEDIARY	\$485,532,000	\$319,744,000	\$165,788,000
Shown in Other Administration Tab	\$485,532,000	\$319,744,000	\$165,788,000

<u>FY 2016-2017 ESTIMATE:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>State Funds</u>
OTHER ADMINISTRATION			
County Administration	\$1,865,909,000	\$1,680,633,400	\$185,275,600
Fiscal Intermediary	\$456,742,000	\$302,671,000	\$154,071,000
Total Other Administration Tab	\$2,322,651,000	\$1,983,304,400	\$339,346,600

Management Summary:

COUNTY ADMINISTRATION	\$4,100,412,000	\$3,239,560,000	\$860,852,000
Shown in Other Administration Tab	\$1,865,909,000	\$1,680,633,400	\$185,275,600
Shown in County Administration Tab	\$2,234,503,000	\$1,558,926,600	\$675,576,400
FISCAL INTERMEDIARY	\$456,742,000	\$302,671,000	\$154,071,000
Shown in Other Administration Tab	\$456,742,000	\$302,671,000	\$154,071,000

OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2015-16		FISCAL YEAR 2016-17	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
DHCS-OTHER					
1	BTR - LIHP - ADMINISTRATIVE COSTS	\$198,382,000	\$0	\$7,650,000	\$0
2	CCS CASE MANAGEMENT	\$184,969,000	\$62,931,000	\$190,064,000	\$64,538,700
3	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$176,139,000	\$0	\$321,586,000	\$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$106,737,000	\$0	\$109,291,000	\$0
5	POSTAGE & PRINTING	\$38,317,000	\$19,437,000	\$26,032,000	\$13,219,500
6	OTLICP AND MEDI-CAL ACCESS PROGRAM	\$36,559,000	\$8,076,100	\$36,559,000	\$6,279,100
7	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,300	\$33,718,000	\$11,871,300
8	ARRA HITECH INCENTIVE PROGRAM	\$32,709,000	\$2,747,000	\$12,556,000	\$732,000
9	SMHS COUNTY UR & QA ADMIN	\$17,329,000	\$600,000	\$17,120,000	\$215,000
10	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$15,851,000	\$1,287,000	\$18,574,000	\$1,864,000
11	SMH MAA	\$15,763,000	\$0	\$16,521,000	\$0
12	PAVE SYSTEM	\$14,610,000	\$1,858,500	\$14,021,000	\$2,197,100
13	MIS/DSS CONTRACT	\$12,476,000	\$3,317,000	\$12,476,000	\$3,317,000
14	PASRR	\$10,223,000	\$2,555,800	\$9,936,000	\$2,484,000
15	CCI-ADMINISTRATIVE COSTS	\$9,695,000	\$4,721,500	\$7,148,000	\$3,574,000
16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000
17	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$9,558,000	\$0	\$0	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$9,075,000	\$4,415,000	\$16,872,000	\$8,207,500
19	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$7,700,000	\$3,850,000
20	MEDI-CAL RECOVERY CONTRACTS	\$5,685,000	\$1,421,300	\$5,685,000	\$1,421,300
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,039,000	\$1,652,300	\$5,291,000	\$1,734,800
22	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,865,000	\$1,216,300	\$4,487,000	\$1,121,800
23	CA-MMIS REPLACEMENT OVERSIGHT	\$4,803,000	\$575,500	\$7,074,000	\$847,100
24	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	\$4,539,000	\$0	\$80,000	\$0
25	MEDS MODERNIZATION	\$3,680,000	\$368,000	\$2,915,000	\$291,500

OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2015-16		FISCAL YEAR 2016-17	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
DHCS-OTHER					
26	CA-MMIS REPLACEMENT & OTHER STATE TRANSITION	\$3,157,000	\$378,000	\$2,277,000	\$273,100
28	BUSINESS RULES EXTRACTION	\$2,580,000	\$645,000	\$0	\$0
29	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500
30	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,188,000	\$1,094,000	\$2,188,000	\$1,094,000
31	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$1,900,000	\$1,900,000	\$950,000	\$950,000
32	MITA	\$1,740,000	\$174,000	\$2,582,000	\$258,200
33	ETL DATA SOLUTION	\$1,389,000	\$364,400	\$398,000	\$39,800
34	HEALTH HOMES PROGRAM - CONTRACTOR COSTS	\$1,225,000	\$612,500	\$0	\$0
35	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500
36	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$1,200,000	\$600,000	\$1,200,000	\$600,000
37	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,000,000	\$0	\$1,000,000	\$0
38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000
39	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$553,000	\$276,500	\$596,000	\$298,000
40	CCT OUTREACH - ADMINISTRATIVE COSTS	\$330,000	\$0	\$630,000	\$0
41	ACA EXPANSION ADMIN COSTS	\$330,000	\$165,000	\$0	\$0
42	RATE STUDIES FOR MAIC AND AAC VENDOR	\$305,000	\$152,500	\$305,000	\$152,500
43	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$300,000	\$150,000	\$0	\$0
44	ANNUAL EDP AUDIT CONTRACTOR	\$257,000	\$128,500	\$0	\$0
45	DENTAL PAPD PROJECT MANAGER	\$247,000	\$61,800	\$226,000	\$56,500
46	RECOVERY AUDIT CONTRACTOR COSTS	\$236,000	\$118,000	\$193,000	\$96,500
47	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	\$125,000	\$62,500	\$125,000	\$62,500
48	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500
49	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0
50	Q5i AUTOMATED DATA SYSTEM ACQUISTION	\$59,000	\$29,500	\$59,000	\$29,500
51	TAR POSTAGE	\$59,000	\$29,500	\$59,000	\$29,500

OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2015-16		FISCAL YEAR 2016-17	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-OTHER</u>					
52	COORDINATED CARE MANAGEMENT PILOT	\$23,000	\$11,500	\$0	\$0
53	DMC COUNTY UR & QA ADMIN	\$0	\$0	\$18,537,000	\$0
99	PERFORMANCE OUTCOMES SYSTEM	\$0	\$0	\$23,748,000	\$11,874,000
	DHCS-OTHER SUBTOTAL	\$992,093,000	\$147,037,900	\$952,898,000	\$150,764,100
<u>DHCS-MEDICAL FI</u>					
54	MEDICAL FI OPERATIONS	\$93,742,000	\$30,470,300	\$90,473,000	\$29,306,000
55	MEDICAL FI SYSTEM REPLACEMENT PROJECT	\$49,644,000	\$7,809,000	\$67,423,000	\$10,605,500
56	MEDICAL FI COST REIMBURSEMENT	\$39,547,000	\$11,420,800	\$30,307,000	\$9,423,600
57	MEDICAL FI HOURLY REIMBURSEMENT	\$23,077,000	\$5,018,400	\$23,072,000	\$5,517,800
58	MEDICAL FI OTHER ESTIMATED COSTS	\$20,978,000	\$4,178,300	\$10,532,000	\$3,083,000
59	MEDICAL FI ENHANCEMENTS	\$5,302,000	\$635,200	\$0	\$0
60	MEDICAL FI MISCELLANEOUS EXPENSES	\$3,157,000	\$1,083,300	\$2,120,000	\$691,000
61	MEDICAL FI DIAGNOSIS RELATED GROUPS	\$70,000	\$35,000	\$26,000	\$13,000
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	\$0	\$0	\$804,000	\$80,400
	DHCS-MEDICAL FI SUBTOTAL	\$235,517,000	\$60,650,100	\$224,757,000	\$58,720,300
<u>DHCS-HEALTH CARE OPT</u>					
63	HCO OPERATIONS	\$52,650,000	\$25,477,100	\$39,189,000	\$18,851,600
64	HCO COST REIMBURSEMENT	\$41,490,000	\$20,076,400	\$46,094,000	\$22,170,700
65	HCO CCI - CAL MEDICCONNECT AND MLTSS	\$18,357,000	\$9,178,500	\$11,665,000	\$5,832,500
66	HCO - ENROLLMENT CONTRACTOR COSTS	\$17,633,000	\$8,532,600	\$10,262,000	\$4,936,400
67	HCO ESR HOURLY REIMBURSEMENT	\$13,716,000	\$6,636,700	\$14,013,000	\$6,740,100
68	HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNT	\$727,000	\$363,500	\$0	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$144,573,000	\$70,264,700	\$121,223,000	\$58,531,400
<u>DHCS-DENTAL FI</u>					

OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2015-16		FISCAL YEAR 2016-17	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-DENTAL FI</u>					
69	DENTAL FI OPERATIONS	\$82,288,000	\$26,734,000	\$85,134,000	\$27,689,300
70	DENTAL FI HOURLY REIMBURSEMENT	\$12,334,000	\$3,083,500	\$12,769,000	\$3,192,300
71	DENTAL FI COST REIMBURSEMENT	\$7,369,000	\$3,504,300	\$7,444,000	\$3,541,800
72	DENTAL FI FEDERAL RULE - REVALIDATION	\$1,438,000	\$719,000	\$1,438,000	\$719,000
73	DENTAL FI FEDERAL RULE - DATABASE CHECKS	\$375,000	\$187,500	\$375,000	\$187,500
74	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSME	\$320,000	\$80,000	\$320,000	\$80,000
75	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA	\$195,000	\$97,500	\$195,000	\$97,500
76	DENTAL FI CD-MMIS COSTS	\$77,000	\$19,300	\$20,000	\$5,000
100	DENTAL FI -BENEFICIARY OUTREACH & ED PROGRAM-ADM	\$1,046,000	\$447,500	\$3,067,000	\$1,307,000
DHCS-DENTAL FI SUBTOTAL		\$105,442,000	\$34,872,500	\$110,762,000	\$36,819,300
<u>OTHER DEPARTMENTS</u>					
77	PERSONAL CARE SERVICES	\$298,575,000	\$0	\$297,785,000	\$0
78	HEALTH-RELATED ACTIVITIES - CDSS	\$260,425,000	\$0	\$319,875,000	\$0
79	CALHEERS DEVELOPMENT	\$142,998,000	\$31,594,800	\$129,171,000	\$25,568,100
80	CDDS ADMINISTRATIVE COSTS	\$50,873,000	\$0	\$44,254,000	\$0
81	MATERNAL AND CHILD HEALTH	\$29,965,000	\$0	\$29,893,000	\$0
82	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,803,000	\$0	\$29,998,000	\$0
83	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILD	\$25,143,000	\$0	\$24,879,000	\$0
84	ACA OUTREACH AND ENROLLMENT COUNSELORS	\$15,978,000	\$7,989,000	\$9,950,000	\$4,975,000
85	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COS	\$11,671,000	\$3,560,000	\$11,463,000	\$3,560,000
86	CLPP CASE MANAGEMENT SERVICES	\$5,596,000	\$0	\$4,200,000	\$0
87	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,584,000	\$0	\$4,085,000	\$0
88	CHHS AGENCY HIPAA FUNDING	\$1,215,000	\$0	\$840,000	\$0
89	KIT FOR NEW PARENTS	\$1,119,000	\$0	\$1,119,000	\$0
90	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,017,000	\$0	\$1,017,000	\$0

OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2015-16		FISCAL YEAR 2016-17	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER DEPARTMENTS					
91	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	\$1,000,000	\$0	\$1,000,000	\$0
92	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0
93	CDPH I&E PROGRAM AND EVALUATION	\$994,000	\$0	\$946,000	\$0
94	VITAL RECORDS DATA	\$900,000	\$0	\$883,000	\$0
95	CDDS DENTAL SERVICES	\$308,000	\$308,000	\$120,000	\$120,000
96	MERIT SYSTEM SERVICES FOR COUNTIES	\$195,000	\$97,500	\$195,000	\$97,500
97	PIA EYEWEAR COURIER SERVICE	\$305,000	\$152,500	\$382,000	\$191,000
	OTHER DEPARTMENTS SUBTOTAL	\$881,620,000	\$43,701,800	\$913,011,000	\$34,511,600
	GRAND TOTAL	\$2,359,245,000	\$356,527,000	\$2,322,651,000	\$339,346,600

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
DHCS-OTHER								
1	3	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$295,361,000	\$0	\$176,139,000	\$0	-\$119,222,000	\$0
2	2	CCS CASE MANAGEMENT	\$183,247,000	\$64,425,750	\$184,969,000	\$62,930,980	\$1,722,000	-\$1,494,770
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$103,275,000	\$0	\$106,737,000	\$0	\$3,462,000	\$0
5	1	BTR - LIHP - ADMINISTRATIVE COSTS	\$50,685,000	\$0	\$198,382,000	\$0	\$147,697,000	\$0
6	7	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,250	\$33,718,000	\$11,871,250	\$0	\$0
8	6	OTLICP AND MEDI-CAL ACCESS PROGRAM	\$36,559,000	\$13,466,850	\$36,559,000	\$8,076,110	\$0	-\$5,390,740
9	8	ARRA HITECH INCENTIVE PROGRAM	\$13,517,000	\$1,154,000	\$32,709,000	\$2,747,000	\$19,192,000	\$1,593,000
10	5	POSTAGE & PRINTING	\$26,032,000	\$13,219,500	\$38,317,000	\$19,437,000	\$12,285,000	\$6,217,500
11	9	SMHS COUNTY UR & QA ADMIN	\$17,294,000	\$600,000	\$17,329,000	\$600,000	\$35,000	\$0
12	11	SMH MAA	\$16,183,000	\$0	\$15,763,000	\$0	-\$420,000	\$0
13	10	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$17,742,000	\$2,113,000	\$15,851,000	\$1,287,000	-\$1,891,000	-\$826,000
14	13	MIS/DSS CONTRACT	\$12,476,000	\$3,317,000	\$12,476,000	\$3,317,000	\$0	\$0
15	16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
16	--	DMC COUNTY UR & QA ADMIN	\$18,537,000	\$0	\$0	\$0	-\$18,537,000	\$0
17	26	CA-MMIS REPLACEMENT & OTHER STATE TRANSITIOI	\$3,820,000	\$563,500	\$3,157,000	\$378,000	-\$663,000	-\$185,500
18	15	CCI-ADMINISTRATIVE COSTS	\$10,705,000	\$5,226,500	\$9,695,000	\$4,721,500	-\$1,010,000	-\$505,000
19	20	MEDI-CAL RECOVERY CONTRACTS	\$5,869,000	\$1,467,250	\$5,685,000	\$1,421,250	-\$184,000	-\$46,000
20	25	MEDS MODERNIZATION	\$3,995,000	\$485,000	\$3,680,000	\$368,000	-\$315,000	-\$117,000
21	14	PASRR	\$9,072,000	\$2,268,000	\$10,223,000	\$2,555,750	\$1,151,000	\$287,750
22	21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$4,902,000	\$1,613,500	\$5,039,000	\$1,652,250	\$137,000	\$38,750
23	23	CA-MMIS REPLACEMENT OVERSIGHT	\$8,286,000	\$992,800	\$4,803,000	\$575,500	-\$3,483,000	-\$417,300
24	22	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,865,000	\$1,216,250	\$4,865,000	\$1,216,250	\$0	\$0
25	19	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$7,700,000	\$3,850,000	\$0	\$0
26	29	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
27	--	FAMILY PACT EVALUATION	\$2,861,000	\$1,430,500	\$0	\$0	-\$2,861,000	-\$1,430,500
28	28	BUSINESS RULES EXTRACTION	\$1,720,000	\$430,000	\$2,580,000	\$645,000	\$860,000	\$215,000
29	24	PREVENTION OF CHRONIC DISEASE GRANT PROJEC	\$1,375,000	\$0	\$4,539,000	\$0	\$3,164,000	\$0
30	30	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,207,000	\$1,103,500	\$2,188,000	\$1,094,000	-\$19,000	-\$9,500
31	35	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
32	33	ETL DATA SOLUTION	\$1,420,000	\$367,450	\$1,389,000	\$364,350	-\$31,000	-\$3,100

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-OTHER</u>								
33	42	RATE STUDIES FOR MAIC AND AAC VENDOR	\$1,000,000	\$500,000	\$305,000	\$152,500	-\$695,000	-\$347,500
34	38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
35	32	MITA	\$2,565,000	\$256,500	\$1,740,000	\$174,000	-\$825,000	-\$82,500
36	31	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$1,900,000	\$1,900,000	\$950,000	\$950,000
37	52	COORDINATED CARE MANAGEMENT PILOT	\$23,000	\$11,500	\$23,000	\$11,500	\$0	\$0
38	36	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$856,000	\$428,000	\$1,200,000	\$600,000	\$344,000	\$172,000
39	41	ACA EXPANSION ADMIN COSTS	\$847,000	\$423,500	\$330,000	\$165,000	-\$517,000	-\$258,500
40	39	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$555,000	\$277,500	\$553,000	\$276,500	-\$2,000	-\$1,000
42	40	CCT OUTREACH - ADMINISTRATIVE COSTS	\$360,000	\$0	\$330,000	\$0	-\$30,000	\$0
44	45	DENTAL PAPD PROJECT MANAGER	\$247,000	\$61,750	\$247,000	\$61,750	\$0	\$0
49	47	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	\$125,000	\$62,500	\$125,000	\$62,500	\$0	\$0
50	48	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500	\$0	\$0
52	49	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0	\$0	\$0
53	51	TAR POSTAGE	\$56,000	\$28,000	\$59,000	\$29,500	\$3,000	\$1,500
54	50	Q5i AUTOMATED DATA SYSTEM ACQUISITION	\$59,000	\$29,500	\$59,000	\$29,500	\$0	\$0
57	17	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$9,558,000	\$0	\$9,558,000	\$0	\$0	\$0
95	37	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,000,000	\$0	\$1,000,000	\$0	\$0	\$0
96	34	HEALTH HOMES PROGRAM - CONTRACTOR COSTS	\$1,380,000	\$690,000	\$1,225,000	\$612,500	-\$155,000	-\$77,500
--	12	PAVE SYSTEM	\$0	\$0	\$14,610,000	\$1,858,500	\$14,610,000	\$1,858,500
--	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$0	\$0	\$9,075,000	\$4,415,000	\$9,075,000	\$4,415,000
--	43	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$0	\$0	\$300,000	\$150,000	\$300,000	\$150,000
--	44	ANNUAL EDP AUDIT CONTRACTOR	\$0	\$0	\$257,000	\$128,500	\$257,000	\$128,500
--	46	RECOVERY AUDIT CONTRACTOR COSTS	\$0	\$0	\$236,000	\$118,000	\$236,000	\$118,000
DHCS-OTHER SUBTOTAL			\$927,473,000	\$142,084,850	\$992,093,000	\$147,037,940	\$64,620,000	\$4,953,090
<u>DHCS-MEDICAL FI</u>								
--	54	MEDICAL FI OPERATIONS	\$0	\$0	\$93,742,000	\$30,470,250	\$93,742,000	\$30,470,250
--	55	MEDICAL FI SYSTEM REPLACEMENT PROJECT	\$0	\$0	\$49,644,000	\$7,808,950	\$49,644,000	\$7,808,950
--	56	MEDICAL FI COST REIMBURSEMENT	\$0	\$0	\$39,547,000	\$11,420,800	\$39,547,000	\$11,420,800
--	57	MEDICAL FI HOURLY REIMBURSEMENT	\$0	\$0	\$23,077,000	\$5,018,350	\$23,077,000	\$5,018,350

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-MEDICAL FI</u>								
--	58	MEDICAL FI OTHER ESTIMATED COSTS	\$0	\$0	\$20,978,000	\$4,178,300	\$20,978,000	\$4,178,300
--	59	MEDICAL FI ENHANCEMENTS	\$0	\$0	\$5,302,000	\$635,200	\$5,302,000	\$635,200
--	60	MEDICAL FI MISCELLANEOUS EXPENSES	\$0	\$0	\$3,157,000	\$1,083,250	\$3,157,000	\$1,083,250
--	61	MEDICAL FI DIAGNOSIS RELATED GROUPS	\$0	\$0	\$70,000	\$35,000	\$70,000	\$35,000
DHCS-MEDICAL FI SUBTOTAL			\$0	\$0	\$235,517,000	\$60,650,100	\$235,517,000	\$60,650,100
<u>DHCS-HEALTH CARE OPT</u>								
58	63	HCO OPERATIONS	\$38,371,000	\$18,898,250	\$52,650,000	\$25,477,090	\$14,279,000	\$6,578,840
59	65	HCO CCI - CAL MEDICONECT AND MLTSS	\$16,135,000	\$8,067,500	\$18,357,000	\$9,178,500	\$2,222,000	\$1,111,000
60	64	HCO COST REIMBURSEMENT	\$40,681,000	\$20,035,250	\$41,490,000	\$20,076,400	\$809,000	\$41,150
62	67	HCO ESR HOURLY REIMBURSEMENT	\$13,716,000	\$6,755,100	\$13,716,000	\$6,636,650	\$0	-\$118,450
63	66	HCO - ENROLLMENT CONTRACTOR COSTS	\$10,275,000	\$5,060,400	\$17,633,000	\$8,532,550	\$7,358,000	\$3,472,150
64	68	HCO- SPD TRANSITION TO MANAGED CARE RURAL C	\$727,000	\$363,500	\$727,000	\$363,500	\$0	\$0
66	--	HCO PPDs - COST SAVINGS	-\$2,996,000	-\$1,475,500	\$0	\$0	\$2,996,000	\$1,475,500
DHCS-HEALTH CARE OPT SUBTOTAL			\$116,909,000	\$57,704,500	\$144,573,000	\$70,264,690	\$27,664,000	\$12,560,190
<u>DHCS-DENTAL FI</u>								
87	69	DENTAL FI OPERATIONS	\$83,761,000	\$27,295,500	\$82,288,000	\$26,734,000	-\$1,473,000	-\$561,500
88	70	DENTAL FI HOURLY REIMBURSEMENT	\$12,334,000	\$3,083,500	\$12,334,000	\$3,083,500	\$0	\$0
89	71	DENTAL FI COST REIMBURSEMENT	\$7,369,000	\$3,504,250	\$7,369,000	\$3,504,250	\$0	\$0
90	76	DENTAL FI CD-MMIS COSTS	\$75,000	\$18,750	\$77,000	\$19,250	\$2,000	\$500
91	75	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BON	\$195,000	\$97,500	\$195,000	\$97,500	\$0	\$0
92	74	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSES	\$320,000	\$80,000	\$320,000	\$80,000	\$0	\$0
93	72	DENTAL FI FEDERAL RULE - REVALIDATION	\$1,438,000	\$719,000	\$1,438,000	\$719,000	\$0	\$0
94	73	DENTAL FI FEDERAL RULE - DATABASE CHECKS	\$375,000	\$187,500	\$375,000	\$187,500	\$0	\$0
--	100	DENTAL FI -BENEFICIARY OUTREACH & ED PROGRAM	\$0	\$0	\$1,046,000	\$447,500	\$1,046,000	\$447,500
DHCS-DENTAL FI SUBTOTAL			\$105,867,000	\$34,986,000	\$105,442,000	\$34,872,500	-\$425,000	-\$113,500

OTHER DEPARTMENTS

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER DEPARTMENTS								
3	79	CALHEERS DEVELOPMENT	\$144,728,000	\$35,660,250	\$142,998,000	\$31,594,800	-\$1,730,000	-\$4,065,450
7	84	ACA OUTREACH AND ENROLLMENT COUNSELORS	\$35,536,000	\$17,768,000	\$15,978,000	\$7,989,000	-\$19,558,000	-\$9,779,000
41	94	VITAL RECORDS DATA	\$883,000	\$0	\$900,000	\$0	\$17,000	\$0
67	77	PERSONAL CARE SERVICES	\$265,178,000	\$0	\$298,575,000	\$0	\$33,397,000	\$0
68	78	HEALTH-RELATED ACTIVITIES - CDSS	\$260,425,000	\$0	\$260,425,000	\$0	\$0	\$0
69	80	CDDS ADMINISTRATIVE COSTS	\$40,652,000	\$0	\$50,873,000	\$0	\$10,221,000	\$0
70	82	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$26,467,000	\$0	\$28,803,000	\$0	\$2,336,000	\$0
71	81	MATERNAL AND CHILD HEALTH	\$34,824,000	\$0	\$29,965,000	\$0	-\$4,859,000	\$0
72	83	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE C	\$25,143,000	\$0	\$25,143,000	\$0	\$0	\$0
73	85	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	\$11,843,000	\$3,358,000	\$11,671,000	\$3,560,000	-\$172,000	\$202,000
74	86	CLPP CASE MANAGEMENT SERVICES	\$5,200,000	\$0	\$5,596,000	\$0	\$396,000	\$0
75	87	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,538,000	\$0	\$3,584,000	\$0	\$46,000	\$0
76	88	CHHS AGENCY HIPAA FUNDING	\$1,215,000	\$0	\$1,215,000	\$0	\$0	\$0
77	91	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	\$1,000,000	\$0	\$1,000,000	\$0	\$0	\$0
78	92	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0	\$0	\$0
79	93	CDPH I&E PROGRAM AND EVALUATION	\$946,000	\$0	\$994,000	\$0	\$48,000	\$0
80	89	KIT FOR NEW PARENTS	\$1,119,000	\$0	\$1,119,000	\$0	\$0	\$0
81	90	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,017,000	\$0	\$1,017,000	\$0	\$0	\$0
82	96	MERIT SYSTEM SERVICES FOR COUNTIES	\$195,000	\$97,500	\$195,000	\$97,500	\$0	\$0
83	95	CDDS DENTAL SERVICES	\$40,000	\$40,000	\$308,000	\$308,000	\$268,000	\$268,000
84	97	PIA EYEWEAR COURIER SERVICE	\$382,000	\$191,000	\$305,000	\$152,500	-\$77,000	-\$38,500
OTHER DEPARTMENTS SUBTOTAL			\$861,287,000	\$57,114,750	\$881,620,000	\$43,701,800	\$20,333,000	-\$13,412,950
OTHER ADMINISTRATION SUBTOTAL			\$2,011,536,000	\$291,890,100	\$2,359,245,000	\$356,527,030	\$347,709,000	\$64,636,930
GRAND TOTAL COUNTY AND OTHER ADMIN.			\$4,107,726,000	\$924,303,750	\$4,459,418,000	\$983,487,680	\$351,692,000	\$59,183,930

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
DHCS-OTHER							
1	BTR - LIHP - ADMINISTRATIVE COSTS	\$198,382,000	\$0	\$7,650,000	\$0	-\$190,732,000	\$0
2	CCS CASE MANAGEMENT	\$184,969,000	\$62,930,980	\$190,064,000	\$64,538,710	\$5,095,000	\$1,607,730
3	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$176,139,000	\$0	\$321,586,000	\$0	\$145,447,000	\$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$106,737,000	\$0	\$109,291,000	\$0	\$2,554,000	\$0
5	POSTAGE & PRINTING	\$38,317,000	\$19,437,000	\$26,032,000	\$13,219,500	-\$12,285,000	-\$6,217,500
6	OTLICP AND MEDI-CAL ACCESS PROGRAM	\$36,559,000	\$8,076,110	\$36,559,000	\$6,279,120	\$0	-\$1,796,990
7	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,250	\$33,718,000	\$11,871,250	\$0	\$0
8	ARRA HITECH INCENTIVE PROGRAM	\$32,709,000	\$2,747,000	\$12,556,000	\$732,000	-\$20,153,000	-\$2,015,000
9	SMHS COUNTY UR & QA ADMIN	\$17,329,000	\$600,000	\$17,120,000	\$215,000	-\$209,000	-\$385,000
10	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$15,851,000	\$1,287,000	\$18,574,000	\$1,864,000	\$2,723,000	\$577,000
11	SMH MAA	\$15,763,000	\$0	\$16,521,000	\$0	\$758,000	\$0
12	PAVE SYSTEM	\$14,610,000	\$1,858,500	\$14,021,000	\$2,197,100	-\$589,000	\$338,600
13	MIS/DSS CONTRACT	\$12,476,000	\$3,317,000	\$12,476,000	\$3,317,000	\$0	\$0
14	PASRR	\$10,223,000	\$2,555,750	\$9,936,000	\$2,484,000	-\$287,000	-\$71,750
15	CCI-ADMINISTRATIVE COSTS	\$9,695,000	\$4,721,500	\$7,148,000	\$3,574,000	-\$2,547,000	-\$1,147,500
16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
17	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$9,558,000	\$0	\$0	\$0	-\$9,558,000	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$9,075,000	\$4,415,000	\$16,872,000	\$8,207,500	\$7,797,000	\$3,792,500
19	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$7,700,000	\$3,850,000	\$0	\$0
20	MEDI-CAL RECOVERY CONTRACTS	\$5,685,000	\$1,421,250	\$5,685,000	\$1,421,250	\$0	\$0
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,039,000	\$1,652,250	\$5,291,000	\$1,734,750	\$252,000	\$82,500
22	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,865,000	\$1,216,250	\$4,487,000	\$1,121,750	-\$378,000	-\$94,500
23	CA-MMIS REPLACEMENT OVERSIGHT	\$4,803,000	\$575,500	\$7,074,000	\$847,100	\$2,271,000	\$271,600
24	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	\$4,539,000	\$0	\$80,000	\$0	-\$4,459,000	\$0
25	MEDS MODERNIZATION	\$3,680,000	\$368,000	\$2,915,000	\$291,500	-\$765,000	-\$76,500
26	CA-MMIS REPLACEMENT & OTHER STATE TRANSITION	\$3,157,000	\$378,000	\$2,277,000	\$273,100	-\$880,000	-\$104,900
28	BUSINESS RULES EXTRACTION	\$2,580,000	\$645,000	\$0	\$0	-\$2,580,000	-\$645,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
DHCS-OTHER							
29	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
30	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,188,000	\$1,094,000	\$2,188,000	\$1,094,000	\$0	\$0
31	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$1,900,000	\$1,900,000	\$950,000	\$950,000	-\$950,000	-\$950,000
32	MITA	\$1,740,000	\$174,000	\$2,582,000	\$258,200	\$842,000	\$84,200
33	ETL DATA SOLUTION	\$1,389,000	\$364,350	\$398,000	\$39,800	-\$991,000	-\$324,550
34	HEALTH HOMES PROGRAM - CONTRACTOR COSTS	\$1,225,000	\$612,500	\$0	\$0	-\$1,225,000	-\$612,500
35	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
36	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$1,200,000	\$600,000	\$1,200,000	\$600,000	\$0	\$0
37	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,000,000	\$0	\$1,000,000	\$0	\$0	\$0
38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
39	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$553,000	\$276,500	\$596,000	\$298,000	\$43,000	\$21,500
40	CCT OUTREACH - ADMINISTRATIVE COSTS	\$330,000	\$0	\$630,000	\$0	\$300,000	\$0
41	ACA EXPANSION ADMIN COSTS	\$330,000	\$165,000	\$0	\$0	-\$330,000	-\$165,000
42	RATE STUDIES FOR MAIC AND AAC VENDOR	\$305,000	\$152,500	\$305,000	\$152,500	\$0	\$0
43	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$300,000	\$150,000	\$0	\$0	-\$300,000	-\$150,000
44	ANNUAL EDP AUDIT CONTRACTOR	\$257,000	\$128,500	\$0	\$0	-\$257,000	-\$128,500
45	DENTAL PAPD PROJECT MANAGER	\$247,000	\$61,750	\$226,000	\$56,500	-\$21,000	-\$5,250
46	RECOVERY AUDIT CONTRACTOR COSTS	\$236,000	\$118,000	\$193,000	\$96,500	-\$43,000	-\$21,500
47	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	\$125,000	\$62,500	\$125,000	\$62,500	\$0	\$0
48	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500	\$0	\$0
49	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0	\$0	\$0
50	Q5i AUTOMATED DATA SYSTEM ACQUISTION	\$59,000	\$29,500	\$59,000	\$29,500	\$0	\$0
51	TAR POSTAGE	\$59,000	\$29,500	\$59,000	\$29,500	\$0	\$0
52	COORDINATED CARE MANAGEMENT PILOT	\$23,000	\$11,500	\$0	\$0	-\$23,000	-\$11,500
53	DMC COUNTY UR & QA ADMIN	\$0	\$0	\$18,537,000	\$0	\$18,537,000	\$0
99	PERFORMANCE OUTCOMES SYSTEM	\$0	\$0	\$23,748,000	\$11,874,000	\$23,748,000	\$11,874,000
DHCS-OTHER SUBTOTAL		\$992,093,000	\$147,037,940	\$952,898,000	\$150,764,130	-\$39,195,000	\$3,726,190

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-OTHER</u>							
<u>DHCS-MEDICAL FI</u>							
54	MEDICAL FI OPERATIONS	\$93,742,000	\$30,470,250	\$90,473,000	\$29,306,000	-\$3,269,000	-\$1,164,250
55	MEDICAL FI SYSTEM REPLACEMENT PROJECT	\$49,644,000	\$7,808,950	\$67,423,000	\$10,605,500	\$17,779,000	\$2,796,550
56	MEDICAL FI COST REIMBURSEMENT	\$39,547,000	\$11,420,800	\$30,307,000	\$9,423,550	-\$9,240,000	-\$1,997,250
57	MEDICAL FI HOURLY REIMBURSEMENT	\$23,077,000	\$5,018,350	\$23,072,000	\$5,517,800	-\$5,000	\$499,450
58	MEDICAL FI OTHER ESTIMATED COSTS	\$20,978,000	\$4,178,300	\$10,532,000	\$3,083,000	-\$10,446,000	-\$1,095,300
59	MEDICAL FI ENHANCEMENTS	\$5,302,000	\$635,200	\$0	\$0	-\$5,302,000	-\$635,200
60	MEDICAL FI MISCELLANEOUS EXPENSES	\$3,157,000	\$1,083,250	\$2,120,000	\$691,000	-\$1,037,000	-\$392,250
61	MEDICAL FI DIAGNOSIS RELATED GROUPS	\$70,000	\$35,000	\$26,000	\$13,000	-\$44,000	-\$22,000
62	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	\$0	\$0	\$804,000	\$80,400	\$804,000	\$80,400
	DHCS-MEDICAL FI SUBTOTAL	\$235,517,000	\$60,650,100	\$224,757,000	\$58,720,250	-\$10,760,000	-\$1,929,850
<u>DHCS-HEALTH CARE OPT</u>							
63	HCO OPERATIONS	\$52,650,000	\$25,477,090	\$39,189,000	\$18,851,600	-\$13,461,000	-\$6,625,490
64	HCO COST REIMBURSEMENT	\$41,490,000	\$20,076,400	\$46,094,000	\$22,170,720	\$4,604,000	\$2,094,320
65	HCO CCI - CAL MEDICCONNECT AND MLTSS	\$18,357,000	\$9,178,500	\$11,665,000	\$5,832,500	-\$6,692,000	-\$3,346,000
66	HCO - ENROLLMENT CONTRACTOR COSTS	\$17,633,000	\$8,532,550	\$10,262,000	\$4,936,440	-\$7,371,000	-\$3,596,110
67	HCO ESR HOURLY REIMBURSEMENT	\$13,716,000	\$6,636,650	\$14,013,000	\$6,740,120	\$297,000	\$103,470
68	HCO- SPD TRANSITION TO MANAGED CARE RURAL CC	\$727,000	\$363,500	\$0	\$0	-\$727,000	-\$363,500
	DHCS-HEALTH CARE OPT SUBTOTAL	\$144,573,000	\$70,264,690	\$121,223,000	\$58,531,380	-\$23,350,000	-\$11,733,310
<u>DHCS-DENTAL FI</u>							
69	DENTAL FI OPERATIONS	\$82,288,000	\$26,734,000	\$85,134,000	\$27,689,250	\$2,846,000	\$955,250
70	DENTAL FI HOURLY REIMBURSEMENT	\$12,334,000	\$3,083,500	\$12,769,000	\$3,192,250	\$435,000	\$108,750
71	DENTAL FI COST REIMBURSEMENT	\$7,369,000	\$3,504,250	\$7,444,000	\$3,541,750	\$75,000	\$37,500
72	DENTAL FI FEDERAL RULE - REVALIDATION	\$1,438,000	\$719,000	\$1,438,000	\$719,000	\$0	\$0
73	DENTAL FI FEDERAL RULE - DATABASE CHECKS	\$375,000	\$187,500	\$375,000	\$187,500	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<u>DHCS-DENTAL FI</u>							
74	DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSES	\$320,000	\$80,000	\$320,000	\$80,000	\$0	\$0
75	DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONI	\$195,000	\$97,500	\$195,000	\$97,500	\$0	\$0
76	DENTAL FI CD-MMIS COSTS	\$77,000	\$19,250	\$20,000	\$5,000	-\$57,000	-\$14,250
100	DENTAL FI -BENEFICIARY OUTREACH & ED PROGRAM-	\$1,046,000	\$447,500	\$3,067,000	\$1,307,000	\$2,021,000	\$859,500
	DHCS-DENTAL FI SUBTOTAL	\$105,442,000	\$34,872,500	\$110,762,000	\$36,819,250	\$5,320,000	\$1,946,750
<u>OTHER DEPARTMENTS</u>							
77	PERSONAL CARE SERVICES	\$298,575,000	\$0	\$297,785,000	\$0	-\$790,000	\$0
78	HEALTH-RELATED ACTIVITIES - CDSS	\$260,425,000	\$0	\$319,875,000	\$0	\$59,450,000	\$0
79	CALHEERS DEVELOPMENT	\$142,998,000	\$31,594,800	\$129,171,000	\$25,568,050	-\$13,827,000	-\$6,026,750
80	CDDS ADMINISTRATIVE COSTS	\$50,873,000	\$0	\$44,254,000	\$0	-\$6,619,000	\$0
81	MATERNAL AND CHILD HEALTH	\$29,965,000	\$0	\$29,893,000	\$0	-\$72,000	\$0
82	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,803,000	\$0	\$29,998,000	\$0	\$1,195,000	\$0
83	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CH	\$25,143,000	\$0	\$24,879,000	\$0	-\$264,000	\$0
84	ACA OUTREACH AND ENROLLMENT COUNSELORS	\$15,978,000	\$7,989,000	\$9,950,000	\$4,975,000	-\$6,028,000	-\$3,014,000
85	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	\$11,671,000	\$3,560,000	\$11,463,000	\$3,560,000	-\$208,000	\$0
86	CLPP CASE MANAGEMENT SERVICES	\$5,596,000	\$0	\$4,200,000	\$0	-\$1,396,000	\$0
87	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,584,000	\$0	\$4,085,000	\$0	\$501,000	\$0
88	CHHS AGENCY HIPAA FUNDING	\$1,215,000	\$0	\$840,000	\$0	-\$375,000	\$0
89	KIT FOR NEW PARENTS	\$1,119,000	\$0	\$1,119,000	\$0	\$0	\$0
90	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,017,000	\$0	\$1,017,000	\$0	\$0	\$0
91	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	\$1,000,000	\$0	\$1,000,000	\$0	\$0	\$0
92	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0	\$0	\$0
93	CDPH I&E PROGRAM AND EVALUATION	\$994,000	\$0	\$946,000	\$0	-\$48,000	\$0
94	VITAL RECORDS DATA	\$900,000	\$0	\$883,000	\$0	-\$17,000	\$0
95	CDDS DENTAL SERVICES	\$308,000	\$308,000	\$120,000	\$120,000	-\$188,000	-\$188,000
96	MERIT SYSTEM SERVICES FOR COUNTIES	\$195,000	\$97,500	\$195,000	\$97,500	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NOV. PC#	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER DEPARTMENTS						
97	PIA EYEWEAR COURIER SERVICE	\$305,000	\$152,500	\$382,000	\$191,000	\$77,000	\$38,500
	OTHER DEPARTMENTS SUBTOTAL	\$881,620,000	\$43,701,800	\$913,011,000	\$34,511,550	\$31,391,000	-\$9,190,250
	OTHER ADMINISTRATION SUBTOTAL	\$2,359,245,000	\$356,527,030	\$2,322,651,000	\$339,346,560	-\$36,594,000	-\$17,180,470
	GRAND TOTAL COUNTY AND OTHER ADMIN.	\$4,459,418,000	\$983,487,680	\$4,557,154,000	\$1,014,922,510	\$97,736,000	\$31,434,830

**MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<u>DHCS-OTHER</u>	
1	BTR - LIHP - ADMINISTRATIVE COSTS
2	CCS CASE MANAGEMENT
3	MEDI-CAL ADMINISTRATIVE ACTIVITIES
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN
5	POSTAGE & PRINTING
6	OTLICP AND MEDI-CAL ACCESS PROGRAM
7	EPSDT CASE MANAGEMENT
8	ARRA HITECH INCENTIVE PROGRAM
9	SMHS COUNTY UR & QA ADMIN
10	DRUG MEDI-CAL COUNTY ADMINISTRATION
11	SMH MAA
12	PAVE SYSTEM
13	MIS/DSS CONTRACT
14	PASRR
15	CCI-ADMINISTRATIVE COSTS
16	LITIGATION RELATED SERVICES
17	INTERIM AND FINAL COST SETTLEMENTS-SMHS
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT
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POLICY CHANGE INDEX**

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BTR - LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1589

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$198,382,000	\$7,650,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$198,382,000	\$7,650,000

DESCRIPTION**Purpose:**

This policy change estimates federal funds for the administrative costs associated with the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:

AB 342 (Chapter 723, Statutes of 2010)
 AB 1066 (Chapter 86, Statutes of 2011)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

Not Applicable

Background:

The LIHP, effective November 1, 2010 through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the Section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

BTR - LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Reason for Change from Prior Estimate:

The change is due to:

- Updated administrative claiming data,
- A higher than previously expected DY 2011-12 payment,
- Inclusion of DY 2012-13 in FY 2015-16,
- Updated DY 2013-14 and delaying the payment to FY 2015-16, and
- Delayed DY 2010-11 to FY 2016-17.

Methodology:

1. Administrative payments will be based on the CMS approved administrative cost claiming protocol and time study.
2. Administrative claiming is comprised of three payment categories. The Department prioritizes these payments in the following order:
 1. Start-up costs
 2. Regular program costs
 3. Close-out costs
3. Invoices for DY 2011-12, DY 2012-13, and DY 2013-14 for administrative payments will be processed in FY 2015-16.
4. Estimates for start-up costs are based on historical data and invoices for DY 2010-11 will be processed in FY 2016-17.
5. Estimated administrative costs are expected to be as follows:

(Dollars in Thousands)

FY 2015-16	TF	LIHP-MCE FF
DY 2011-12	\$76,554	\$76,554
DY 2012-13	\$89,524	\$89,524
DY 2013-14	\$32,304	\$32,304
Total FY 2015-16	\$198,382	\$198,382

(Dollars in Thousands)

FY 2016-17	TF	LIHP-MCE FF
DY 2010-11 (Start-up costs)	\$7,650	\$7,650
Total FY 2016-17	\$7,650	\$7,650

Funding:

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

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 230

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$184,969,000	\$190,064,000
STATE FUNDS	\$62,930,980	\$64,538,710
FEDERAL FUNDS	\$122,038,020	\$125,525,290

DESCRIPTION

Purpose:

This policy change estimates the California Children's Services (CCS) case management cost.

Authority:

Health & Safety Code, sections 123800-123995

Interdependent Policy Changes:

PC 50 Pediatric Palliative Care Expansion and Savings

Background:

CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating the medical need for specific services, and determining appropriate providers. The state shares case management activities administered by CCS state regional office employees in Sacramento, San Francisco, and Los Angeles for counties with populations less than 200,000 (dependent counties). The Children's Medical Services Net (CMS Net) automated system is utilized by the CCS Medi-Cal program to assure case management activities.

CCS Case Management for Pediatric Palliative Care (PPC) involves enrolling new CCS clients into the Palliative Care program including indirect services, administrative support, overhead, and program training.

Effective January 1, 2013, the Healthy Family Program (HFP) ceased to enroll new subscribers and began transitioning HFP subscribers into the Medi-Cal Optional Targeted Low Income Children Program (OTLICP). The transition of HFP subscribers to OTLICP completed in November 2013.

A portion of CCS case management transitioned into the Health Plan of San Mateo (HPSM) beginning April 2013.

Reason for Change from Prior Year:

CMS Net amounts and funding allocations have been updated.

Methodology:

1. The county administrative estimate for the budget year is updated every May based on additional data collected.
2. For FY 2015-16, the CCS case management costs are based on budgeted county expenditures of \$151,969,000 in the May 2015 Estimate.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

For FY 2016-17, caseload is expected to increase 1.85% from FY 2015-16 to FY 2016-17.

$$\$151,969,000 \times (1 + 1.85\%) = \$154,780,000$$

3. Assume administrative costs of \$176,000 in FY 2015-16 and \$1,057,000 in FY 2016-17 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.
4. For FY 2015-16, PPC Nurse Liaison costs are estimated as follows:
 - Each county has one medical professional (nurse) and one support staff (clerk) for every 25 palliative care participants.
 - The annual cost is \$200,000 per one nurse and one clerk pair.
 - Of the nine original counties, eight have 25 or less palliative care participants and one county has between 75 and 100 palliative care participants.
 - PPC caseload is expanding to seven additional counties, with a staggered rollout, through FY 2015-16. Each county will have 17-18 members enrolled.

$$\begin{aligned} & \$200,000 \times 8 \text{ (counties)} = \$1,600,000 \\ & \$200,000 \times 1 \text{ (county)} \times 4 \text{ (pairs of nurse/clerk)} = \$800,000 \\ & \$1,600,000 + \$800,000 = \$2,400,000 \text{ PPC Nurse Liaison costs for original counties.} \\ & \$2,400,000 + \$517,000 \text{ (expansion Nurse Liaison costs)} = \$2,917,000 \end{aligned}$$

5. For FY 2016-17, PPC Nurse Liaison costs are estimated as follows:
 - Each county will have one medical professional (nurse) and one support staff (clerk) for every 25 palliative care participants.
 - The annual cost is \$200,000 per one nurse and one clerk pair.
 - 16 counties will be active the full FY.
 - Of the 16 counties, one county has between 75 and 100 palliative care participants.

$$\begin{aligned} & \$200,000 \times 15 \text{ (counties)} = \$3,000,000 \\ & \$200,000 \times 1 \text{ (county)} \times 4 \text{ (pairs of nurse/clerk)} = \$800,000 \\ & \$3,000,000 + \$800,000 = \$3,800,000 \end{aligned}$$

6. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be \$1,794,000 in FY 2015-16 and \$1,788,000 in FY 2016-17.
7. Medi-Cal OTLIPC costs are separate from other Medi-Cal costs. The following Medi-Cal OTLIPC costs include the county share of cost:

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
County Administration:	\$31,656,000	\$31,656,000

8. County data processing costs associated with CMS Net for OTLIPC are estimated to be \$265,000 in FY 2015-16 and \$258,000 in FY 2016-17.
9. HPSM begins operation in April 2013 and receives monthly payments beginning May 2013. Payments to HPSM will be applied against CCS Case Management. All June payments will be made in July. Both CY and BY payments include a net 12 months of cost.

FY 2015-16:	(\$2,160,000) TF
FY 2016-17:	(\$2,160,000) TF

CCS CASE MANAGEMENT**OTHER ADMIN. POLICY CHANGE NUMBER: 2**

10. AB 1745 requires the Department to conduct a waiver pilot project to determine whether PPC should be provided as a benefit under the Medi-Cal program. These expenditures have been rolled into the CCS case management costs.
11. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2015-16 and FY 2016-17.

FY 2015-16				
CCS Medi-Cal	TF	GF	FF	CF*
CCS Case Management	\$151,969,000	\$57,243,000	\$94,726,000	
Medi-Cal Expansion	\$176,000	\$176,000		
Pediatric Palliative Care	\$2,917,000	\$729,000	\$2,188,000	
CMS Net	\$1,794,000	\$897,000	\$897,000	
Subtotal	\$156,856,000	\$59,045,000	\$97,811,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	\$30,008,000	\$4,919,000	\$25,089,000	\$1,649,000
CMS Net	\$265,000	\$47,000	\$218,000	
Subtotal	\$30,273,000	\$4,966,000	\$25,307,000	\$1,649,000
Health Plan of San Mateo	(\$2,160,000)	(\$1,080,000)	(\$1,080,000)	
Total	\$184,969,000	\$62,931,000	\$122,038,000	\$1,649,000

FY 2016-17				
CCS Medi-Cal	TF	GF	FF	CF*
CCS Case Management	\$154,780,000	\$58,302,000	\$96,478,000	
Medi-Cal Expansion	\$1,057,000	\$1,057,000		
Pediatric Palliative Care	\$3,800,000	\$950,000	\$2,850,000	
CMS Net	\$1,788,000	\$894,000	\$894,000	
Subtotal	\$161,425,000	\$61,203,000	\$100,222,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	\$30,541,000	\$4,385,000	\$26,157,000	\$1,115,000
CMS Net	\$258,000	\$31,000	\$227,000	
Subtotal	\$30,799,000	\$4,416,000	\$26,384,000	\$1,115,000
Health Plan of San Mateo	(\$2,160,000)	(\$1,080,000)	(\$1,080,000)	
Total	\$190,064,000	\$64,539,000	\$125,525,000	\$1,115,000

* County Funds are not included in the Total Fund

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

Funding:

FY 2015-16	TF	GF	FF	CF*
50% GF / 50% Title XIX (4260-101-0001/0890)	\$76,637,000	\$38,318,000	\$38,318,000	
25% GF/ 75% Title XIX (4260-101-0001/0890)	\$90,964,000	\$22,741,000	\$68,223,000	
35% GF / 65% Title XXI (4260-113-0001/0890)	\$66,000	\$23,000	\$43,000	
17.5% GF / 17.5% CF / 65% Title XXI (4260-113-0001/0890)	\$3,831,000	\$813,000	\$3,019,000	\$813,000
12% GF / 88% Title XXI (4260-113-0001/0890)	\$199,000	\$24,000	\$175,000	
6% GF / 6% CF / 88% Title XXI (4260-113-0001/0890)	\$13,096,000	\$836,000	\$12,260,000	\$836,000
100% GF (4260-101-0001)	\$176,000	\$176,000		
Total	\$184,969,000	\$62,931,000	\$122,038,000	\$1,649,000

FY 2016-17	TF	GF	FF	CF*
50% GF / 50% Title XIX (4260-101-0001/0890)	\$78,055,000	\$39,027,000	\$39,028,000	
25% GF/ 75% Title XIX (4260-101-0001/0890)	\$93,233,000	\$23,308,000	\$69,925,000	
12% GF / 88% Title XXI (4260-113-0001/0890)	\$258,000	\$31,000	\$227,000	
6% GF / 6% CF / 88% Title XXI (4260-113-0001/0890)	\$17,461,000	\$1,115,000	\$16,346,000	\$1,115,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000		
Total	\$190,064,000	\$64,538,000	\$125,526,000	\$1,115,000

* County Funds are not included in the Total Fund

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 235

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$176,139,000	\$321,586,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$176,139,000	\$321,586,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs), local education agencies (LEAs), and Native American Indian tribes for Medicaid administrative activities.

Authority:

AB 2377 (Chapter 147, Statutes of 1994)
 AB 2780 (Chapter 310, Statutes of 1998)
 SB 308 (Chapter 253, Statutes of 2003)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

AB 2780 allowed LEAs (including school districts and county offices of education), the option of claiming MAA through either their local educational consortium (one of the State's eleven administrative districts) or through the LGAs. In June 2012, CMS deferred the school based MAA (SMAA) program retroactively to October 2011. During the deferral period, schools continued to submit invoices which will be processed as an "Early Claim" in order to meet the two-year retrospective federal claiming limitation. In October 2014, the Department and CMS came to a settlement agreement to pay deferred invoices on a tiered basis and backcast the remaining balance once the Random Moment Time Study (RMTS) process had been in place for four quarters. The RMTS was implemented effective January 2015.

SB 308 redefined LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows tribes to participate in MAA and Targeted Case Management programs. Reimbursements for non-emergency and non-medical transportation expenditures are also available for Tribal entities.

In June 2011, CMS approved the Department's request to allow LGAs participating in the County Medi-Cal Administrative Activities (CMAA) program to submit interim claims for MAA reimbursements utilizing FY 2009-10 time survey data for FY 2010-11, FY 2011-12, and FY 2012-13 claims. CMS also stipulated that CMAA program interim claims would require reconciliation. On May 3, 2013, CMS

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3

approved the CMAA Implementation Plan which included a new, statistically valid time survey methodology and a revised operational plan. The CMAA program will use FY 2013-14 time survey data to backcast invoices for FY 2010-11, FY 2011-12, and FY 2012-13.

Reason for Change from Prior Estimate:

The change is due to:

- Decreased CMAA backcasting estimates,
- Decreased CMAA and Tribal MAA baseline estimates adjusted based on actual prior year payments,
- An additional three quarters of FY 2012-13 SMAA claims in FY 2015-16, and
- Reduced SMAA claim amounts per settlement for FY 2013-14 and FY 2014-15.

Methodology:

County Medi-Cal Administrative Activities

1. For the FY 2015-16 CMAA estimate, FY 2012-13 invoice totals of \$63,282,000 was used as the baseline estimate. FY 2012-13 was the last year of fully paid invoices, which occurred in FY 2014-15. A 5% growth factor was added to this baseline to account for inflation.

$$\$63,282,000 \times (1+5\% \text{ increase}) = \$66,446,000$$

FY 2015-16 includes CMAA backcasting invoices for the following years:

CMAA Backcasting	FY 2015-16
FY 2010-11	\$1,424,000
FY 2011-12	\$1,425,000
FY 2012-13	\$1,425,000
Total	\$4,274,000

In addition, FY 2015-16 includes payments for prior year claims:

CMAA Prior Year Claims	FY 2015-16
FY 2011-12	\$54,000
FY 2012-13	\$458,000
Total	\$512,000

Total CMAA FY 2015-16: \$66,446,000 + \$4,274,000 + \$512,000 = **\$71,232,000**

2. The CMAA FY 2016-17 estimate is based on the FY 2015-16 baseline of \$66,446,000, plus an additional 5% growth factor.

Total CMAA FY 2016-17: \$66,446,000 x (1+5% increase) = **\$69,768,000**

Tribal Medi-Cal Administrative Activities (TMAA)

3. The TMAA FY 2015-16 estimate is based on FY 2014-15 paid invoices in the amount of \$887,000 with a 5% growth factor.

Total TMAA FY 2015-16: \$887,000 x (1+5% increase) = **\$931,000**

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3

4. The FY 2016-17 estimate uses the base from FY 2015-16 with a 5% growth factor.

Total TMAA FY 2016-17: \$931,000 x (1+5% increase) = **\$978,000**

FY 2015-16	\$931,000
FY 2016-17	\$978,000

School Medi-Cal Administrative Activities

5. The FY 2015-16 SMAA estimate includes the remaining settlement amount for FY 2012-13 and FY 2013-14 invoices that remain to be paid, plus an estimate for FY 2014-15 Q1 and Q2 invoice claims.

SMAA (Based on CMS settlement)	FY 2015-16
FY 2012-13 (Q1-Q4) Remaining settlement amount	\$40,379,000
FY 2013-14 (Q1-Q4) Remaining invoice claims	\$42,398,000
FY 2014-15 (Q1-Q2) Estimated claims	\$21,199,000
SMAA Total	\$103,976,000

6. For FY 2016-17, SMAA includes an estimate of FY 2014-15 Q3 and Q4 invoice claims, an estimate of FY 2015-16 Q1 and Q2 invoice claims, and backcasting estimates for FY 2009-10 and FY 2010-11.

SMAA (Based on CMS settlement)	FY 2016-17
FY 2014-15 (Q3-Q4) Estimated claims	\$85,310,000
FY 2015-16 (Q1-Q2) Estimated claims	\$89,576,000
FY 2009-10 Backcasting	\$9,859,000
FY 2010-11 Backcasting	\$66,095,000
SMAA Total	\$250,840,000

7. Total MAA reimbursements for FY 2015-16 and FY 2016-17 on a cash basis are:

FY 2015-16	TF	FF
County MAA	\$71,232,000	\$71,232,000
Tribal MAA	\$931,000	\$931,000
School MAA	\$103,976,000	\$103,976,000
Total	\$176,139,000	\$176,139,000

FY 2016-17	TF	FF
County MAA	\$69,768,000	\$69,768,000
Tribal MAA	\$978,000	\$978,000
School MAA	\$250,840,000	\$250,840,000
Total	\$321,586,000	\$321,586,000

Funding:

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

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1721

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$106,737,000	\$109,291,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$106,737,000	\$109,291,000

DESCRIPTION

Purpose:

This policy change estimates the county administrative costs for the Specialty Mental Health Medi-Cal Program and Healthy Families Program administered by county mental health departments.

Authority:

Welfare & Institutions Code 14711(c)

Interdependent Policy Changes:

Not Applicable

Background:

Counties may obtain federal reimbursement for certain costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

Reason for Change from Prior Estimate:

The Specialty Mental Health Services (SMHS) costs have increased slightly based on additional claims payment data up to June 2015.

Methodology:

- Mental Health administration costs are based on historical claims payment data. Below are the costs on an accrual basis for Medi-Cal (MC), Healthy Families Program (HFP), and Children's Health Insurance Program (CHIP). Due to the transition of HFP to Medi-Cal, the HFP costs will entirely shift to CHIP in FY 2014-15.

(Dollars In Thousands)

Fiscal Year	MC	HFP	CHIP	Total
FY 2013-14	\$201,317	\$1,027	\$3,007	\$205,351
FY 2014-15	\$206,104	\$0	\$4,130	\$210,234
FY 2015-16	\$210,609	\$0	\$4,221	\$214,830
FY 2016-17	\$214,852	\$0	\$4,306	\$219,157

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

2. Based on historical claims received, assume 23% of each fiscal year claims will be paid in the year the services occur, 67% is paid in the following year, and 10% in the third year.

(Dollars In Thousands)

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
MC	\$201,317	\$20,132	\$0
HFP	\$1,027	\$0	\$0
CHIP	\$3,007	\$403	\$0
FY 2013-14	\$205,351	\$20,535	\$0
MC	\$206,104	\$138,090	\$20,610
CHIP	\$4,130	\$2,767	\$413
FY 2014-15	\$210,234	\$140,857	\$21,023
MC	\$210,609	\$48,440	\$141,108
CHIP	\$4,221	\$971	\$2,828
FY 2015-16	\$214,830	\$49,411	\$143,936
MC	\$214,852	\$0	\$49,416
CHIP	\$4,306	\$0	\$990
FY 2016-17	\$219,157	\$0	\$50,406

3. Mental Health administration costs are shared between federal funds (FF) and county funds. MC claims are eligible for 50% federal reimbursement. CHIP claims are eligible for federal reimbursement of 65%. Beginning October 1, 2015, enhanced CHIP funding increases to 88%.

(Dollars In Thousands)

Claim Type	FY 2015-16			FY 2016-17		
	TF	FF	County	TF	FF	County
MC	\$206,662	\$103,331	\$103,331	\$211,134	\$105,567	\$105,567
CHIP*	\$4,141	\$3,406	\$735	\$4,232	\$3,724	\$508
Total	\$210,803	\$106,737	\$104,066	\$215,366	\$109,291	\$106,075

Funding:

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

100% Title XXI FFP (4260-113-0890)*

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 7/1993
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 231

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$38,317,000	\$26,032,000
STATE FUNDS	\$19,437,000	\$13,219,500
FEDERAL FUNDS	\$18,880,000	\$12,812,500

DESCRIPTION

Purpose:

This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

Authority:

Welfare & Institutions Code 14124.5 and 10725
 Title 42, Code of Federal Regulations (CFR), Section 435.905
 Title 45, Code of Federal Regulations (CFR), Section 164.520

Interdependent Policy Changes:

Not Applicable

Background:

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item since these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees and to existing beneficiaries at least every 3 years. Postage and printing costs for the HIPAA NPP, Quarterly JvR ("Your Fair Hearing Rights"), Incarceration Verification Program (IVP), Earned Income Tax Credit (EITC), IRS form 1095B, Home Community Base Services (HCBS) and Waiver Personal Care Services (WPCS) notices, and Public Assistance Reporting Information System (PARIS) are included in this item.

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP and the Earned Income Tax Credit (EITC) notice are 100% general fund (GF).

Reason for Changes from Prior Estimate:

The primary change is related to the additional Affordable Care Act (ACA) mailing costs associated with printing and postage for the required IRS 1095B form that will be distributed to all beneficiaries in early 2016. Newly Qualified Immigrants (NQI), Home Community Based Services (HCBS) and Waiver Personal Care Services (WPCS) printing and mailing costs are added to this estimate as well.

Methodology:

1. The Department estimates the printing and postage costs for FY 2015-16 and FY 2016-17 are:

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 5

(Dollars in Thousands)						
FY 2015-16		Printing	Mailing	TF	GF	FF
Mass Mailings		\$1,000	\$14,000	\$15,000	\$7,500	\$7,500
Eligibility	Distribution	\$0	\$520	\$520	\$260	\$260
	Routine	\$2,400	\$1,600	\$4,000	\$2,000	\$2,000
	EITC Annual insert*	\$550	\$0	\$550	\$550	\$0
	IRS 1095B	\$3,000	\$9,000	\$12,000	\$6,000	\$6,000
	NQI	\$0	\$0	\$0	\$0	\$0
	PARIS	\$154	\$46	\$200	\$100	\$100
Incarceration Verification Program		\$39	\$12	\$51	\$26	\$25
Benefits		\$600	\$1,000	\$1,600	\$800	\$800
BCCTP (35% State-Only Eligs)		\$5	\$16	\$21		
	*35% State-Only	\$0	\$0	\$0	\$7	\$0
	65% 50/50 Split	\$0	\$0	\$0	\$7	\$7
HIPAA NPP - M/C		\$2,200	\$2,000	\$4,200	\$2,100	\$2,100
HIPAA NPP - BCCTP		\$30	\$10	\$40	\$20	\$20
HCBS & WPCS		\$35	\$100	\$135	\$67	\$68
TOTAL (Rounded)		\$10,013	\$28,304	\$38,317	\$19,437	\$18,880
FY 2016-17		Printing	Mailing	TF	GF	FF
Mass Mailings		\$0	\$15,000	\$15,000	\$7,500	\$7,500
Eligibility	Distribution	\$0	\$520	\$520	\$260	\$260
	Routine	\$2,400	\$1,600	\$4,000	\$2,000	\$2,000
	EITC Annual insert*	\$400	\$0	\$400	\$400	\$0
	PARIS	\$154	\$46	\$200	\$100	\$100
Incarceration Verification Program		\$39	\$12	\$51	\$26	\$25
Benefits		\$600	\$1,000	\$1,600	\$800	\$800
BCCTP (35% State-Only Eligs)		\$5	\$16	\$21		
	35% State-Only*	\$0	\$0	\$0	\$7	\$0
	65% 50/50 Split	\$0	\$0	\$0	\$7	\$7
HIPAA NPP - M/C		\$2,200	\$2,000	\$4,200	\$2,100	\$2,100
HIPAA NPP - FPACT		\$0	\$0	\$0	\$0	\$0
HIPAA NPP - BCCTP		\$30	\$10	\$40	\$20	\$20
TOTAL (Rounded)		\$5,828	\$20,204	\$26,032	\$13,220	\$12,812

Funding:

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

100 % GF (4260-101-0001)*

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1748

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$36,559,000	\$36,559,000
STATE FUNDS	\$8,076,110	\$6,279,120
FEDERAL FUNDS	\$28,482,890	\$30,279,880

DESCRIPTION

Purpose:

This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP) and Medi-Cal Access Program (MCAP).

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM) and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013. The transition ended on February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014. AIM has been renamed the Medi-Cal Access Program.

Beginning January 1, 2014, the Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway and refer applicants to the application portal and toll-free line at Covered California. The shutdown process was completed in FY 2013-14.

As of July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. For FY 2015-16 and FY 2016-17, MAXIMUS will provide administrative vendor services for Medi-Cal Access Program, Medi-Cal Access Infants Program and OTLICP. Due to the number of applications still available in the community, the HFP applications continue to be received by MAXIMUS and are then forwarded to the appropriate CWD for a determination without the benefit of screening for accelerated enrollment.

In September 2013 the HFP and Children's Health Insurance Program (CHIP) were transitioned into the Medi-Cal program. Title XXI CHIP program requires the State to contract with an External Quality

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Review Organization (ERQO) to conduct performance measures validation, performance improvement projects, focus studies, encounter data activities, and an annual survey and other EQRO activities for the duration of the contract. In July 2014 the Department became responsible to have the EQRO conduct the annual survey and other EQRO activities under the terms of the contract.

In October 2015 eligibility for MCAP will be integrated into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). It is anticipated that this integration will increase enrollment in MCAP. By December 2015 initial data will be available to help determine the scale of the increase.

Administrative vendor services include costs for the following services; applications processing, call center rate per minute, transaction forwarding fee, processing letters and notices and printing and courier fees. FY 2015-16 and FY 2016-17 costs also includes implementation costs to automate system interfaces between MAXIMUS and the Department.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.
2. Contract costs for two Medi-Cal programs are eligible for Title XXI 65/35 FMAP, Title XXI 88/12 FMAP, Title XIX 50/50 FMAP and Title XIX 75/25 FMAP.
3. Administrative vendor services costs for the two Medi-Cal programs are eligible for Title XIX 50/50 FMAP, Title XXI 65/35 FMAP AND Title XXI 88/12 FMAP.

FY 2015-16	TF	GF	FF
Contract Costs	\$22,200,000	\$4,138,000	\$18,062,000
Applications Processing	\$2,865,000	\$786,000	\$2,079,000
Letters and Notices	\$697,000	\$191,000	\$506,000
Printing and Courier Fees	\$110,000	\$30,000	\$80,000
Call Minute Rate per Minute	\$3,852,000	\$1,056,000	\$2,796,000
Transaction Forwarding Fee	\$874,000	\$240,000	\$634,000
Implementation Costs	\$5,961,000	\$1,635,000	\$4,326,000
Total	\$36,559,000	\$8,076,000	\$28,483,000

FY 2016-17	TF	GF	FF
Contract Costs	\$22,200,000	\$2,919,000	\$19,281,000
Applications Processing	\$2,864,000	\$670,000	\$2,194,000
Letters and Notices	\$697,000	\$163,000	\$534,000
Printing and Courier Fees	\$111,000	\$26,000	\$85,000
Call Minute Rate per Minute	\$3,852,000	\$901,000	\$2,951,000
Transaction Forwarding Fee	\$875,000	\$205,000	\$670,000
Implementation Costs	\$5,960,000	\$1,395,000	\$4,565,000
Total	\$36,559,000	\$6,279,000	\$30,280,000

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 6

Funding:

FY 2015-16	TF	GF	FF
50% Title XIX/50% GF (4260-101-0890/0001)	\$4,807,700	\$2,403,850	\$2,403,850
65% Title XXI/35% GF (4260-113-0890/0001)	\$7,812,825	\$2,734,489	\$5,078,336
88% Title XXI/12% GF (4260-113-0890/0001)	\$23,438,475	\$2,812,617	\$20,625,858
75% Skilled Professional FMAP/25% GF	\$500,000	\$125,000	\$375,000
Total	\$36,559,000	\$8,075,956	\$28,483,044

FY 2016-17	TF	GF	FF
50% Title XIX/50% GF (4260-101-0890/0001)	\$4,807,700	\$2,403,850	\$2,403,850
88% Title XXI/12% GF (4260-113-0890/0001)	\$31,251,300	\$3,750,156	\$27,501,144
75% Skilled Professional FMAP/25% GF	\$500,000	\$125,000	\$375,000
Total	\$36,559,000	\$6,279,006	\$30,279,994

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 7/1996
 ANALYST: Peter Bjorkman
 FISCAL REFERENCE NUMBER: 229

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$33,718,000	\$33,718,000
STATE FUNDS	\$11,871,250	\$11,871,250
FEDERAL FUNDS	\$21,846,750	\$21,846,750

DESCRIPTION

Purpose:

This policy change estimates Medi-Cal's Early and Periodic Screening Diagnosis and Treatment (EPSDT) Case Management allocation.

Authority:

Health & Safety Code 124075(a)
 Welfare & Institutions Code 10507

Interdependent Policy Changes:

Not Applicable

Background:

Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.

The EPSDT Case Management budget is allocated to individual counties and controlled on an accrual basis.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- The set allocation amount is \$33,718,000 (\$11,871,000 GF) annually based on a formula calculated by the Child Health and Disability Prevention program.

	TF	GF	FFP
Allocation	\$33,718,000	\$11,871,000	\$21,847,000

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 75% Title XIX / 25% GF (4260-101-0001/0890)
 100% Title XIX (4260-101-0890)

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1370

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$32,709,000	\$12,556,000
STATE FUNDS	\$2,747,000	\$732,000
FEDERAL FUNDS	\$29,962,000	\$11,824,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009.

Authority:

ARRA of 2009
 SB 945 (Chapter 433, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)
 SB 870 (Chapter 40, SEC 15, Budget Act of 2014)
 Welfare & Institutions Code, Sections 14046.1 and 14046.7

Interdependent Policy Changes:

OA 62 Medical FI Optional Contractual Services
 PC 170 ARRA HITECH Provider Payments

Background:

The HITECH Act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must adopt, implement, or upgrade (AIU) and meaningfully use certified Electronic Health Records (EHR) technology in accordance with the HITECH Act requirements. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011. The payments to the providers under HITECH are budgeted in the ARRA HITECH – Provider Payments policy change. The HITECH Act pays provider incentive payments at 100% federal funds (FF).

In 2011, SB 945 authorized the Department to establish and administer the ARRA HITECH Incentive Program only to the extent that FF was available and there would be no General Fund (GF) impact. In 2012, AB 1467 provided that no more than \$200,000 from the GF may be used annually for state administrative costs associated with the program.

SB 870 appropriates \$3,750,000 from the Major Risk Medical Insurance Fund (MRMIF) to the Department for purposes of an EHR provider technical assistance program in accordance with the State Medicaid Health Information Technology Plan (SMHP) as specified in Section 14046.1 of the Welfare and Institutions Code. The appropriated sum amounts to a ten percent match for the \$37,500,000 allocation from CMS to procure vendors for the statewide EHR provider technical assistance program for eligible providers.

The Department received CMS approval of the SMHP and Implementation Advance Planning Document (IAPD) on September 30, 2011. The SMHP and IAPD authorized implementation of the

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

EHR Incentive Program, which occurred on October 3, 2011. An IAPD Update (IAPD-U) was submitted for CMS review and approved on July 6, 2015. The IAPDU requests additional funds for ongoing Department administrative costs for Federal Fiscal Year (FFY) 2016, as well as support for meaningful use (MU) measures including immunization registries, electronic lab reporting, and provider technical assistance.

The Department is required by CMS to assess the current usage of and barriers to EHR adoption by providers and continued administration of the Incentive Program. Multiple contracts are required in order to complete the assessments. The Department, in collaboration with a wide variety of stakeholder organizations, developed a Medi-Cal EHR Incentive Program Project Book that identifies a series of projects to facilitate the ongoing development and evaluation of the program.

The Medi-Cal Fiscal Intermediary (FI), Xerox State Healthcare, LLC continues to develop an enrollment and eligibility portal for Medi-Cal professionals and hospitals. SB 945 limitations did not apply to the Xerox projects as the funding for these projects were approved as part of the FI budget prior to the passage of SB 945. The cost of the incentive program application portal developed by Xerox, which is eligible for FFP, is budgeted in PC 104 Medical FI Optional Contractual Services. These costs include maintenance and operation and the development of additional functionalities.

The Department and the California Department of Public Health (CDPH) have partnered on a project to upgrade the California Immunization Registry (CAIR). The CAIR 2.0 project will transform the existing CAIR infrastructure and software to fully support MU data exchange among EHRs.

In addition to CAIR 2.0, the Department will administer the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

- The Department and CDPH partnered on the California Reportable Disease Information Exchange (CalREDIE) project to implement a computer application system for web-based disease reporting and surveillance.
- The Department awarded contracts to multiple vendors who provide HER system technical assistance to eligible providers preparing to meet AIU and/or MU objectives.
- The Department contracted with the University of California, San Francisco (UCSF) to conduct periodic surveys over the course of the EHR Incentive Program which are required to refine the initial landscape assessment of HER use and to document activities. A California Physicians' Use of EHR survey was completed in March 2014 and will be used to facilitate Health Information Exchange and EHR adoption for Medi-Cal.
- The Department will collaborate with the California Health and Human Services (CHHS) and the California Office of Health Information Integrity to facilitate the California Health Information Technology (HIT)/Health Information Exchange (HIE) Stakeholder Summit (Summit) in November 2015 for FY 2015-16. The Summit is anticipated to reoccur at a later date in FY 2016-17. The Summit will help stakeholders understand how individuals and organizations fit into HIE in California; enable stakeholders to learn about available resources for planning clinical and administrative integration; and provide a forum for stakeholders to have a voice in shaping the future of HIE in California.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Reason for Change from Prior Estimate:

For FY 2015-16, CAIR 2.0 project costs have increased due to initial infrastructure costs and the procurement of licenses. Due to the delayed launch of the Provider Technical Assistance Program from FY 2014-15 to FY 2015-16, project costs for FY 2015-16 have increased. CalREDIE project costs have increased in FY 2015-16 due to changes in project requirements.

Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.
2. For the CAIR 2.0 and CalREDIE projects, the 10% non-federal share is budgeted by CDPH. This policy change budgets the Title XIX 90% FF that will be provided to CDPH for the CAIR 2.0 and CalREDIE contracts through an interagency agreement.
3. The Provider Technical Assistance project is eligible for Title XIX 90% FF. In FY 2015-16 and FY 2016-17, the 10% non-federal share will be provided by the MRMIF.
4. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share is budgeted by CHHS. This policy change budgets the Title XIX 90% FF that will be provided to CHHS for the California HIT/HIE Stakeholder Summit contract through an interagency agreement.
5. In FY 2015-16 and FY 2016-17, the 10% non-federal share for the other projects will be provided by outside entities.
6. Xerox projects are eligible for ARRA HITECH funding under the FI contract.

FY 2015-16	TF	Reimbursement	SF	FF
CAIR 2.0 (90% FF/10% GF)	\$3,929,000	\$0	\$0	\$3,929,000
CalREDIE (90% FF/10% GF)	\$961,000	\$0	\$0	\$961,000
Provider Technical Assist. (90% FF/10% SF)*	\$25,935,000	\$0	\$2,593,000	\$23,342,000
California HIT/HIE Summit (90% FF/10% GF)	\$349,000	\$0	\$0	\$349,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$0	\$1,381,000
Total	\$32,709,000	\$154,000	\$2,593,000	\$29,962,000
Xerox projects (PC 104)	\$800,000	\$80,000	\$0	\$720,000
Total FY 2015-16	\$33,509,000	\$234,000	\$2,593,000	\$30,682,000

FY 2016-17	TF	Reimbursement	SF	FF
CAIR 2.0 (90% FF/10% GF)	\$3,929,000	\$0	\$0	\$3,929,000
CalREDIE (90% FF/10% GF)	\$961,000	\$0	\$0	\$961,000
Provider Technical Assist. (90% FF/10% SF)*	\$5,782,000	\$0	\$578,000	\$5,204,000
California HIT/HIE Summit (90% FF/10% GF)	\$349,000	\$0	\$0	\$349,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$0	\$1,381,000
Total	\$12,556,000	\$154,000	\$578,000	\$11,824,000
Xerox projects (PC 104)	\$800,000	\$80,000	\$0	\$720,000
Total FY 2016-17	\$13,356,000	\$234,000	\$578,000	\$12,544,000

Funding:

100% Title XIX (4260-101-0890)
 100% Reimbursement (4260-601-0995)
 100% Reimbursement (4260-602-0313)*

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1729

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$17,329,000	\$17,120,000
STATE FUNDS	\$600,000	\$215,000
FEDERAL FUNDS	\$16,729,000	\$16,905,000

DESCRIPTION

Purpose:

This policy change estimates the county utilization review (UR) and quality assurance (QA) administrative costs for Specialty Mental Health Services (SMHS).

Authority:

Welfare & Institutions Code 14711

Interdependent Policy Changes:

Not Applicable

Background:

UR and QA activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel claims.

The responsibility for Specialty Mental Health child welfare and protective services was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

Reason for Change from Prior Estimate:

The UR and QA costs increased based on additional historical data up to June 2015.

Methodology:

1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF).
2. Based on historical claims received, assume 28% of the each fiscal year claims will be paid in the year the services occur. Assume 69% is paid in the following year and 3% is paid in the third year.

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
FY 2013-14	\$24,106	\$723	\$0
FY 2014-15	\$24,680	\$17,029	\$740
FY 2015-16	\$25,219	\$7,061	\$17,401
FY 2016-17	\$25,727	\$0	\$7,204
Total		\$24,813	\$25,345

- SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.
- Based on historical claims received, assume 60% are SPMP and the remaining 40% of the total claims are other personnel costs.
- An additional \$1,200,000 has been added to other personnel costs in FY 2015-16 to prepare semi-annual reports for the Katie A. v. Bontá settlement agreement. The Katie A. v. Bontá settlement agreement costs are eligible for 50% FF and 50% General Fund (GF).

(Dollars in Thousands)

FY 2015-16				
Personnel	TF	FF	CF	GF
SPMP	\$14,888	\$11,166	\$3,722	\$0
Other	\$11,125	\$5,563	\$4,962	\$600
Total	\$26,013	\$16,729	\$8,684	\$600

- FY 2016-17 includes an estimate for additional work, at the county level, to collect and report data elements and post Mental Health Plan (MHP) data on the county's website as specified by the Special Terms and Conditions (STC) related to the SMHS waiver.

(Dollars in Thousands)

FY 2016-17				
Personnel	TF	FF	CF	GF
SPMP	\$15,207	\$11,405	\$3,802	\$0
Other	\$10,138	\$5,069	\$5,069	\$0
STC	\$861	\$431	\$215	\$215
Total	\$26,206	\$16,905	\$9,086	\$215

Funding:

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

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1813

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$15,851,000	\$18,574,000
STATE FUNDS	\$1,287,000	\$1,864,000
FEDERAL FUNDS	\$14,564,000	\$16,710,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

Authority:

State Plan Amendment #09-022

Interdependent Policy Changes:

Not Applicable

Background:

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by providers under contract with the counties or with the State. The Department requires counties to report and bill for their administrative expenses separately from direct treatment services expenses. This policy change budgets administrative costs for the following DMC programs:

- Narcotic Treatment Program
- Intensive Outpatient Treatment Services
- Outpatient Drug Free Treatment Services
- Residential Treatment Services

Effective July 1, 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 limits. Counties will begin participating in the waiver in four phases. Phases one and two will be implemented in FY 2015-16 and include 22 counties. Phases three and four will be implemented in FY 2016-17 and include 31 counties. Prior to July 1, 2015, RTS was available only to perinatal beneficiaries.

Reason for Change from the Prior Estimate:

The changes are due to the following:

- RTS cost for regular DMC beneficiaries has been added due to the expansion of services to non-perinatal beneficiaries.
- Cost projection has been updated with updated cost report data.

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 10

Methodology:

1. Based on updated cost report data and projections for DMC county administrative expenses from FY 2011-12 through FY 2014-15, the Department projects a 10.3% increase for Regular DMC (excluding RTS) and a 9.7% increase for Perinatal DMC services.
2. RTS expansion to counties will occur in phases, therefore cost is adjusted to reflect percentage of phase-in in each fiscal year.

Regular DMC	FY 2015-16	FY 2016-17
Narcotic Treatment Program	\$11,516,000	\$12,702,000
Intensive Outpatient Treatment	\$3,505,000	\$3,866,000
Outpatient Drug Free	\$8,989,000	\$9,915,000
Residential Treatment Services	\$622,000	\$1,855,000
Perinatal DMC		
Narcotic Treatment Program	\$36,000	\$39,000
Intensive Outpatient Treatment	\$171,000	\$188,000
Outpatient Drug Free (ODF)	\$110,000	\$121,000
Residential Treatment Services	\$241,000	\$264,000
Total	\$25,190,000	\$28,950,000

3. The estimated DMC county administration cost for FY 2015-16 and FY 2016-17 is:

FY 2015-16	County Admin Cost	Title XIX	Title XXI	County	GF
Regular DMC	\$24,633,000	\$14,060,000	\$154,000	\$9,171,000	\$1,248,000
Perinatal DMC	\$557,000	\$188,000	\$162,000	\$168,000	\$39,000
Total	\$25,190,000	\$14,248,000	\$316,000	\$9,339,000	\$1,287,000

FY 2016-17	County Admin Cost	Title XIX	Title XXI	County	GF
Regular DMC	\$28,338,000	\$16,145,000	\$182,000	\$10,191,000	\$1,820,000
Perinatal DMC	\$612,000	\$205,000	\$178,000	\$185,000	\$44,000
Total	\$28,950,000	\$16,350,000	\$360,000	\$10,376,000	\$1,864,000

Funding:

- 100% General Fund (4260-101-0001)
- 100% Title XIX FFP (4260-101-0890)
- 100% Title XXI FFP (4260-113-0890)

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1722

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$15,763,000	\$16,521,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$15,763,000	\$16,521,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of specialty mental health plans (MHPs) for Medicaid administrative activities (MAA).

Authority:

Welfare & Institutions Code 14132.47
 AB 2377 (Chapter 147, Statutes of 1994)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2377 authorized the State to implement the Medi-Cal Administrative Claiming Process. The Specialty Mental Health waiver program submits claims on behalf of MHPs to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the specialty mental health waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of specialty mental health services.

Reason for Change from Prior Estimate:

The estimates are revised to include the most current available claims data. Also, the payment lag has been adjusted based on updated expenditure data.

Methodology:

1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.
2. Based on claims from FY 2008-09 through FY 2013-14, the average annual increase in mental health (MH) MAA claims was 4.81%.
3. Assume claims will continue to increase by 4.81% each fiscal year.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 11

4. For FY 2013-14, the Department received \$25,662,000 in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
FY 2013-14	\$25,662	4.81%	\$1,234
FY 2014-15	\$26,897	4.81%	\$1,294
FY 2015-16	\$28,191	4.81%	\$1,356
FY 2016-17	\$29,547	4.81%	\$1,421

5. Based on historical claims received, assume 9.29% of fiscal year claims will be paid in the year the services occur. The remaining 90.71% is paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2015-16	FY 2016-17
FY 2014-15	\$26,897	\$24,398	\$0
FY 2015-16	\$28,191	\$2,619	\$25,572
FY 2016-17	\$29,547	\$0	\$2,745
Total	\$84,635	\$27,017	\$28,317

6. MH MAA total expenditures are shared between FFP and county funds (CF). Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement. Based on actual claims submitted for costs incurred in FY 2013-14, assume that 33.38% of costs are eligible for 75% reimbursement and the remaining 66.62% are eligible for 50% reimbursement.

(Dollars in Thousands)

Expenditures	FY 2015-16			FY 2016-17		
	TF	FF	CF	TF	FF	CF
Medical	\$9,018	\$6,764	\$2,254	\$9,452	\$7,089	\$2,363
Other	\$17,999	\$8,999	\$9,000	\$18,865	\$9,432	\$9,433
Total	\$27,017	\$15,763	\$11,254	\$28,317	\$16,521	\$11,796

Funding:

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

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 1/2016
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1932

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$14,610,000	\$14,021,000
STATE FUNDS	\$1,858,500	\$2,197,100
FEDERAL FUNDS	\$12,751,500	\$11,823,900

DESCRIPTION

Purpose:

This policy change estimates the costs for completing the Provider Application and Validation for Enrollment (PAVE) system with a new contractor.

Authority:

42, Code of Federal Regulations 455 Subpart E

Interdependent Policy Changes:

Not Applicable

Background:

The Department is deploying an enterprise-wide enrollment portal and associated business processes to automate provider management activities to comply with provider integrity mandates under the Affordable Care Act (ACA). Some of the requirements are:

- Perform monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing (ORP) providers that bill claims to Medi-Cal;
- Periodic checks of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File; and
- Revalidation of all providers every five years.

The Department's Fiscal Intermediary (FI) has taken steps to accomplish DD&I of the PAVE system. Due to contractual issues and delays, the Department is contracting with a new contractor for completing the DD&I and ongoing maintenance and operations (M&O) of the PAVE system.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Of the DD&I costs, \$3 million is budgeted in the FI contract (OA-102 Medical FI Other Estimated Costs) and offsets the FY 2015-16 DD&I costs in this policy change.

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 12

2. FY 2015-16 and FY 2016-17 costs are as follows:

FY 2015-16	TF	GF	FF
DD&I	\$14,100,000	\$1,410,000	\$12,690,000
DD&I (FI contract)	(\$3,000,000)	(\$300,000)	(\$2,700,000)
M&O*	\$2,650,000	\$662,000	\$1,988,000
Consultants	\$860,000	\$86,000	\$774,000
Total	\$14,610,000	\$1,858,000	\$12,752,000

FY 2016-17	TF	GF	FF
DD&I	\$7,000,000	\$700,000	\$6,300,000
M&O*	\$5,300,000	\$1,325,000	\$3,975,000
Consultants	\$1,721,000	\$172,000	\$1,549,000
Total	\$14,021,000	\$2,197,000	\$11,824,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)*

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

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 7/2002
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 252

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$12,476,000	\$12,476,000
STATE FUNDS	\$3,317,000	\$3,317,000
FEDERAL FUNDS	\$9,159,000	\$9,159,000

DESCRIPTION

Purpose:

The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. The system is used by the Department and other approved entities. The Department uses the system in various ways, including:

- The Medi-Cal Managed Care Division in its monitoring of Health Plan performance,
- The Third Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

Ongoing enhancement, maintenance and operation of the MIS/DSS are accomplished through a multi-year contract. The Department has awarded a nine year contract for the ongoing maintenance and operation of the MIS/DSS that began March 1, 2015.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. It is estimated that the contractor will be paid the following amounts in FY 2015-16 and FY 2016-17:

FY 2015-16	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	\$8,875,000	\$2,219,000	\$6,656,000
Additional Fixed Costs (50% FF / 50% GF)	\$792,000	\$396,000	\$396,000
Variable Costs (75% FF / 25% GF)	\$2,809,000	\$702,000	\$2,107,000
Total	\$12,476,000	\$3,317,000	\$9,159,000

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 13

FY 2016-17	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	\$8,875,000	\$2,219,000	\$6,656,000
Additional Fixed Costs (50% FF / 50% GF)	\$792,000	\$396,000	\$396,000
Variable Costs (75% FF / 25% GF)	\$2,809,000	\$702,000	\$2,107,000
Total	\$12,476,000	\$3,317,000	\$9,159,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1720

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$10,223,000	\$9,936,000
STATE FUNDS	\$2,555,750	\$2,484,000
FEDERAL FUNDS	\$7,667,250	\$7,452,000

DESCRIPTION

Purpose:

This policy change estimates the contract cost for the Preadmission Screening and Resident Review (PASRR) Level II evaluations. The policy change also estimates the costs of designing, testing, and implementing a web based automation system to bring PASRR into compliance with federal mandates.

Authority:

Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:

Not Applicable

Background:

Federal regulations mandate that the Department have an independent contractor complete all Level II PASRR Evaluations. The current contractor completes Level II evaluations for the federally mandated PASRR program. A Level II evaluation consists of a face to face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. The contractor's licensed clinical evaluators conduct the Level II evaluations on behalf of the State and enter their findings into the PASRR database.

A contract was awarded to provide Level II evaluations from January 2, 2015 through December 31, 2017 with two one-year options to renew.

The Department's PASRR program received funding to design, test, and implement a web based automated system to bring the preadmission Level I Screening, Level II evaluation, and Level II determination processes into compliance with federally mandated regulations for PASRR. The IT project will replace a mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department will save money by not contracting with a consultant to support the current mainframe and by hosting the new application in-house. The new IT system will:

- Be in compliance with federal mandates related to PASRR,
- Allow nursing facilities, hospitals, and evaluators to submit electronic Level I and II screening forms and evaluations,
- Significantly reduce processing time for submissions,
- Eliminate paper submissions,

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 14

- Reduce the time a contractor takes to return completed evaluations, and
- Increase efficiencies for PASRR clinicians by reducing processing time for determinations.

The Department is in the process of issuing a Request for Offer for the following enhancements:

- Addressing issues related to the effectiveness of evaluation questions and reconfiguring them accordingly.
- Developing a Reconsideration Letter feature for the NFs to request a reconsideration if they disagree with the Department's determination and care plan for the patient.
- Providing the Department with the ability to activate, deactivate, and reset user accounts directly from the new application instead of using the Web Admin tool.
- Developing the new system to look up ICD 9/10 codes for the Program Clinicians and the Level II evaluators.

The PASRR program will also provide electronic trainings to NFs and general acute care hospitals in efforts to integrate the new automated PASRR system. Electronic trainings will begin December 31, 2015 and continue to June 30, 2016.

Reason for Change from Prior Estimate:

Costs have been updated for the increased Level II evaluations for FY 2015-16.

Methodology:

1. A new Level II evaluations contractor was hired in January 2015 and payments began in February 2015.
2. Electronic training costs for the NFs and general acute care hospitals are based on an industry-wide survey. The end date for electronic training costs is June 30, 2016.
3. The IT project requires funds to complete the integration work into CA-MMIS' Health Enterprise (HE) Portal Identity Access Management (IDAM) tool. The IT project end date is June 30, 2016.

FY 2015-16	TF	GF	FF
Evaluations	\$9,748,000	\$2,437,000	\$7,311,000
Electronic Training	\$53,000	\$13,000	\$40,000
IT Project	\$234,000	\$58,000	\$176,000
Ongoing M&O Costs	\$188,000	\$47,000	\$141,000
Total	\$10,223,000	\$2,555,000	\$7,668,000

FY 2016-17	TF	GF	FF
Evaluations	\$9,748,000	\$2,437,000	\$7,311,000
Ongoing M&O Costs	\$188,000	\$47,000	\$141,000
Total	\$9,936,000	\$2,484,000	\$7,452,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1677

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$9,695,000	\$7,148,000
STATE FUNDS	\$4,721,500	\$3,574,000
FEDERAL FUNDS	\$4,973,500	\$3,574,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs for the Coordinated Care Initiative (CCI).

Authority:

SB 1008 (Chapter 33, Statutes of 2012)

SB 1036 (Chapter 45, Statutes of 2012)

SB 94 (Chapter 37, Statutes of 2013)

SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:

Not Applicable

Background:

In coordination with Federal and State Government, the CCI will provide benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles). CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services will be provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department will be hiring contractors to do the following:

- Stakeholder and Advocate Outreach,
- Rate Setting,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Evaluation,
- System Design – Infrastructure Support (IT),
- Project Management,
- IT Project Management, and
- Data Outcomes and Evaluation Development (Encounter Data Quality and Performance Measures).

Reason for Change from Prior Estimate:

In FY 2015-16, the changes are due to:

- Updates to the total cost and funding for Encounter Data Quality and Performance Measures,
- Addition of new Evaluation costs, and
- Addition of existing activities: System Design - Infrastructure Support (IT), Project Management, and EQRO monitoring costs.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 15

Methodology:

1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2016-17.
2. The Affordable Care Act (ACA) authorized funding for the CCI and provides 75% federal financial participation (FFP) in FY 2014-15 to carry out the deliverables between the Department and the Centers for Medicare and Medicaid Services (CMS).
3. The ACA funding expired August 31, 2015. In FY 2015-16, for those activities subject to ACA funding, two months of costs will be funded at the ACA 75/25 Federal Medical Assistance Percentage (FMAP). Any remaining costs will be funded at 50/50 FMAP.

FY 2015-16	TF	GF	FF	ACA FF
Stakeholder and Advocate Outreach	\$4,248,000	\$2,124,000	\$2,124,000	\$0
Encounter Data Quality & Perform. Measures	\$2,322,000	\$1,119,000	\$1,077,000	\$126,000
Evaluation	\$288,000	\$144,000	\$144,000	\$0
System Design - Infrastructure Support (IT)	\$319,000	\$152,250	\$145,000	\$21,750
Technical Project Manager (IT)	\$1,034,000	\$493,500	\$470,000	\$70,500
Project Management	\$484,000	\$231,000	\$220,000	\$33,000
EQRO Monitoring	\$1,000,000	\$458,250	\$416,500	\$125,250
Total	\$9,695,000	\$4,722,000	\$4,596,500	\$376,500

FY 2016-17	TF	GF	FF
Stakeholder and Advocate Outreach	\$4,248,000	\$2,124,000	\$2,124,000
Encounter Data Quality & Perform. Measures	\$1,000,000	\$500,000	\$500,000
Evaluation	\$900,000	\$450,000	\$450,000
EQRO Monitoring	\$1,000,000	\$500,000	\$500,000
Total	\$7,148,000	\$3,574,000	\$3,574,000

Funding:

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

ACA 75% Title XIX / 25% GF (4260-101-0001/0890)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 16
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1381

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$9,980,000	\$9,980,000
STATE FUNDS	\$4,990,000	\$4,990,000
FEDERAL FUNDS	\$4,990,000	\$4,990,000

DESCRIPTION

Purpose:

This policy change estimates the costs of litigation and actuarial consulting.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department continues to experience an increase in the number and complexity of litigation cases challenging legislation implementing changes to the Medi-Cal program. As a result, the Department of Justice costs and other litigation support costs have increased from previous years.

Several significant cases, which had previously been inactive awaiting a precedential decision by the United States Supreme Court, continue to be active. Also, ongoing litigation filed by managed care plans relating to capitation rates has resulted in significant time expended by actuarial staff in evaluating the cases and developing defense strategies.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be \$7,880,000 for FY 2015-16, and \$7,880,000 for FY 2016-17.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in FY 2015-16 and \$2,100,000 in FY 2016-17.

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 16

(Dollars in Thousands)	FY 2015-16		FY 2016-17	
	TF	GF	TF	GF
Litigation Representation	\$7,880	\$3,940	\$7,880	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$2,100	\$1,050
Total	\$9,980	\$4,990	\$9,980	\$4,990

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1757

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$9,558,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$9,558,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the federal funds (FF) for the interim and final cost settlements on specialty mental health services (SMHS) administrative expenditures.

Authority:

Welfare & Institution Code 14705(c)

Interdependent Policy Changes:

Not Applicable

Background:

The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change from Prior Estimate:

There is no change.

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 administration, UR/QA, and MH MAA are each determined separately.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 17

Interim Settlements			
FY 2009-10	Underpaid	Overpaid	Net FF
SMH Admin	\$8,182,000	(\$2,263,000)	\$5,919,000
MCHIP*	\$346,000	\$0	\$346,000
UR/QA	\$1,855,000	(\$299,000)	\$1,556,000
MH MAA	\$956,000	\$0	\$956,000
HFP Admin*	\$790,000	\$0	\$790,000
Total FY 2009-10	\$12,129,000	(\$2,562,000)	\$9,567,000
FY 2010-11	Underpaid	Overpaid	Net FF
SMH Admin	\$11,368	(\$20,994)	(\$9,626)
MCHIP*	\$47	(\$248)	(\$201)
UR/QA	\$3,836	(\$4,186)	(\$350)
MH MAA	\$798	(\$223)	\$575
HFP Admin*	\$189	(\$30)	\$159
Total FY 2010-11	\$16,238	(\$25,681)	(\$9,443)
Total FY 2015-16	\$12,145,238	(\$2,587,681)	\$9,557,557

4. The net FFP to be paid in FY 2015-16 is shown below:

	FY 2015-16
100% Title XIX FF (4260-101-0890)	\$8,422,000
100% Title XXI FF (4260-113-0890)*	\$1,136,000
Total	\$9,558,000

Funding:

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

100% Title XXI FF (4260-113-0890)*

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18
 IMPLEMENTATION DATE: 9/2015
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1937

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$9,075,000	\$16,872,000
STATE FUNDS	\$4,415,000	\$8,207,500
FEDERAL FUNDS	\$4,660,000	\$8,664,500

DESCRIPTION

Purpose:

This policy change estimates the costs for contracted actuarial rate development services.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Federal requirements for obtaining federal financial participation (FFP) require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Rates are developed in accordance with generally accepted actuarial principles,
- Practices are appropriate for the populations to be covered,
- The services to be furnished under the contract,
- Rates have been certified by actuaries who meet the qualification standards established by the American Academy of actuaries, and
- Follow the practice standards established by the Actuarial Standards Board.

The Department entered into a contract with an actuarial services consultant to ensure that we meet our responsibilities to develop actuarially sound capitation rates.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. This policy change collectively budgets for all actuarial services received for different managed care programs.
2. Per payment terms, 10% of the contractor's fees are withheld for six months pending completion of outstanding projects.
3. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Affordable Care Act (ACA) Expansion, and Health Homes Program), however, ongoing actuarial services are needed as these, and other new, programs are integrated into the overall managed care delivery system rate setting process.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 18

The FY 2015-16 and FY 2016-17 amounts on an accrual basis are estimated to be:

PC #	PC Title	FY 2015-16	FY 2016-17
OA-15	CCI - Administrative Costs	\$1,010,000	\$1,010,000
OA-41	ACA Expansion Admin Costs	\$517,000	\$517,000
OA-34	Health Homes Program - Contractor Costs	\$650,000	\$650,000
N/A	Ongoing Actuarial Services	\$7,000,000	\$15,100,000
	Total	\$9,177,000	\$17,277,000

The FY 2015-16 and FY 2016-17 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

	TF	GF	FF
FY 2015-16	\$9,075	\$4,415	\$4,660
FY 2016-17	\$16,872	\$8,208	\$8,664

Funding:

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

75% Title XIX FF / 25% GF (4260-101-0890/0001)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1824

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$7,700,000	\$7,700,000
STATE FUNDS	\$3,850,000	\$3,850,000
FEDERAL FUNDS	\$3,850,000	\$3,850,000

DESCRIPTION

Purpose:

This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:

AB 2780 (Chapter 310, Statutes of 1998)
 Health & Safety Code Section 123975 and Sections 124115 - 124120.5

Interdependent Policy Changes:

Not Applicable

Background:

The NHSP contracts with both the Hearing Coordination Centers (HCC) and the Infant Data Management Service (IDMS). The HCCs provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to assure they receive the needed services and referrals.

The IDMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The IDMS provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.

The IDMS and HCC contract breakdowns are as follows:

- IDMS contract
 - IDMS contract #14-90182 began on December 19, 2014 and has a two-year term.
 - The Request for Proposal (RFP) process will begin in late FY 2015-16 to award an IDMS contract effective December 2016.
- HCC contracts
 - A single, statewide HCC RFP has been awarded, contract #15-92041, and started on July 1, 2015 to replace the separate HCC contracts.
 - The new contract supersedes the following HCC contracts and has a five-year term.
 - HCC contract #10-87040 A02, Loma Linda, expired on June 30, 2015.
 - HCC contract #10-87041 A02, Miller Children's Hospital, expired on June 30, 2015.
 - HCC contract #13-90151 A01, Natus Medical Incorporated, expires on September 30, 2015.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The estimated IDMS and HCC contract costs for FY 2015-16 and FY 2016-17 are as follows:

FY 2015-16	TF	GF	FF
HCC contract	\$6,500,000	\$3,250,000	\$3,250,000
IDMS contract	\$1,200,000	\$600,000	\$600,000
Total	\$7,700,000	\$3,850,000	\$3,850,000

FY 2016-17	TF	GF	FF
HCC contract	\$6,500,000	\$3,250,000	\$3,250,000
IDMS contract (current)	\$500,000	\$250,000	\$250,000
IDMS contract (new)	\$700,000	\$350,000	\$350,000
Total	\$7,700,000	\$3,850,000	\$3,850,000

Funding:

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20
 IMPLEMENTATION DATE: 2/2008
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1551

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$5,685,000	\$5,685,000
STATE FUNDS	\$1,421,250	\$1,421,250
FEDERAL FUNDS	\$4,263,750	\$4,263,750

DESCRIPTION

Purpose:

This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible health insurance (HI) or workers' compensation (WC) insurance. The policy change also includes online database contracts to access online activity and data matches in support of recovery.

Authority:

Contracts:

Dep. of Industrial Relations – Electronic Adjudication Management System (EAMS)	14-90130
Dep. of Industrial Relations – Worker's Compensation Information System (WCIS)	14-90133
Department of Social Services	10-87009 A01
Department of Social Services	15-92000
Health Management Systems Inc. (HI)	13-90283
Health Management Systems Inc. (WC)	03-75807 A03
Health Management Systems Inc. (WC)	03-75060 A03
Health Management Systems Inc. (WC)	07-65000 A06
Health Management Systems Inc. (WC)	07-65001 A06
Health Management Systems Inc. (WC)	12-89100
Health Management Systems Inc. (WC)	12-89101
Lexis-Nexis	14-90131
Boehm & Associates	97-10689 A02
Boehm & Associates	97-10690 A02
Department of Public Health	13-90373
Department of Public Health	14-90132

Interdependent Policy Changes:

Not Applicable

Background:

Since Medi-Cal is the payer of last resort, all legally responsible third parties must first be billed before the Medi-Cal program. The above contracts provide:

1. Data matches between the Department's Medi-Cal recipient eligibility file and the contractor's policy holder/subscriber file;
2. Identification and recovery of Medi-Cal expenditures in WC actions;

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

3. Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer;
4. Online access to research database services for public records of Medi-Cal recipients; and
5. Cost avoidance activities.

When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries. Recoveries due to third party liability vendor activities are incorporated into the Base Recoveries policy change.

The contract with the Department of Industrial Relations currently sunsets on January 1, 2017. Proposed legislation will eliminate the sunset date.

Reason for Change from Prior Estimate:

FY 2015-16 estimates have decreased for the following reasons:

- WC Contract costs decreased due to temporary suspension of data transmissions, contractor staff turnover and workload process changes, and
- Online Database Contract costs increased due to higher Lexis-Nexis contract costs in FY 2015-16.

Methodology:

1. The amounts paid to the contractors are based upon recoveries. The payments shown below include recent recovery activity.

FY 2015-16	TF	GF	FF
Health Insurance	\$5,100,000	\$1,275,000	\$3,825,000
WC	\$433,000	\$108,000	\$325,000
Online Database Contracts	\$152,000	\$38,000	\$114,000
Total	\$5,685,000	\$1,421,000	\$4,264,000

FY 2016-17	TF	GF	FF
Health Insurance	\$5,100,000	\$1,275,000	\$3,825,000
WC	\$433,000	\$108,000	\$325,000
Online Database Contracts	\$152,000	\$38,000	\$114,000
Total	\$5,685,000	\$1,421,000	\$4,264,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 21
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1441

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$5,039,000	\$5,291,000
STATE FUNDS	\$1,652,250	\$1,734,750
FEDERAL FUNDS	\$3,386,750	\$3,556,250

DESCRIPTION

Purpose:

This policy change estimates the system development, maintenance and operations, and other Department reimbursements for the Medi-Cal Eligibility Data System (MEDS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following:

- MEDS Master Client Index maintenance,
- Data matches from various federal and state agencies,
- Supplemental Security Income termination process support,
- Medi-Cal application alerts,
- Medicare Modernization Act Part D buy-in process improvements,
- Eligibility renewal process, and
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities.

Maintenance and operations (M&O) funding is required for the Business Objects software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS. These system development and M&O costs are offset by reimbursements made from other departments.

MEDS supports the Advance Premium Tax Credit and Cost Share Reduction programs with Covered California and respective interfaces with CalHEERS, and County consortia. The MEDS Statewide Client Index generates unique Client Index Numbers for all populations.

Reason for Change from Prior Estimate:

The FY 2015-16 costs increased based on FY 2014-15 actuals and a planned 5% increase in M&O costs.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Methodology:

1. The following are the projected costs for FY 2015-16 and FY 2016-17.

FY 2015-16	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	\$466,000	\$233,000	\$233,000	\$0
Maintenance & Operations (75% FF / 25% GF)	\$4,205,000	\$1,051,000	\$3,154,000	\$0
Other Department Reimbursement (100% Reimbursement)	\$368,000	\$0	\$0	\$368,000
Total	\$5,039,000	\$1,284,000	\$3,387,000	\$368,000

FY 2016-17	TF	GF	FF	Reimbursement
System Development (50% FF / 50% GF)	\$490,000	\$245,000	\$245,000	\$0
Maintenance & Operations (75% FF / 25% GF)	\$4,415,000	\$1,104,000	\$3,311,000	\$0
Other Department Reimbursement (100% Reimbursement)	\$386,000	\$0	\$0	\$386,000
Total	\$5,291,000	\$1,349,000	\$3,556,000	\$386,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

100% Reimbursement (4260-601-0995)

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1318

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$4,865,000	\$4,487,000
STATE FUNDS	\$1,216,250	\$1,121,750
FEDERAL FUNDS	\$3,648,750	\$3,365,250

DESCRIPTION

Purpose:

This policy change estimates the contract costs to make improvements, maintain, and operate the existing Health Insurance Portability and Accountability Act (HIPAA) Capitation Payment Reporting system (CAPMAN). The HIPAA imposes new transaction requirements (5010).

Authority:

45 CFR Part 162

Interdependent Policy Changes:

Not Applicable

Background:

The CAPMAN system was implemented by the Department in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the beneficiary level while increasing the effectiveness of monthly reconciliations and supporting research efforts to perform recoveries.

Due to the Affordable Care Act (ACA) and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to accommodate the influx of new beneficiaries. Modifications are being made to further enhance the system to incorporate a paperless accounting interface and accommodate the Coordinated Care Initiative (CCI) Duals Demonstration project. The system will have to be maintained on an ongoing basis, as new functionality is required. A two-year contract was executed in July 2013, and a one-year extension was exercised in April 2014 to address these issues. The contract has an end date of April 30, 2016.

In January 2015, the Functional/Architect/Manager and a Technical/Lead were replaced using a different vendor. No additional costs were incurred. A one-year optional extension will be exercised to extend the contract to April 30, 2017, in order to continue enhancements to the systems to complete the incorporation of a paperless accounting interface and accommodate the CCI Duals Demonstration project.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The contract costs will be \$17,456,040 upon approval of the contract amendment. Payments started August 2013.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 22

2. The remaining balance of \$9,351,800 will be paid out over FY 2015-16 and FY 2016-17.
3. Contract costs:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2015-16	\$4,865	\$1,216	\$3,649
FY 2016-17	\$4,487	\$1,122	\$3,365

Funding:

75% HIPAA FFP / 25% HIPAA Fund (4260-117-0001/0890)

CA-MMIS REPLACEMENT OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 23
 IMPLEMENTATION DATE: 10/2007
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1278

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$4,803,000	\$7,074,000
STATE FUNDS	\$575,500	\$847,100
FEDERAL FUNDS	\$4,227,500	\$6,226,900

DESCRIPTION

Purpose:

This policy change estimates the cost of contractors who assist with the oversight of the replacement of the California Medicaid Management Information System (CA-MMIS).

Authority:

Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:

Not Applicable

Background:

CA-MMIS is the claims processing system used for Medi-Cal. Given the business critical nature of CA-MMIS, a detailed assessment was completed and the recommendation was to immediately modernize CA-MMIS. The Department contracts with various vendors to assist with highly specialized Fiscal Intermediary oversight activities, documentation of business rules, technical architecture, federal certification management, project management, transition management, user acceptance testing, business process re-engineering (BPR), and independent verification and validation services during transition and replacement of the CA-MMIS system.

Reason for Change from Prior Estimate:

FY 2015-16 costs decreased due to a delay, resulting in costs shifting from FY 2015-16 to FY 2016-17. Expenditures have also been updated based on actuals received.

Methodology:

- The estimated costs are based upon the contract provisions.

FY	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
50% Title XXI / 50% GF	\$22,000	\$11,000	\$11,000	\$32,000	\$16,000	\$16,000
90% Title XIX / 10% GF	\$4,685,000	\$468,500	\$4,216,500	\$6,901,000	\$690,000	\$6,211,000
100% GF	\$96,000	\$96,000	\$0	\$141,000	\$141,000	\$0
Total	\$4,803,000	\$575,500	\$4,227,500	\$7,074,000	\$847,000	\$6,227,000

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)
 90% Title XIX FF / 10% GF (4260-101-0001/0890)
 100% GF (4260-101-0001)

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1635

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$4,539,000	\$80,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,539,000	\$80,000

DESCRIPTION

Purpose:

This policy change budgets the federal funds awarded to the Department by the Centers of Medicare and Medicaid Services (CMS) for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project.

Authority:

Affordable Care Act (ACA), Section 4108

Interdependent Policy Changes:

Not Applicable

Background:

Section 4108 of the ACA authorized the five-year MIPCD grant project. California's MIPCD proposal created the Medi-Cal Incentives to Quit Smoking Project to use outreach and incentives to encourage access to smoking cessation services.

The Department contracted with the University of California San Francisco (UCSF) to implement, administer and evaluate the MIPCD program. The UCSF- California Medicaid Research Institute provides administrative support, coordination with key University of California (UC) partners, and contracts directly with the University of California San Diego (UCSD) to operate the California Smokers Helpline.

The California Smokers Helpline offers various incentives such as free counseling and nicotine replacement therapy to Medi-Cal beneficiaries. The MIPCD project also provides outreach services to Medi-Cal beneficiaries and Medi-Cal providers via the California Diabetes Program, which is administered by the Department of Public Health and UCSF.

The Department was awarded the MIPCD grant on September 13, 2011 by CMS and a contract with UCSF was secured on January 27, 2012. The MIPCD grant sunsets on September 12, 2016.

Reason for Change from Prior Estimate:

The FY 2015-16 estimate was revised to include the full amount of the approved by CMS per the Notice of Grant Awards.

Methodology:

1. Projected costs are based on proposed contract amounts with UCSF for administration, implementation and evaluations associated with the MIPCD grant project.

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 24

2. On June 15, 2015, the Department submitted a request for the following:
 - A \$206,000 carryover request of unspent funds from Project Year 2014-15 (9/13/14 - 9/13/15) to be carried over into Project Year 2015-16 (9/13/15 – 9/12/16).
 - A \$932,000 continuation request for Project Year 2015-16 (9/13/15 – 9/12/16).
3. FY 2015-16 estimated expenditures increased to \$4,539,000. Previous FY 2014-15 and FY 2015-16 estimates did not reflect CMS-approved funding for the project period of 9/13/14 – 9/12/15.

FY 2015-16	TF	FF
Project Year 2014-15	\$2,289,000	\$2,289,000
Project Year 2015-16	\$2,250,000	\$2,250,000
FY 2015-16 Total	\$4,539,000	\$4,539,000

FY 2016-17	TF	FF
Project Year 2015-16	\$80,000	\$80,000

Funding:

MIPCD Federal Grant (4260-107-0890)

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 25
 IMPLEMENTATION DATE: 2/2013
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1731

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$3,680,000	\$2,915,000
STATE FUNDS	\$368,000	\$291,500
FEDERAL FUNDS	\$3,312,000	\$2,623,500

DESCRIPTION

Purpose:

This policy change estimates the cost to hire contractors to comply with a new state project approval process, develop Advance Planning Documents (APDs), participate in the project planning efforts, and maintain existing Business Rules Extraction (BRE) software.

Authority:

Title 42, Code of Federal Regulations, Sections 95.611 and 433.110

Interdependent Policy Changes:

Not Applicable

Background:

The Department is seeking to transition the Medi-Cal Eligibility Data System (MEDS) from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the federal Affordable Care Act, and increases the Department's alignment with the federal Medicaid Information Technology Architecture.

The Department's Planning APD (PAPD), for the planning phase of the MEDS Modernization Project, was approved by the Centers for Medicare and Medicaid Services (CMS) in September 2014. Project planning phase activities are anticipated to continue through December 2018. In FY 2015-16, the project schedule has been aligned with the State's new project approval requirements and resource needs have been adjusted to reflect the joint project partnership with the Office of Systems Integration and Department of Social Services.

In FY 2016-17, additional items are needed for the MEDS Modernization Project.

- County Welfare Director's Association (CWDA) consultants serve as the principal liaison between CWDA and the MEDS Modernization Project team.
- Information Technology Project Oversight and Consulting (ITPOC) review and provide feedback on project approval requests and project planning documents.
- Independent Verification and Validation (IV&V) externally monitor project office and contractor efforts. IV&V reviews both products and processes.
- Operating Expenses and Equipment (OEE) costs are necessary to cover general expense, printing, communications, travel, and training costs for the contracted consultants.

Reason for Change from Prior Estimate:

Project planning and technical consulting needs decreased while enterprise architect consulting costs increased due to a larger than anticipated volume of work effort. Project support and other contractor costs shifted to FY 2016-17.

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 25

Methodology:

1. The FY 2015-16 and FY 2016-17 costs are based on estimated payments for the project planning, enterprise architect consulting, and Business Rules Extraction (BRE) software maintenance. FY 2015-16 also includes costs for technical consulting.
2. In addition, FY 2016-17 will include costs for project support, CWDA consultants, ITPOC, IV&V, and OEE.

FY 2015-16	TF	GF	FF
Project Planning	\$610,000	\$61,000	\$549,000
Technical Consulting Services	\$500,000	\$50,000	\$450,000
Enterprise Architect Consulting	\$2,000,000	\$200,000	\$1,800,000
BRE Software Maintenance	\$570,000	\$57,000	\$513,000
Total	\$3,680,000	\$368,000	\$3,312,000

FY 2016-17	TF	GF	FF
Project Planning	\$610,000	\$61,000	\$549,000
Enterprise Architect Consulting	\$665,000	\$67,000	\$598,000
Project Support	\$540,000	\$54,000	\$486,000
BRE Software Maintenance	\$570,000	\$57,000	\$513,000
CWDA Consultants	\$240,000	\$24,000	\$216,000
ITPOC	\$56,000	\$6,000	\$50,000
IV&V	\$150,000	\$15,000	\$135,000
OE&E	\$84,000	\$8,000	\$76,000
Total	\$2,915,000	\$292,000	\$2,623,000

Funding:

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

CA-MMIS REPLACEMENT & OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 5/2010
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1322

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$3,157,000	\$2,277,000
STATE FUNDS	\$378,000	\$273,100
FEDERAL FUNDS	\$2,779,000	\$2,003,900

DESCRIPTION

Purpose:

This policy change estimates the transition cost related to replacement and transition of the California Medicaid Management Information System (CA-MMIS).

Authority:

Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:

Not Applicable

Background:

CA-MMIS is the claims processing system used for Medi-Cal. The transition costs incurred for CA-MMIS Replacement activities include interfacing with other Departmental mission critical systems such as Medi-Cal Eligibility Data System, Enhanced Medi-Cal Budget Estimate Redesign, State Controller's Office, Management Information System and Decision Support System, California Healthcare Eligibility, Enhancement and Retention System and Paid Claims and Encounters Standardization applications that require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system, user acceptance and parallel), testing tools, support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Replacement phase. The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during the Replacement phase. Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS Replacement phase.

Reason for Change from Prior Estimate:

FY 2015-16 contract costs decreased due to contracts not procured as planned as well as the delay in the procurement of others.

Methodology:

1. Advanced planning documents for these activities provide the basis for these estimates.

CA-MMIS REPLACEMENT & OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 26

	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
50% Title XIX / 50% GF	\$14,000	\$7,000	\$7,000	\$10,000	\$5,000	\$5,000
90% Title XIX / 10% GF	\$3,080,000	\$308,000	\$2,772,000	\$2,221,000	\$222,000	\$1,999,000
100% GF	\$63,000	\$63,000	\$0	\$46,000	\$46,000	\$0
Total	\$3,157,000	\$378,000	\$2,779,000	\$2,277,000	\$273,000	\$2,004,000

Funding:

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

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

100% GF (4260-101-0001)

BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1814

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$2,580,000	\$0
STATE FUNDS	\$645,000	\$0
FEDERAL FUNDS	\$1,935,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of procuring a Business Rules Extraction (BRE) suite of tools and services, through the General Services Software License Program, for use in the creation and maintenance of a modernized automated comprehensive procurement library.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department included the BRE enhancement in the 2010 request for proposal (RFP) for the California Dental Medicaid Management Information System (CD-MMIS). The RFP was subsequently awarded, but it was not approved by the Centers for Medicare and Medicaid Services (CMS). The Department plans to procure a new dental MMIS contract that meets CMS requirements. In addition, the Department has solicited a new BRE enhancement contract which was approved by CMS on March 6, 2015.

In order to provide an equal advantage to all participating bidders, the Department plans to purchase a BRE suite of tools and services for use in the creation and maintenance of a modernized automated comprehensive procurement library. Bidders will gain a better understanding of the functionality and complexity of the legacy system CD-MMIS enabling them to complete an informed, more competitive bid.

This modernized procurement library will provide the following:

- Full disclosure of graphic and logical views of the applications/programs,
- Update business rules periodically, allowing viewing of the latest versions of process diagrams, source code flow charts, and source code details,
- Ability to electronically store documentation,
- Utilize extracted business rules to support future system enhancements, replacement, or the migration to one enterprise-wide system.

Reason for Change from Prior Estimate:

In FY 2014-15, an invoice of \$860,000 was expected to be paid. However, due to invoicing delays, these costs shifted from FY 2014-15 to FY 2015-16.

BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER: 28

Methodology:

1. The BRE was initially its own project funded at 50/50 FF, but is now included in the CD-MMIS re-procurement Advance Planning Document and therefore, qualifies for 75/25 FF.
2. The BRE suite of tools and services were procured in March 2015 and the services will be completed by March 2016.
3. Total estimated costs are \$2.58 million TF (\$645,000 GF).
4. The one-time payment of \$2.58 million TF (\$645,000 GF) was made in July 2015.

	TF	GF	FF
FY 2015-16	\$2,580,000	\$645,000	\$1,935,000

Funding:

75% Title XIX FF / 25% GF (4260-101-0001/0890)

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 29
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1732

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$2,325,000	\$2,325,000
STATE FUNDS	\$1,162,500	\$1,162,500
FEDERAL FUNDS	\$1,162,500	\$1,162,500

DESCRIPTION

Purpose:

This policy change estimates the infrastructure and contractor's costs to perform the ongoing maintenance and operations support for the Short-Doyle/Medi-Cal (SDMC) system.

Authority:

Contract OHC-11-077

Interdependent Policy Changes:

Not Applicable

Background:

The SDMC system adjudicates Medi-Cal claims for Specialty Mental Health and Substance Use Disorder Services. The Department signed a two-year contract beginning July 1, 2014, with two one-year optional extensions. Due to the Affordable Care Act, Medi-Cal is expecting an increase in the volume of claims which has created a need for system upgrades, including application servers, reporting servers, middleware, database, and storage.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The estimated contractor cost for the new four-year contract is \$8,000,000.
2. The contractor was hired in July 2014, and payments began in September 2014.
3. Projections include the cost of ongoing maintenance and operation (M&O) for the accounting system that processes Mental Health and Substance Use Disorder Services claims payments for the SDMC system.

FY 2015-16	TF	GF	FF
Contractor cost	\$2,000,000	\$1,000,000	\$1,000,000
M&O	\$325,000	\$162,000	\$163,000
Total	\$2,325,000	\$1,162,000	\$1,163,000

SDMC SYSTEM M&O SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 29

FY 2016-17	TF	GF	FF
Contractor cost	\$2,000,000	\$1,000,000	\$1,000,000
M&O	\$325,000	\$162,000	\$163,000
Total	\$2,325,000	\$1,162,000	\$1,163,000

Funding:

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

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 30
 IMPLEMENTATION DATE: 1/1989
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 237

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$2,188,000	\$2,188,000
STATE FUNDS	\$1,094,000	\$1,094,000
FEDERAL FUNDS	\$1,094,000	\$1,094,000

DESCRIPTION

Purpose:

This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:

Social Security Act 1634(a)

Interdependent Policy Changes:

Not Applicable

Background:

The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change from Prior Estimate:

Recent actual billings from SSA came in lower than previously projected.

Methodology:

- The following projections are based upon recent actual billings from SSA.

(Dollars in Thousands)	TF	GF	FF
FY 2015-16	\$2,188	\$1,094	\$1,094
FY 2016-17	\$2,188	\$1,094	\$1,094

Funding:

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

SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 31
 IMPLEMENTATION DATE: 7/2002
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 258

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,900,000	\$950,000
STATE FUNDS	\$1,900,000	\$950,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of the contract with the County of San Diego for administrative services.

Authority:

Welfare & Institutions Code, sections 14089(g) and 14089.05

Interdependent Policy Changes:

Not Applicable

Background:

The Department contracts with the County of San Diego to provide administrative services for the San Diego Geographic Managed Care program. The Department reimburses the County for staff, postage, printing, data center access, travel, health care options presentations to explain the enrollment and disenrollment process, customer assistance and problem resolution. Effective August 2003, these services are no longer eligible for federal match.

Reason for Change from Prior Estimate:

Payments for FY 2014-15 were paid in FY 2015-16 because of a delay in processing the contract renewal.

Methodology:

1. Based on contract provisions, the administrative activities costs will be \$1,900,000 for FY 2015-16 and \$950,000 for FY 2016-17.

Funding:

100% State GF (4260-101-0001)

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 32
IMPLEMENTATION DATE: 1/2011
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1137

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$1,740,000	\$2,582,000
STATE FUNDS	\$174,000	\$258,200
FEDERAL FUNDS	\$1,566,000	\$2,323,800

DESCRIPTION

Purpose:

This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA).

Authority:

MITA Initiative sponsored by Centers for Medicare and Medicaid Services (CMS)

Interdependent Policy Changes:

Not Applicable

Background:

CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department will develop the ability to streamline the process to access information from various systems, which will result in cost effectiveness. CMS will not approve Advanced Planning Documents (APDs) or provide federal funding to the Department without adherence to MITA.

To operate more effectively and efficiently, the Department must take steps to achieve the maturity goals of the MITA Framework and focus strategic planning, system changes, and upgrades around department-wide business processes rather than focusing on separate program needs. These steps will prevent the Department from potentially duplicating efforts regarding hardware, software, and resources across the enterprise.

This MITA project will help mature the business processes and position the Department to be more flexible as it serves the growing number of members. Enacting the MITA Framework and associated governance will also allow the Department to more quickly and accurately react to federal and state laws. Additionally, the Department will be better prepared to use the immense amounts of Medicaid data the Department collects daily to better manage the program.

The Department conducts an annual MITA State Self-Assessment (SS-A) required by CMS, which includes a State MITA roadmap.

Reason for Change from Prior Estimate:

Adjusted existing contract costs based on actual payments made in FY 2015-16.

MITA**OTHER ADMIN. POLICY CHANGE NUMBER: 32****Methodology:**

1. The MITA project will employ contracted positions to enter the implementation phase in FY 2015-16 and FY 2016-17. Therefore, FY 2015-16 amounts include the costs associated with the new contracts, in addition to the existing contract that ended August 31, 2015.
2. Existing contract costs were paid in July 2015 and August 2015, with remaining payments to be made in September 2015.
3. The new contracts are effective November 2015. Payments for the new contracts will begin December 2015 and take 19 months to complete.
4. Projected costs:

Fiscal Year	TF	GF	FF
FY 2015-16	\$1,740,000	\$174,000	\$1,566,000
FY 2016-17	\$2,582,000	\$258,200	\$2,323,800

Funding:

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

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 33
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1768

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,389,000	\$398,000
STATE FUNDS	\$364,350	\$39,800
FEDERAL FUNDS	\$1,024,650	\$358,200

DESCRIPTION

Purpose:

This policy change estimates the cost for the design, development and implementation (DD&I) of the Extract, Transform and Load (ETL) data solution.

Authority:

Affordable Care Act (ACA)

Interdependent Policy Changes:

Not Applicable

Background:

CMS requires data in a standardized format from the states to review system projects related to the ACA. The Department implemented an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS's Transformed Statistical Information System. The project provides modern capabilities to improve business processes; by collecting comprehensive data regarding cost, quantity and quality of health care provided for Medi-Cal beneficiaries. The project will begin production in January 2016.

Reason for Change from Prior Estimate:

Some DD&I costs shifted from FY 2015-16 to FY 2016-17.

Methodology:

1. The contractor began DD&I work in August 2013 and will continue through December 2016. This DD&I contract includes implementation and stabilization.
2. The DD&I contract for consulting services to provide technical support is being procured in FY 2015-16 and will continue through December 2016.
3. The software will be procured in September 2015.
4. The Department has developed an Advance Planning Document Update that extended the project to meet the additional CMS requirements. The anticipated completion date of the DD&I phase is December 2016. M&O will start in January 2017, after DD&I is complete.

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 33

FY 2015-16	TF	GF	FF
DD&I (90% FF / 10% GF)	\$136,000	\$14,000	\$122,000
Software (75% FF / 25% GF)	\$1,103,000	\$275,000	\$828,000
Hardware (50% FF / 50% GF)	\$150,000	\$75,000	\$75,000
Total FY 2015-16	\$1,389,000	\$364,000	\$1,025,000

FY 2016-17	TF	GF	FF
DD&I (90% FF / 10% GF)	\$52,000	\$5,000	\$47,000
M & O (90% FF / 10% GF)	\$346,000	\$35,000	\$311,000
Total FY 2016-17	\$398,000	\$40,000	\$358,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

HEALTH HOMES PROGRAM - CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 34
 IMPLEMENTATION DATE: 12/2015
 ANALYST: Jerrold Anub
 FISCAL REFERENCE NUMBER: 1911

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,225,000	\$0
STATE FUNDS	\$612,500	\$0
FEDERAL FUNDS	\$612,500	\$0

DESCRIPTION

Purpose:

This policy change estimates contractor costs for the Health Home Program (HHP).

Authority:

AB 361 (Chapter 642, Statutes of 2013)

SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:

PC 118 - Health Homes for Patients with Complex Needs

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 contractor costs.

Reason for Change from Prior Estimate:

Due to delays in establishing the contracts, costs for FY 2015-16 have decreased slightly.

Methodology:

1. Assume establishment of contracts with outside vendors beginning November 1, 2015.
2. These vendors will be contracted for the following administrative activities: project management, provider and beneficiary outreach, and program evaluation.
3. For these contracted administrative costs the Department will receive 50% federal reimbursement for FY 2015-16. The remaining 50% will be funded by non-GF sources.
4. These contracted administrative costs for FY 2015-16 are expected to be:

HEALTH HOMES PROGRAM - CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 34

(Dollars in Thousands)	TF	FF	HHP Fund*
FY 2015-16	\$1,225	\$613	\$612

Funding:

50% Title XIX FF (4260-101-0890)

50% HHP Fund (4260-601-0942)*

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 35
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1675

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,207,000	\$1,207,000
STATE FUNDS	\$603,500	\$603,500
FEDERAL FUNDS	\$603,500	\$603,500

DESCRIPTION

Purpose:

This policy change estimates the cost for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:

AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The Family PACT program has two main objectives. One is to increase access to services for low-income women and men, including adolescents. The other is to increase the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach,
- Provider enrollment, recruitment, and training,
- Training and technical assistance for medical and non-medical staff,
- Education and counseling services,
- Preventive clinical services,
- Sexually transmitted infection/HIV training and technical assistance services, and
- Toll-free referral number.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The administrative costs for the Family PACT program are estimated in the table below:

	TF	GF	FF
FY 2015-16	\$1,207,000	\$603,500	\$603,500
FY 2016-17	\$1,207,000	\$603,500	\$603,500

Funding:

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

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 266

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,200,000	\$1,200,000
STATE FUNDS	\$600,000	\$600,000
FEDERAL FUNDS	\$600,000	\$600,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs of contracting for the annual independent audit of the Disproportionate Share Hospital (DSH) program.

Authority:

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
 Title 42, Code of Federal Regulations, section 455.300 et. seq.

Interdependent Policy Changes:

Not Applicable

Background:

The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals (approximately 150 hospitals) have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.
2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

The audits will be funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31.

Reason for Change from Prior Estimate:

The change is due to increased contractor costs for the additional hours needed to complete the current audit activities through December 31, 2015.

Methodology:

1. Each fiscal year, all auditing activity will cost \$1,200,000 (\$600,000 GF).
2. The current contract ends December 31, 2015. On January 1, 2016, a new contractor will take over starting with the FY 2012-13 audit.
3. In FY 2015-16, the Department will make final payment for the FY 2011-12 audit and partial payment for the FY 2012-13 audit.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 36

4. In FY 2016-17, the Department will make final payment for the FY 2012-13 audit and partial payment for the FY 2013-14 audit.

Fiscal Years	TF	GF	FF
FY 2015-16	\$1,200,000	\$600,000	\$600,000
FY 2016-17	\$1,200,000	\$600,000	\$600,000

Funding:

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

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 7/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1902

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$1,000,000	\$1,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,000,000	\$1,000,000

DESCRIPTION

Purpose:

This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

CHIS is a random-dial telephone survey that asks question on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups, county-level information for most counties to aid with health planning, priority setting, and to compare health outcomes in numerous ways.

CHIS is conducted by the University of California, Los Angeles (UCLA) Center for Health Policy Research in collaboration with the California Department of Public Health (CDPH) and the Department. The Department currently has a shared contract with CDPH to provide federal funding for CHIS, which is budgeted in Other Administrative policy change titled FFP for Department of Public Health Support Costs. The Department's contract with CDPH ended June 30, 2015.

Effective July 1, 2015, the Department contracts directly with UCLA to utilize CHIS for program needs and performance. The prior contract with CDPH had limited the Department's ability to increase survey contents necessary for program administration. The new contract is funded by Federal Financial Participation (FFP); the non-federal share is paid through certified public expenditures (CPEs).

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.
2. Estimated expenditure for FY 2015-16 and FY 2016-17 is \$1,000,000 FFP.

Funding:

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 5/2010
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1452

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$750,000	\$750,000
STATE FUNDS	\$375,000	\$375,000
FEDERAL FUNDS	\$375,000	\$375,000

DESCRIPTION

Purpose:

This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining electronic Protected Health Information (PHI).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department acquired hardware, supplies, and associated maintenance and support services that are necessary to protect and secure electronic data stored on backup systems. The data on these systems contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates.

The protection of these systems will:

- Secure and protect Department information assets from unauthorized disclosure,
- Protect the privacy of Medi-Cal beneficiaries,
- Prevent lawsuits from citizens for privacy violations,
- Avoid costs to notify millions of people if a large breach does occur, and
- Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

The Department is continuing its effort in upgrading the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies such as backup to disk, data de-duplication, offsite data replication, and data encryption. The maintenance and increasing amount of data involved with the migration of the Department with these technologies allows the Department to continue to grow and support its virtualization infrastructure and to provide backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth,
- Provide additional backup, recovery, and storage for the business programs, and
- Ensure the data is secure and managed.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The following amounts are based upon the latest projections of cost.

FY 2015-16	TF	GF	FF
	\$750,000	\$375,000	\$375,000

FY 2016-17	TF	GF	FF
	\$750,000	\$375,000	\$375,000

Funding:

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

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 7/1996
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 240

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$553,000	\$596,000
STATE FUNDS	\$276,500	\$298,000
FEDERAL FUNDS	\$276,500	\$298,000

DESCRIPTION**Purpose:**

This policy change estimates the Third Party Liability postage and printing costs.

Authority:

Government Code 7295.4
 AB 155 (Chapter 820, Statutes of 1999)

Interdependent Policy Changes:

Not Applicable

Background:

The Department uses direct mails and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms printed and mailed, as well as the number of reports received, correlates to the Medi-Cal caseload.

All forms related to Medicare Operations are available online. The Department purchased a document folder/insert machine in FY 2012-13 to automate the mailings done in-house.

Reason for Change from Prior Estimate:

Postage decreased as a result of continuous paperless efforts. Printing increased slightly to account for slight rate change for envelope costs to print.

Methodology:

1. The cost breakdown is shown below:

FY 2015-16	Postage	Printing	Total
Personal Injury	\$123,000	\$18,000	\$141,000
Estate Recovery	\$117,000	\$279,000	\$396,000
Overpayments	\$7,000	\$1,000	\$8,000
Cost Avoidance	\$5,000	\$1,000	\$6,000
*AB 155 Invoices	\$1,000	\$0	\$1,000
**Document Folder Inserter	\$0	\$1,000	\$1,000
Total	\$253,000	\$300,000	\$553,000

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 39

FY 2016-17	Postage	Printing	Total
Personal Injury	\$130,000	\$19,000	\$149,000
Estate Recovery	\$123,000	\$308,000	\$431,000
Overpayments	\$7,000	\$1,000	\$8,000
Cost Avoidance	\$5,000	\$1,000	\$6,000
*AB 155 Invoices	\$1,000	\$0	\$1,000
**Document Folder Inserter	\$0	\$1,000	\$1,000
Total	\$266,000	\$330,000	\$596,000

*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.

** Cost of maintenance agreement for the Document Folder Inserter used to process mailings in-house.

2. The estimated postage and printing costs are:

	TF	GF	FF
FY 2015-16	\$553,000	\$276,500	\$276,500
FY 2016-17	\$596,000	\$298,000	\$298,000

Funding:

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 40
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1556

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$330,000	\$630,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$330,000	\$630,000

DESCRIPTION

Purpose:

This policy change budgets the federal funding to cover administrative costs for increasing the California Community Transitions (CCT) enrollment.

Authority:

Money Follows the Person (MFP) Rebalancing Demonstration (42 USC 1396a)
 Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403

Interdependent Policy Changes:

Not Applicable

Background:

Pursuant to the ACA, on September 3, 2010 the Centers for Medicare and Medicaid Services (CMS) authorized the Department to draw down \$750,000 in MFP Rebalancing Demonstration supplemental grant funding. The Department allocated the supplemental grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify individuals who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase CCT enrollment. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

CMS granted the Department an extension of the supplemental grant through December 2015 to complete the objectives set forth in the grant.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase CCT enrollment. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

Reason for Change from Prior Estimate:

Supplemental grant funding was extended through December 31, 2015 for administrative support activities to increase CCT enrollment. In addition, CMS approved the Department's proposal to continue to use 100% federal funding for administrative, marketing, and outreach activities under the general MFP grant, effective January 1, 2016, through the end of the MFP grant period. Some costs for marketing and outreach were shifted from FY 2014-15 to FY 2015-16.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 40

Methodology:

1. Costs began in April 2011 totaling approximately \$11,400 during FY 2010-11; approximately \$11,300 in FY 2012-13; approximately \$202,000 paid in FY 2013-14; and approximately \$286,000 in FY 2014-15.
2. Assume costs for Outreach & Marketing Summits, scheduled to begin in May 2015, have been delayed to FY 2016-17.
3. As of July 1, 2015, \$240,000 continues to be available under the supplemental grant.
4. Assume the remaining grant funds plus the additional MFP grant funding of \$330,000 will be paid between July 2015 and June 2016 for administrative support and marketing and outreach.
5. Assume \$630,000 from the additional MFP grant funding is expected to be paid in FY 2016-17. Approximately \$360,000, will be for administrative support and approximately \$270,000 will be for the Outreach and Marketing Summits.
6. Estimated costs are based on proposed expenditures for the following activities:
 - ADRC planning and implementation,
 - ADRC/MFP collaborative strategic planning,
 - MDS 3.0 Section Q referrals policy development,
 - MDS/Options counseling training sessions,
 - Home and Community-Based Advisory Workgroup Series,
 - Marketing and outreach mail campaign, and
 - CCT/MFP Summits.

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 OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 40

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)

ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 41
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1795

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$330,000	\$0
STATE FUNDS	\$165,000	\$0
FEDERAL FUNDS	\$165,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the contract costs for implementing required provisions of the Affordable Care Act (ACA).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, 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. As result of the significant Medi-Cal growth, additional testing resources are required to keep pace with the many enhancements to the Medi-Cal Eligibility Data Base mandated by eligibility changes.

This policy change estimates the contract costs associated with IT consultant services including:

- Providing technical expertise in preparing test cases, scenarios, data, and documentation,
- Ensuring quality controls are adhered to prior to implementing system changes,
- Coordinating quality assurance activities, enterprise testing, release management, and other levels of system testing,
- Providing technical assistance for the Department.

Reason for Change from Prior Estimate:

Costs for actuarial work are budgeted in a separate policy change as of the November 2015 estimate.

Methodology:

1. The Department estimates IT consultant services for the ACA expansion population will cost \$330,000 TF (\$165,000 GF) in FY 2015-16.

Funding:

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

RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER: 42
 IMPLEMENTATION DATE: 9/2015
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1483

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$305,000	\$305,000
STATE FUNDS	\$152,500	\$152,500
FEDERAL FUNDS	\$152,500	\$152,500

DESCRIPTION

Purpose:

This policy change estimates the cost related to hiring a contractor to survey drug price information from pharmacies.

Authority:

AB 102 (Chapter 29, Statutes of 2011)
 Welfare & Institutions (W&I) Code, sections 14105.45 and 14105.451

Interdependent Policy Changes:

Not Applicable

Background:

W&I Code section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. Currently, the Department is subject to a court injunction which precludes implementation of the MAIC methodology.

AB 102 authorized the Department to develop a reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price. Additionally, on February 2, 2012 the Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) on Medicaid covered outpatient drugs in the Federal Register. This proposed rule will revise requirements pertaining to Medicaid reimbursement for covered outpatient drugs. CMS expects to release the final rule in FY 2015-16.

To obtain information from providers necessary to establish the MAICs and AACs, the Department will hire a contractor to survey drug price information from Medi-Cal pharmacy providers and update MAICs and AACs on an ongoing basis.

MAIC litigation remains unresolved and the CMS Medicaid covered outpatient drugs proposed rule is still pending. The Department will be conducting a preliminary study to examine and evaluate the CMS national pricing benchmark, National Average Drug Acquisition Cost (NADAC). The outcome of this study will not result in the establishment of new MAICs.

In order to obtain the necessary drug pricing information, the Department entered into a contract with Mercer. Mercer will conduct a survey of the purchase prices paid by California retail pharmacies for MAIC qualifying drugs and prepare a report comparing the results of that survey to the NADAC and the amount Medi-Cal currently reimburses for each product. The contract with Mercer is from September 1, 2015 to June 2016. The Department plans to hire a new contractor in FY 2016-17 to transition from the current Average Wholesale Price reimbursement to a new AAC based methodology.

RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER: 42

Reason for Change from Prior Estimate:

The implementation date changed from July 1, 2015 to September 1, 2015.

Methodology:

1. The current contract, for \$305,000, is from September 1, 2015 to June 2016.
2. Assume the contractor costs in FY 2016-17 will be the same as FY 2015-16.

Contractors	FY 2015-16	FY 2016-17
Project Management Contractor	\$305,000	\$0
MAIC/AAC Vendor Contractor	\$0	\$305,000

Funding:

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

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 43
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1590

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$300,000	\$0
STATE FUNDS	\$150,000	\$0
FEDERAL FUNDS	\$150,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of a contract with the University of Massachusetts (UMASS) to identify potential overpayments to Centers for Medicare and Medicaid Services (CMS) or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles.

Authority:

Welfare & Institutions Code 14124.92
 Contract 10-87134 A01

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into a three-year contract with UMASS on October 1, 2010 and on May 17, 2012, the Department of General Services approved extending the agreement to June 30, 2015. UMASS assisted the Department in auditing the invoices received from CMS to pay the Medicare premiums. The Department did not extend this contract for FY 2015-16.

The payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers. These payments are 10% of the amounts recovered.

Reason for Change from Prior Estimate:

Near the end of the contract, UMASS submitted approximately 5,000 cases for review of potential overpayment recoveries. As these cases still need to be reviewed by the Social Security Administration before a final invoice amount can be determined, the Department agreed to extend the deadline for UMASS to submit the final contract invoice for the contract that expired June 30, 2015.

Methodology:

1. The cost of the contractor is 10% of the amount recovered.
2. 5,000 cases were submitted for potential recoveries. The Department estimates that 980 of these cases are likely to result in recovery. Based on 980 cases pending SSA's review, assume the amount recovered will be \$3,000,000 for FY 2015-16.

MEDICARE BUY-IN QUALITY REVIEW PROJECT**OTHER ADMIN. POLICY CHANGE NUMBER: 43**

3. Assume the cost of the contractor will be \$300,000 in FY 2015-16.

$\$3,000,000 \times 10\% = \$300,000$ annual contractor cost for FY 2015-16

	TF	GF	FF
FY 2015-16	\$300,000	\$150,000	\$150,000

Funding:

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

ANNUAL EDP AUDIT CONTRACTOR

OTHER ADMIN. POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 8/2013
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1734

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$257,000	\$0
STATE FUNDS	\$128,500	\$0
FEDERAL FUNDS	\$128,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost related to procuring an annual Electronic Data Processing (EDP) audit of the Medi-Cal fiscal intermediary (FI).

Authority:

Title 45, Code of Federal Regulations 95.621
 Contract 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

Title 45, Code of Federal Regulations 95.621 requires the Department to conduct periodic onsite surveys and reviews of EDP methods and practices. The survey determines the adequacy of EDP methods and practices. Federal regulations require the Department to develop a schedule between the Department and State or local agencies prior to conducting such surveys or reviews. In addition, the Medi-Cal Fiscal Intermediary contract requires the Department to procure an audit contractor to perform an annual EDP audit. The Department currently provides this annual audit to the Bureau of State Audits to incorporate into the Single State Federal Compliance Audit for the Medicaid program.

Reason for Changes from Prior Estimate:

There are two changes: 1) the final invoice was not received in FY 2014-15, resulting in costs shifting from FY 2014-15 to FY 2015-16, and 2) the final invoice was higher than previously estimated.

Methodology:

1. The estimate is based on actual bid amounts.
2. Costs for the new audit services that will be procured under a new contract/vendor will be budgeted in the FI tab under cost reimbursement.

	TF	GF	FF
FY 2015-16	\$257,000	\$128,500	\$128,500

Funding:

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

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 45
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1739

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$247,000	\$226,000
STATE FUNDS	\$61,750	\$56,500
FEDERAL FUNDS	\$185,250	\$169,500

DESCRIPTION

Purpose:

This policy change estimates the cost of a Certified Project Manager (CPM) assisting in the development of a Planning Advanced Planning Document (PAPD) and managing the project to procure a new Medi-Cal Dental Fiscal Intermediary contract.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) determined the new dental Fiscal Intermediary (FI) contract no longer meets the regulatory criteria and conditions as a Medicaid Management Information System (MMIS) acquisition. Therefore, the contract is not eligible for enhanced federal funding. The Department has procured a CPM. The CPM will work closely with Department staff, CMS, and key stakeholders. The Department and CPM have developed a PAPD to ensure the CD-MMIS is in compliance with federal regulations and eligible for enhanced federal funding. The PAPD was approved by CMS in July of 2014.

The CPM consultant is responsible for performing the full range of project management functions for the duration of this project including:

- Resource planning,
- Contract development and management,
- Risk management,
- Project reporting,
- Fiscal monitoring and reporting,
- Issue management,
- Performing a marketplace analysis of the vendor community and identify procurement alternatives and recommendations for the procurement of a new dental FI contract,
- Developing a complete and thorough PAPD that meets the regulatory criteria and conditions as a MMIS and to ensure the PAPD is developed timely and approval by CMS is obtained, and
- Assisting Department staff in responding to CMS inquiries and provide additional documentation if required.

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 45

Reason for Change from Prior Estimate:

Due to contract limitations and the need to reprocore a new Medi-Cal Dental Administrative Services Organization (ASO) contract, the Department is in the process of procuring a new CPM contract for the period November 1, 2015 through May 31, 2017. FY 2015-16 costs remain the same; however, costs for FY 2016-17 are new.

Methodology:

1. Due to the need to reprocore a new Medi-Cal Dental ASO contract total estimated project costs have increased from \$629,000 TF (\$157,250 GF) to \$868,000 TF (\$217,000 GF).
2. The current project manager was hired in June 2013 and the current contract will end October 31, 2015.
3. The Department is in the process of procuring a new CPM contract for the period November 1, 2015 through May 31, 2017.
4. Payments for the new contractor will begin in November 2015.

	TF	GF	FF
FY 2015-16	\$247,000	\$62,000	\$185,000

	TF	GF	FF
FY 2016-17	\$226,000	\$57,000	\$169,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

RECOVERY AUDIT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 46
 IMPLEMENTATION DATE: 4/2016
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1740

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$236,000	\$193,000
STATE FUNDS	\$118,000	\$96,500
FEDERAL FUNDS	\$118,000	\$96,500

DESCRIPTION

Purpose:

This policy change estimates the costs of a Recovery Audit Contractor (RAC) retained to identify savings.

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 in April 2012 and approved the contract in April 2013. This policy change budgets the recovery audit contractor costs. See the PC 32 Recovery Audit Contractor Savings for the identified and recovered savings.

The four provider types identified for RAC audit are Optometrists, Podiatrists, Non-Emergency Medical Transportation (NEMT) 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:

Expansion of audits to new provider types resulted in an increase of estimated recoveries. There were no recoveries in the May 2015 estimate. As this policy change only applies when there are recoveries, it was inactive in May 2015.

Methodology:

1. Underpayments are not anticipated for FY 2015-16 and FY 2016-17.
2. Cost applies to the Department only when savings are identified and recovered.

RECOVERY AUDIT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 46

3. Previously, there were no estimated payments for FY 2014-15 and FY 2015-16. Based on the 0.5% estimated recoveries for new providers for FY 2015-16 and FY 2016-17, HMS will be paid at the rate of 12.5% of the recoveries.
4. Total Estimated Recoveries for FY 2015-16 = \$1,891,000 TF
RAC costs = 12.5% x \$1,891,000 = \$236,375 TF
5. Total Estimated Recoveries for FY 2016-17 = \$1,547,000 TF
RAC costs = 12.5% x \$1,547,000 = \$193,375 TF

	TF	GF	FF
FY 2015-16	\$236,000	\$118,000	\$118,000
FY 2016-17	\$193,000	\$96,500	\$96,500

Funding:

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

MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION

OTHER ADMIN. POLICY CHANGE NUMBER: 47
 IMPLEMENTATION DATE: 3/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1868

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$125,000	\$125,000
STATE FUNDS	\$62,500	\$62,500
FEDERAL FUNDS	\$62,500	\$62,500

DESCRIPTION

Purpose:

This policy change estimates the cost for an independent vendor to perform the Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots test certifications required by the Centers for Medicare and Medicaid (CMS) for the new CalHEERS eligibility determination system.

Authority:

State Health Official (SHO) letter # 13-005

Interdependent Policy Changes:

Not Applicable

Background:

The Affordable Care Act (ACA) brought significant changes to the way the states adjudicated eligibility for applicants for Medicaid and CHIP. Changes included the use of the Modified Adjusted Gross Income methodology for income determinations and household compositions, the use of a single streamlined application, availability of multiple channels for submitting application information, and the need for data sharing and account transfers between the Marketplace, Medicaid and CHIP. To assess these changes, CMS implemented an interim change in methodology for conducting eligibility reviews. The SHO Letter 13-005, issued on August 15, 2013, directs states to implement four Medicaid and CHIP Eligibility Review Pilots in place of the Payment Error Rate Measurement and Medicaid Eligibility Quality Control eligibility review requirements for fiscal years (FY) 2014-2016. These pilots will provide more targeted, detailed information on the accuracy of eligibility determinations using the new ACA rules, and provide states and CMS with critical feedback. CMS has given specific guidance regarding the process for certifying the test cases for the second pilot and has stated that an independent vendor must certify the pilot test results prior to its submission. If this is not implemented the Department would be non-compliant with CMS program requirements and could be subject to monetary fines or sanctions.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- 1) Based upon current California Multiple Award Schedule pricing for consultant contracts, the estimated contract costs are \$125,000 TF (\$62,500 GF) for FY 2015-16 and FY 2016-17.

Funding:

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

EPOCRATES

OTHER ADMIN. POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 4/2007
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1157

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$107,000	\$107,000
STATE FUNDS	\$53,500	\$53,500
FEDERAL FUNDS	\$53,500	\$53,500

DESCRIPTION

Purpose:

This policy change estimates the cost of a contract with Epocrates Rx™.

Authority:

Contract #10-87055

Interdependent Policy Changes:

Not Applicable

Background:

Epocrates Rx™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country.

The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) and up to three other departmental "formularies", for example, Family Planning, Access, and Treatment (Family PACT) or AIDS Drug Assistance Program (ADAP), in the Epocrates system for access by subscribers.

Epocrates provides the Department with an opportunity to reach a large network of health professionals via a unique point-of-care clinical reference solution for physicians and other health professionals accessible on both handheld devices and Internet based desktop computers.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. According to the contract, the annual amount paid to Epocrates for their services is \$107,000 TF for FY 2015-16. The contract ends in July 2016. The Department plans to extend the contract through FY 2016-17.

<u>Fiscal Year</u>	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2015-16	\$107,000	\$53,500	\$53,500
FY 2016-17	\$107,000	\$53,500	\$53,500

Funding:

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

CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 49
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Stephanie Hockman
 FISCAL REFERENCE NUMBER: 1388

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$100,000	\$100,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$100,000	\$100,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for county funds expended above the CCS Case Management allocations on administrative activities in support of a county's California Children's Services (CCS) Medi-Cal caseload using Certified Public Expenditures (CPE).

Authority:

California Health & Safety Code § 123955(f)
 Code of Federal Regulations, Title 42, 433.51

Interdependent Policy Changes:

Not Applicable

Background:

County costs for determination of CCS Medi-Cal eligibility, care coordination, utilization management and prior authorization of services are reimbursed by Medi-Cal. County funds expended above the allocations on administrative activities in support of a county's CCS Medi-Cal caseload may be used as CPE to draw down Title XIX federal financial participation (FFP).

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. It is assumed that \$100,000 will be drawn down with counties' CPE in FY 2015-16 and FY 2016-17.

	FFP
FY 2015-16	\$100,000
FY 2016-17	\$100,000

Funding:

100% Title XIX (4260-101-0890)

Q5i AUTOMATED DATA SYSTEM ACQUISITION

OTHER ADMIN. POLICY CHANGE NUMBER: 50
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1440

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$59,000	\$59,000
STATE FUNDS	\$29,500	\$29,500
FEDERAL FUNDS	\$29,500	\$29,500

DESCRIPTION

Purpose:

This policy change estimates the cost of the Q5i automated data system and the ongoing support costs.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance, and support. The Q5i system supports quality control efforts for federally mandated programs. As a result of implementation of the Affordable Care Act, the Centers for Medicare and Medicaid Services issued guidance to states that ended previous quality control programs and implements a series of four new pilot programs that will replace the Medicaid Eligibility Quality Control and Payment Error Rate Measurement programs, to be conducted over federal fiscal years 2014 – 2016. Q5i will need to be modified to accommodate the new federal requirements over this three year period.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Ongoing costs began in March 2012.
2. These estimates are provided by the vendor:

FY	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
Ongoing Costs	\$59,000	\$29,500	\$29,500	\$59,000	\$29,500	\$29,500

Funding:

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

TAR POSTAGE

OTHER ADMIN. POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 267

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$59,000	\$59,000
STATE FUNDS	\$29,500	\$29,500
FEDERAL FUNDS	\$29,500	\$29,500

DESCRIPTION

Purpose:

This policy change estimates postage costs for Medi-Cal Treatment Authorization Requests (TAR).

Authority:

Welfare & Institutions Code, section 14103.6

Interdependent Policy Changes:

Not Applicable

Background:

Medi-Cal beneficiaries receive health care services from medical, pharmacy, or dental providers enrolled in the Medi-Cal Program. Providers must receive authorization from Medi-Cal in order to provide and/or be paid for some of these services. The form a provider uses to request authorization is called a Treatment Authorization Request (TAR).

TARs are used by Medi-Cal to help ensure that necessary medical, pharmacy, or dental services are provided to Medi-Cal recipients and that providers are reimbursed appropriately. TARs are confidential documents and the information included on them is protected by state and federal privacy laws.

Reason for Change from Prior Estimate:

Effective May 2015, there was an increase in United States Postal Service (USPS) postage rates which increased the overall estimated costs in FY 2015-16 and FY 2016-17.

Methodology:

1. TAR postage costs for Medi-Cal are assumed to be \$59,000 for FY 2015-16 and FY 2016-17.
2. Estimates are based on actual expenditures from July 2014 through June 2015.

Funding:

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

COORDINATED CARE MANAGEMENT PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 2/2010
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 1125

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$23,000	\$0
STATE FUNDS	\$11,500	\$0
FEDERAL FUNDS	\$11,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the costs for the Coordinated Care Management (CCM) pilot project.

Authority:

Budget Act of 2006

Interdependent Policy Change:

Not Applicable

Background:

The CCM pilot project consisted of two pilot programs designed to improve healthcare outcomes and achieve cost containment in the fee-for-service (FFS) Medi-Cal system. The CCM pilot project was intended to test the ability to provide more efficient care coordination in a FFS environment.

Key elements of the CCM pilot project included maintaining access to medically necessary and appropriate services, improving health, and providing care in a more cost-effective manner for two populations enrolled in the FFS Medi-Cal program who were not on Medicare:

- CCM 1 - Seniors and persons with disabilities who had chronic conditions, or who may have been seriously ill and near the end of life. CCM-1 was completed with the transition of the Seniors and Persons with Disabilities population into Medi-Cal managed care health plans; and
- CCM 2 - Persons with chronic health condition(s) and serious mental illnesses (SMI). The SMI scope of work expired on July 31, 2013. This contract was amended to include Adult Day Health Care (ADHC) scope of work services to transition eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit. The CBAS scope of work was terminated in the contract on July 31, 2013 with the transition of services to the Department's Long Term Care Division.

The Department entered into two contracts with APS Healthcare to implement the CCM pilot project. CCM 1 began operations in January 2010, with payments for services beginning in February 2010. CCM 2 began operations in April 2010, with payments for services beginning in May 2010.

The contract term for CCM 1 was from March 1, 2009 to December 31, 2012. The contract term for CCM 2 was from August 20, 2009 to August 31, 2014. However, the CCM 2 contract terminated 13 months earlier on July 31, 2013. The contract term for the University of California, Los Angeles (UCLA) independent evaluation (IE) is from July 1, 2012 through June 30, 2015.

COORDINATED CARE MANAGEMENT PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 52

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The final payment for the UCLA IE will be issued by December 31, 2015. The following chart shows the FY 2015-16 costs:

<u>FY 2015-16</u>	<u>TF</u>	<u>GF</u>	<u>FF</u>
UCLA IE	\$23,000	\$11,500	\$11,500

Funding:

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

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 53
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1871

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$0	\$18,537,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$18,537,000

DESCRIPTION

Purpose:

This policy change estimates the federal fund reimbursement for Drug Medi-Cal (DMC) Utilization Review (UR) and Quality Assurance (QA) administrative costs.

Authority:

Welfare & Institutions Code, Section 14711

Interdependent Policy Changes:

Not Applicable

Background:

UR and QA activities safeguard against unnecessary and inappropriate medical care and expenses. Federal Funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

DMC UR and QA administrative activities are expected to begin July 1, 2016.

Reason for Change from Prior Estimate:

Due to delay in implementation, DMC UR and QA services start date has shifted from July 1, 2015 to July 1, 2016.

Methodology:

1. Assume the UR and QA will begin July 1, 2016.
2. UR and QA expenditures are shared between FF and county funds (CF).
3. Assume the DMC cost of performing UR and QA activities is the same as the mental health cost of performing the same activities based on the similarity of duties.
4. The UR and QA estimated cost on an accrual basis is \$38,022,000 TF.
5. Assume 75% of each fiscal year claims will be paid in the year that the services occur and 25% is paid in the following year. The UR and QA estimated cost on a cash basis is \$28,517,000 TF.
 $(\$38,022,000 \times 75\% = \$28,517,000)$
6. SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 53

7. Assume 60% of the total claims are for SPMP costs and the remaining 40% are for other personnel costs.

(Dollars in Thousands)

FY 2016-17	TF	FFP	CF
SPMP	\$17,110	\$12,833	\$4,277
Other Personnel	\$11,407	\$5,704	\$5,703
Total	\$28,517	\$18,537	\$9,980

Funding:

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

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 54
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1916

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$93,742,000	\$90,473,000
STATE FUNDS	\$30,470,250	\$29,306,000
FEDERAL FUNDS	\$63,271,750	\$61,167,000

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract#09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Many functions of the Medical FI Contract services are performed and paid under the Base Volume Method of Payment (BVMP) or All Volume Method of Payment processes. For BVMP categories, the Contractor bid on fixed transaction volume ranges and a fixed rate for each range. For the All Volume Method of Payment categories, the Contractor is paid a fixed rate per transaction. The Department receives a discount when total transactions fall below the base range, and pays a premium when total transactions exceed the base range.

- The volume ranges and corresponding bid rates vary from year to year.
- The State Medi-Cal caseload also varies from year to year.

Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- General Adjudicated Claim Lines (ACLs) - Lines of service associated with a Medi-Cal medical claim. Payments to FI are based on the number of ACLs processed.
- Online Drug ACLs – Lines of service associated with a Medi-Cal online drug claim. Payments to FI are based on the number of ACLs processed.
- Prospective Drug Use Review (DUR) – DUR is performed during adjudication of on-line

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 54

pharmacy claims and is the process of utilization review and quality assessment of drug prescribing and dispensing and educational intervention; before and after the drug is dispensed.

- Retrospective DUR – Similar to Prospective DUR, “retrospective” reviews of claims data are done to identify patterns of improper use of drug program benefits among providers and recipients.
- Encounter Claim Lines – Lines of service associated with encounters received from Managed Care Organizations (MCO) contracted to process Medi-Cal claims.
- California Eligibility Verification and Management Systems (CA-EVS/CMS) processing - A non-mainframe system that includes on-line, real time processing of eligibility verification, share of cost, Medi-services, and pharmacy claims transaction using a POS devices, AEVS, CERTS, Internet, or through approved user-developed/modified systems.
- Medicare Drug Discount Program – The processing of inquiries that consists of unique requests for Medicare prices for CA-EV/CMS by provider for the beneficiary for a date of service.
- Treatment Authorization Requests (TARS) – The process used by providers to request for authorization to provide specified service(s) to a recipient.
- Telephone Services Center (TSC) – Claim volume associated with Contractor work activity and responsibility to telephone responses to provider and beneficiary inquiries received over telephone lines.

Xerox has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

Reason for Change from Prior Estimate:

The change is due to updated General and Online Drug ACLs, and increases in TSC costs.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the FI contract.
2. Costs are shared between FF and general funds (GF).
3. Medi-Cal Administration/Operations costs are funded at 75% FF and 25% GF
4. 16.1% of the TSC costs are funded at 50% GF and 83.9% of TSC costs are funded at 25% GF.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 54

FY 2015-16	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	\$60,151,000	\$21,052,000	\$39,099,000
On-Line ACLs (75% FF/25% GF, 50% FF/50% GF)	\$4,448,000	\$1,557,000	\$2,891,000
Prospective DUR (75% FF/25% GF)	\$320,000	\$80,000	\$240,000
Retrospective DUR (50% FF/50% GF)	\$76,000	\$38,000	\$38,000
Encounter Claim Lines (75% FF/25% GF)	\$530,000	\$133,000	\$397,000
CA-EVS/CMS Processing (75% FF/25% GF)	\$4,800,000	\$1,200,000	\$3,600,000
Medicare Drug Discount (100% GF)	\$17,000	\$17,000	\$0
TARS (75% FF/25% GF)	\$9,900,000	\$2,475,000	\$7,425,000
TSC (75% FF/25% GF, 50% FF/50% GF)	\$13,500,000	\$3,919,000	\$9,581,000
Total Operations Costs	\$93,742,000	\$30,471,000	\$63,271,000

FY 2016-17	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	\$56,709,000	\$19,848,000	\$36,861,000
On-Line ACLs (75% FF/25% GF, 50% FF/50% GF)	\$4,416,000	\$1,546,000	\$2,870,000
Prospective DUR (75% FF/25% GF)	\$320,000	\$80,000	\$240,000
Retrospective DUR (50% FF/50% GF)	\$76,000	\$38,000	\$38,000
Encounter Claim Lines (75% FF/25% GF)	\$635,000	\$158,750	\$476,250
CA-EVS/CMS Processing (75% FF/25% GF)	\$4,900,000	\$1,225,000	\$3,675,000
Medicare Drug Discount (100% GF)	\$17,000	\$17,000	\$0
TARS (75% FF/25% GF)	\$9,900,000	\$2,475,000	\$7,425,000
TSC (75% FF/25% GF, 50% FF/50% GF)	\$13,500,000	\$3,919,000	\$9,581,000
Total Operations Costs	\$90,473,000	\$29,306,750	\$61,166,250

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI SYSTEM REPLACEMENT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 55
 IMPLEMENTATION DATE: 12/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1924

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$49,644,000	\$67,423,000
STATE FUNDS	\$7,808,950	\$10,605,500
FEDERAL FUNDS	\$41,835,050	\$56,817,500

DESCRIPTION

Purpose:

This policy change estimates the California Medicaid Management Information System (CA-MMIS) replacement costs.

Authority:

Contract#09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

System Replacement (SR) constitutes the contractual responsibilities required for the Contractor to replace the existing CA-MMIS, as defined by the FI Contract. The Department plans to replace the 30-year old CA-MMIS, which ensures timely and accurate claims processing for Medical providers. The Department continues to update the current system to incorporate technological advances. The updates address new business and legislative requirements. The CA-MMIS legacy system is extremely complex, difficult to maintain, and near the end of its useful life cycle. There are five Releases:

- Release 1: Health Enterprise Framework
- Release 2: Initial Claims Processing
- Release 3: Pharmacy, Medical Supplies, PADs, and Long Term Care Claims and Drug Rebate
- Release 4: Medical Authorizations and Claims
- Release 5: Claims and Supporting Processes

At the end of each Release, business functionality is provided the Department in the form of code that can be transferred into the system and built upon in future Releases. This solution is more beneficial to the Department than the previous approach, which did not provide business functionality until the completion of the project. Currently, while the System Replacement aspect of the FI contract details works to be done in the original approach and in phases, an amendment to formally reflect the new approach, its Releases, processes, milestones, and payment implications, is currently under

MEDICAL FI SYSTEM REPLACEMENT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 55

development. This approach, although not specifically detailed in the contract, is how CA-MMIS manages the project and any future payments for SRP would only be made after the finalizing the amendment.

Reason for Change from Prior Estimate:

The change is due to the delay of Releases scheduled for FY 2015-16 as well as a shift in payments due to the pending amendment. Further payments will not be made prior to the approval of the amendment.

Methodology:

1. Costs are shared between federal funds (FF) and general funds (GF).

FY	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
SR Costs	\$49,644,000	\$7,809,000	\$41,835,000	\$67,423,000	\$10,606,000	\$56,817,000

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

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

FI 100% GF (4260-101-0001)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 56
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1917

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$39,547,000	\$30,307,000
STATE FUNDS	\$11,420,800	\$9,423,550
FEDERAL FUNDS	\$28,126,200	\$20,883,450

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract #09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.
- Parcel Services and Common Carriers - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.
- Personal Computers, Monitors, Printers, Related Equipment, and Software – The installation and monthly charges for data lines; and the purchase, lease, installation, and maintenance of desktops for State staff at Field Office and Contractor facilities, or at the Direction of the Contracting Officer and Point-of-Sale (POS) devices.
- Printing – Costs to print the forms, documents, and other State program printing requests as

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 56

directed by the State.

- Telephone Toll Charges – Actual telecommunication charges paid for by the Contractor for maintaining toll-free lines available to providers and beneficiaries, telephone lines for audiotext equipment, Computer Media claims, TAR submissions, the Print and Distribution Center, on-line pharmacy claims processing and on-line eligibility verification, and any other beneficiary or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.
- Data Center Access – Actual charges incurred by the Contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.
- Special Training Sessions – Payment for training sessions that exceeds the fixed price training bid.
- Facilities Improvement and Modifications – The direct costs for modifications and improvements to facilities, for the purposes of housing State or federal on-site audit and monitoring staff.
- Audits and Research – Annual audits for the Electronic Data Processing Application System shall be cost reimburse for the direct cost of the audit as paid to the independent auditor by the Contractor, excluding procurement costs or effort expended by the Contractor.
- Sales Tax – The Department will reimburse the Contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the Operations of this Contract.
- Change Order and/or Amendments – Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.
- The Medi-Cal Print and Distribution Center – Contractor shall be reimbursed for the Medi-Cal Print and Distribution Center staff required to perform the functions of printing as described in the Contract. The Department will also reimburse the Contractor for all space, cost of equipment, fire suppressant system, cabinets, staff, printing and distribution services.
- Drug Use Review (DUR) and Eligibility Verification Telecommunications – Real-time drug use approvals and eligibility verifications that take place via California Point of Services.
- Field Office Automation Group (FOAG) equipment and furniture – Direct costs incurred for the purchase and maintenance of computer equipment and furniture for FOAG staff located in State offices. Excludes supplies, purchase and maintenance for computer equipment and furniture in TAR Processing Centers.
- Independent Verification & Validation (IV&V) and Consultant Contracts – IV&V and Consultant Contracts utilized for Operational project oversight that are paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 56

Reason for Change from Prior Estimate:

The change is due to cost reimbursable items related to ICD-10 not being paid in FY 2014-15. Costs therefore, shifted from FY 2014-15 to FY 2015-16.

Methodology:

1. Contract costs are shared between federal funds (FF) and general funds (GF).

FY 2015-16	TF	GF	FF
Postage (50% FF/50% GF)	\$2,683,000	\$1,341,500	\$1,341,500
Parcel Services & Common Carriers (50% FF/50% GF)	\$109,000	\$54,500	\$54,500
Equipment/Services (50% FF/50% GF, 75% FF/25% GF)	\$7,878,000	\$2,007,000	\$5,871,000
Print/Distribut. Center (75% FF/25% GF, 50% FF/50% GF)	\$1,152,000	\$460,750	\$691,250
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	\$1,648,000	\$618,000	\$1,030,000
Facilities Improvement & Modification (50% FF/50% GF)	\$713,000	\$356,500	\$356,500
Audits & Research (50% FF/50% GF)	\$800,000	\$400,000	\$400,000
Change Orders (50% FF/50% GF)	\$8,000	\$4,000	\$4,000
Sales Tax (75% FF/25% GF)	\$5,330,000	\$1,332,500	\$3,997,500
Consultant Contracts (75% FF/25% GF, 90% FF/10%)	\$15,114,000	\$3,665,000	\$11,449,000
Telecommunication (75% FF / 25% GF)	\$1,291,000	\$322,750	\$968,250
Other Cost Reimb. Items (50% FF/50% GF, 90% FF/10%)	\$2,821,000	\$858,500	\$1,962,500
Total	\$39,547,000	\$11,421,000	\$28,126,000

FY 2016-17	TF	GF	FF
Postage (50% FF/50% GF)	\$2,683,000	\$1,341,500	\$1,341,500
Parcel Services & Common Carriers (50% FF/50% GF)	\$109,000	\$54,500	\$54,500
Equipment/Services (50% FF/50% GF, 75% FF/25% GF)	\$5,537,000	\$1,421,750	\$4,115,250
Print/Distribut. Center (75% FF/25% GF, 50% FF/50% GF)	\$1,383,000	\$553,250	\$829,750
Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	\$1,977,000	\$741,500	\$1,235,500
Facilities Improvement & Modification (50% FF/50% GF)	\$778,000	\$389,000	\$389,000
Audits & Research (50% FF/50% GF)	\$400,000	\$200,000	\$200,000
Change Orders (50% FF/50% GF)	\$0	\$0	\$0
Sales Tax (75% FF/25% GF)	\$5,084,000	\$1,271,000	\$3,813,000
Consultant Contracts (75% FF/25% GF, 90% FF/10%)	\$9,336,000	\$2,264,000	\$7,072,000
Telecommunication (75% FF / 25% GF)	\$1,291,000	\$322,750	\$968,250
Other Cost Reimb. Items (50% FF/50% GF, 90% FF/10%)	\$1,729,000	\$864,500	\$864,500
Total	\$30,307,000	\$9,423,750	\$20,883,250

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF/25% GF (4260-101-0001/0890)

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

FI HIPAA 50% FF / 50% GF (4260-117-0001/0890)

FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)

FI HIPAA 90% FF / 10% GF (4260-117-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1918

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$23,077,000	\$23,072,000
STATE FUNDS	\$5,018,350	\$5,517,800
FEDERAL FUNDS	\$18,058,650	\$17,554,200

DESCRIPTION

Purpose:

This policy change estimates the hourly reimbursement costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract #09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG) and Field Office Automation Group (FOAG) Pharmacists. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the CA-MMIS. FOAG Pharmacists administer processes and review drug Treatment Authorization Requests (TAR) in accordance with the Department's criteria, guidelines and policy. They provide consultation services to Contractor staff consultants, physicians, nurses, and Field Office personnel. FOAG Pharmacists independently evaluate and adjudicate TARs and maintain currency with continuously evolving healthcare practices, equipment and technology.

Reason for Change from Prior Estimate:

The change is due to an increase in estimated billable SG hours.

Methodology:

1. SG costs are based on Contract Bid Price for SG Hourly Reimbursements.
2. Costs are shared between federal funds (FF) and general funds (GF), based on fixed price Base Volume Method of Payment bid rates.

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 57

FY 2015-16	TF	GF	FF
Systems Group			
Non-HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	\$12,514,000	\$3,065,000	\$9,449,000
HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	\$10,012,000	\$1,815,000	\$8,197,000
Systems Group Total	\$22,526,000	\$4,880,000	\$17,646,000
FOAG Pharmacists (75% FF / 25% GF)	\$551,000	\$138,000	\$413,000
Total Hourly Reimbursement	\$23,077,000	\$5,018,000	\$18,059,000

FY 2016-17	TF	GF	FF
Systems Group			
Non-HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	\$12,931,000	\$3,108,000	\$9,823,000
HIPAA (75% FF / 25% GF and 90% FF / 10% GF)	\$9,595,000	\$2,273,000	\$7,322,000
Systems Group Total	\$22,526,000	\$5,381,000	\$17,145,000
FOAG Pharmacists (75% FF / 25% GF)	\$546,000	\$137,000	\$409,000
Total Hourly Reimbursement	\$23,072,000	\$5,518,000	\$17,554,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

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

FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)

FI HIPAA 90% FF / 10% GF (4260-117-0001/0890)

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 58
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1921

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$20,978,000	\$10,532,000
STATE FUNDS	\$4,178,300	\$3,083,000
FEDERAL FUNDS	\$16,799,700	\$7,449,000

DESCRIPTION

Purpose:

This policy change estimates the total of other estimated costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract#09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Costs under this category consist of payment to the Contractor for other contract services, such as:

- Beneficiary ID Cards (BIC) – Plastic card issued by the Department to each Medi-Cal recipient.
- Health Access Program Cards (HAP) - Plastic card issued by the Department to beneficiaries participating in Family Planning, Access, Care, and Treatment (FPACT) and other special health care programs.
- Provision 11 & 57 – Provisions of the Contract that require all CA-MMIS hardware, equipment, and software Operations, technical standards, and supportive services meet all performance requirements for both Legacy and Replacement Systems.
- Rebate Accounting and Information System (RAIS) Medi-Cal – The processing of RAIS invoices/claims in fee-for-services.
- RAIS Managed Care Organizations (MCO) – The processing of RAIS invoices/claims for MCOs.
- Cost containment – Items brought to the attention of the Department by the Contractor that result in savings in Medi-Cal program expenditures and which the Contractor shares a portion of the savings.

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

- Fixed price hourly billable Systems Group: projects such as PAVE and ICD-10, etc.

Reason for Change from Prior Estimate:

Changes are due to changes in the individual categories including BIC, RAIS, cost containment, as well as the fixed billable remaining SG costs for the PAVE project shifting to FY 2015-16, with no payments being made in FY 2016-17.

Methodology:

1. Costs are shared between federal funds (FF) and general funds (GF).
2. Provision 11 & 57 are updated annually based on the General Adjudicated Claim Line (ACL) volume.
 FY 2015-16: \$0.01012 (Phase price per amendment) x 163,217,299 General ACLs = \$1,651,759
 FY 2016-17: \$0.01012 (Phase price per amendment) x 196,667,809 General ACLs = \$1,990,278
3. Payment calculated by a transaction rate multiplied by volume basis, based on Contract Year and General ACL volume.

FY 2015-16	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	\$1,200,000	\$300,000	\$900,000
Health Access Program Cards (75% FF / 25% GF)	\$280,000	\$70,000	\$210,000
Provision 11 & 57 (75% FF / 25% GF)	\$1,990,000	\$498,000	\$1,492,000
RAIS Medi-Cal (75% FF / 25% GF)	\$1,500,000	\$375,000	\$1,125,000
RAIS MCO (75% FF / 25% GF)	\$4,100,000	\$1,024,000	\$3,076,000
Cost Containment (50% FF / 50% GF)	\$1,800,000	\$900,000	\$900,000
Fixed Priced Billable SG (90% FF / 10% GF)	\$10,108,000	\$1,011,000	\$9,097,000
Total Other Estimated Costs	\$20,978,000	\$4,178,000	\$16,800,000

FY 2016-17	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	\$1,200,000	\$300,000	\$900,000
Health Access Program Cards (75% FF / 25% GF)	\$280,000	\$70,000	\$210,000
Provision 11 & 57 (75% FF / 25% GF)	\$1,652,000	\$413,000	\$1,239,000
RAIS Medi-Cal (75% FF / 25% GF)	\$1,500,000	\$375,000	\$1,125,000
RAIS MCO (75% FF / 25% GF)	\$4,100,000	\$1,025,000	\$3,075,000
Cost Containment (50% FF / 50% GF)	\$1,800,000	\$900,000	\$900,000
Total Other Estimated Costs	\$10,532,000	\$3,083,000	\$7,449,000

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF/25% GF (4260-101-0001/0890)

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

FI HIPAA 90% FF / 10% GF (4260-117-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI ENHANCEMENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 59
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1920

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$5,302,000	\$0
STATE FUNDS	\$635,200	\$0
FEDERAL FUNDS	\$4,666,800	\$0

DESCRIPTION

Purpose:

This policy estimates the cost of enhancements of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract#09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Enhancements are work activities that have been identified as a new feature or modification of an existing feature requiring a change to the automated system. The Contractor is paid for the Design, Development and Implementation of each Enhancement. Unlike regular operations activities, Enhancements are not always part of the FI Budget. Costs in this category may be due to new laws or regulations such as Health Insurance Portability and Accountability Act (HIPAA), International Classification of Diseases, 10th revision (ICD-10), Affordable Care Act (ACA), etc., that alter the bid requirements, changes in hardware or software requirements, technical and/or schedule delays that cause a shift in milestone payment dates, etc.

These cost categories consist of:

- HIPAA ICD-10 – Intended to modify the California Medicaid Management Information System (CA-MMIS) to accept and process all claims/transactions submitted with ICD-10 diagnosis and procedure codes in order for the Department to be HIPAA compliant.
- Business Rules Extraction (BRE) – Utilized to define a new rules base for the legacy MMIS and store the rules, once confirmed, in a requirements traceability tool for tracking future testing management and updating.

MEDICAL FI ENHANCEMENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 59

Reason for Change from Prior Estimate:

Project and invoicing delays resulted in a shift of costs from FY 2014-15 to FY 2015-16.

Methodology:

1. Costs are shared between federal funds (FF) and general funds (GF).

FY 2015-16	TF	GF	FF
HIPAA ICD-10 (100% GF, 90% FF/10% GF, 50% FF/50% GF)	\$3,302,000	\$395,000	\$2,907,000
BRE (100% GF, 90% FF / 10% GF, 50% FF / 50% GF)	\$2,000,000	\$240,000	\$1,760,000
Total	\$5,302,000	\$635,000	\$4,667,000

Funding:

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

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

FI 100% GF (4260-101-0001)

FI HIPAA 90% FF / 10% GF (4260-117-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 60
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1922

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$3,157,000	\$2,120,000
STATE FUNDS	\$1,083,250	\$691,000
FEDERAL FUNDS	\$2,073,750	\$1,429,000

DESCRIPTION

Purpose:

This policy change estimates the cost of miscellaneous expenses of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract #09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

Pursuant to an interagency agreement with the Department, the California State Controller's Office (CSCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption. The CSCO also provides the Department various administrative and project activities as they relate to the electronic claims process for the Health Enterprise (HE) System.

Pursuant to an interagency agreement with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify that prospective providers are currently licensed prior to enrollment in the Medical program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

Pursuant to an interagency agreement with the Department, the California Office of Systems Integration (COSI) assists in the procurement of a consultant to perform an overall health assessment of the Department's California Medicaid Management Information System (CA-MMIS) Project.

Also included are the administrative costs for the Family Planning, Access, Care, and Treatment Family Pact (FPACT) program which provides services at no cost to low-income residents of reproductive age.

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 60

Reason for Change from Prior Estimate:

The changes are due to the addition of two new interagency agreements which have resulted in an increase in costs related to warrant and Remittance Advice Detail (RAD) production, and the addition of HE, and health assessment costs. FFACT costs, previously budgeted separately in the FI Estimate, have now been included in this policy change.

Methodology:

1. Costs are shared between federal funds (FF) and general funds (GF).

FY 2015-16	TF	GF	FF
CSCO - Warrants and RADs (75% FF / 25% GF)	\$1,331,000	\$332,750	\$998,250
CSCO - Postage (50% FF / 50% GF)	\$976,000	\$488,000	\$488,000
CSCO - HE Claims - Admin. (75% FF / 25% GF)	\$67,000	\$16,750	\$50,250
CSTO - Warrant Redemption (75% FF / 25% GF)	\$81,000	\$20,250	\$60,750
CDCA - Provider Verification File (75% FF / 25% GF)	\$2,000	\$500	\$1,500
COSI - CA-MMIS Health Assessment (75% FF / 25% GF)	\$500,000	\$125,000	\$375,000
FFACT (50% FF / 50% GF)	\$200,000	\$100,000	\$100,000
Total*	\$3,157,000	\$1,083,000	\$2,074,000

FY 2016-17	TF	GF	FF
CSCO - Warrants and RADs (75% FF / 25% GF)	\$1,331,000	\$332,750	\$998,250
CSCO - Postage (50% FF / 50% GF)	\$444,000	\$222,000	\$222,000
CSCO - HE Claims - Admin. (75% FF / 25% GF)	\$62,000	\$15,500	\$46,500
CSTO Warrant Redemption (75% FF / 25% GF)	\$81,000	\$20,250	\$60,750
CDCA -Provider Verification File (75% FF / 25% GF)	\$2,000	\$500	\$1,500
COSI - CA-MMIS Health Assessment (75% FF / 25% GF)	\$0	\$0	\$0
FFACT (50% FF / 50% GF)	\$200,000	\$100,000	\$100,000
Total	\$2,120,000	\$691,000	\$1,429,000

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI DIAGNOSIS RELATED GROUPS

OTHER ADMIN. POLICY CHANGE NUMBER: 61
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1919

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$70,000	\$26,000
STATE FUNDS	\$35,000	\$13,000
FEDERAL FUNDS	\$35,000	\$13,000

DESCRIPTION

Purpose:

This policy change estimates the cost of developing and implementing a Medical payment methodology based in Diagnostic Related Groups (DRG) to the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract #09-86210
 SB 853 Chapter 717, Statutes of 2010

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

SB 853 requires the Department to develop and implement a Medi-Cal payment methodology based on DRG. The DRG reflects the costs and staffing levels associated with quality of care for patients unless otherwise specified. As the implementation of SB 853 was not originally known or knowable at the time the Contract was procured, and requires an increased level of work and effort, the Department has agreed to reimburse Xerox for all documentable expenses that are as a direct result of efforts to implement the DRG requirement.

Reason for Change from Prior Estimate:

FY 2015-16 costs have decreased due to a reduction in billable hours. This Change Order (CO) will end June 30, 2016, resulting in a decrease in staffing and activities needed, such as, outreach and education.

Methodology:

1. Certain costs such as software, travel expenses, etc. can be paid through Cost Reimbursement. These costs are budgeted in the Medical FI Cost Reimbursement OA policy change.
2. The Contract allows for overhead and profit to be included in CO expenses, not to exceed thirty-percent.

MEDICAL FI DIAGNOSIS RELATED GROUPS

OTHER ADMIN. POLICY CHANGE NUMBER: 61

3. Assume this CO will end in June 30, 2016, and the last payment is expected to be made in FY 2016-17.
4. Costs are shared between federal funds (FF) and general funds (GF).
5. The administration costs of this policy change are budgeted below.

	FY 2015-16			FY 2016-17		
	TF	GF	FF	TF	GF	FF
DRG Administration	\$70,000	\$35,000	\$35,000	\$26,000	\$13,000	\$13,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 8/2016
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1923

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$0	\$804,000
STATE FUNDS	\$0	\$80,400
FEDERAL FUNDS	\$0	\$723,600

DESCRIPTION

Purpose:

This policy change estimates the cost of optional contractual services (OCS) of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract#09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Med-Cal beneficiaries. The FI Contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009 and became effective May 3, 2010, which began the takeover phase. The FI contract term runs through June 30, 2016, with five one year optional extensions which could extend the contract through June 30, 2021. The term Medical FI is also used interchangeably, to differentiate the Medical FI from the Dental FI, also overseen by the Department.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. OCS can apply to the CA-MMIS Legacy System or to the CA-MMIS Replacement System. Unlike regular operations activities, OCS are not always part of the FI Budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS. The identified costs are for the implementation of the Medicaid Incentive program, which provide incentives to providers who adopt and use Electronic Health Records in accordance with the Health Information Technology for Economic and Clinical Health Act.

Reason for Change from Prior Estimate:

Due to compliance issues related to OCS, no payments will be made in FY 2015-16.

Methodology:

- Costs are shared between federal funds (FF) and general funds (GF).

FY 2016-17	TF	GF	FF
OCS costs	\$804,000	\$80,000	\$724,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1856

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$52,650,000	\$39,189,000
STATE FUNDS	\$25,477,090	\$18,851,600
FEDERAL FUNDS	\$27,172,910	\$20,337,400

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Health Care Options (HCO) program.

Authority:

HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with current operations ending on December 31, 2018. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) (50/50 for Administration; and 65/35 or 88/12 for Medicaid Expansion Children's Health Insurance Program).

Operational costs are the routine expenses incurred by HCO's operations such as:

- Transactions – Enrollment or disenrollment processing activities and transactions with the Department.
- Mailings – Mailings include initial informing, re-informing, monthly reconciliation, and annual re-notification mailings.
- Beneficiary Dental Exception (BDE) Mailings – Mailings to dental beneficiaries in Sacramento County for exception to plan enrollment.
- Beneficiary Direct Assistance/Call Center – Telephone Call Center (TCC) agent informing and enrollment assistance to Medi-Cal applicants/beneficiaries and/or their authorized representatives in understanding, selecting, and using managed care medical and dental plans. In addition, the TCC assists providers, health plans, and counties or other interested parties who request information regarding the HCO program and/or Medi-Cal managed care.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 63

- Personalized Provider Directory (PPD) Project– Fixed price costs for the PPD Project.
- Seniors and Persons with Disabilities (SPD) County Inserts – Incremental Costs – Special inserts for SPD informing packets.
- Medi-Cal Publications Management Services – Publication management services for the development, revision, reproduction, and distribution of Medi-Cal publications that do not pertain to HCO informing materials.
- Initial Health Screen Questionnaire - Health Information Form (HIF) - The purpose of the HIF is to ensure applicants/beneficiaries with existing disabilities or with chronic conditions identify themselves to assure timely access to care. The HIFs are distributed and processed to be mailed with the HCO informing packet and are also available at Enrollment Service Representatives presentation sites.
- Base Volume Increase Projection - The estimated cost for the entire infrastructure necessary for HCO Operations for occurrences when current base contract volumes are exceeded from additional and new projects.
- Prior Year Unpaid Invoices - Prior year unpaid invoices will be accrued and paid in the following fiscal year.

Reason for change from Prior Estimate:

Prior year unpaid invoices for May and June of FY 2014-15 will be paid in FY 2015-16.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract.
2. Prior year unpaid invoices for May and June of FY 2014-15 will be paid in FY 2015-16 for a total of \$14,280,000.

(Dollars in Thousands)

FY 2015-16	TF	GF	FF	GF	FF	GF	FF
		Title XIX	Title XIX	Title XXI	Title XXI	Enhanced XXI	Enhanced XXI
		50%	50%	35%	65%	12%	88%
Transactions	\$10,665	\$5,066	\$5,066	\$47	\$87	\$48	\$352
Packet Mailings	\$7,857	\$3,732	\$3,732	\$34	\$64	\$35	\$259
BDE PacketMailings	\$183	\$87	\$87	\$1	\$1	\$1	\$6
BDA/Call Center	\$4,824	\$2,291	\$2,292	\$21	\$39	\$22	\$159
PPD	\$458	\$218	\$217	\$2	\$4	\$2	\$15
SPD Inserts	\$66	\$33	\$33	\$0	\$0	\$0	\$0
Medi-Cal Publications	\$394	\$187	\$187	\$2	\$3	\$2	\$13
HIF	\$174	\$83	\$82	\$1	\$1	\$1	\$6
Base Volume Increase	\$13,749	\$6,531	\$6,531	\$60	\$112	\$62	\$453
Prior Year Unpaid Invoices	\$14,280	\$6,783	\$6,783	\$62	\$116	\$64	\$471
Total	\$52,650	\$25,011	\$25,010	\$230	\$427	\$237	\$1,735

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 63

(Dollars in Thousands)

FY 2016-17	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	\$10,763	\$5,112	\$5,113	\$65	\$473
Packet Mailings	\$8,205	\$3,897	\$3,898	\$49	\$361
BDE PacketMailings	\$183	\$87	\$87	\$1	\$8
BDA/Call Center	\$4,979	\$2,365	\$2,365	\$30	\$219
PPD	\$669	\$318	\$318	\$4	\$29
SPD Inserts	\$66	\$33	\$33	\$0	\$0
Medi-Cal Publications	\$399	\$190	\$189	\$2	\$18
HIF	\$176	\$84	\$83	\$1	\$8
Base Volume Increase	\$13,749	\$6,531	\$6,531	\$82	\$605
Prior Year Unpaid Invoices	\$0	\$0	\$0	\$0	\$0
Total	\$39,189	\$18,617	\$18,617	\$234	\$1,721

Funding:

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

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

FI 88% Title XXI / 12% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1858

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$41,490,000	\$46,094,000
STATE FUNDS	\$20,076,400	\$22,170,720
FEDERAL FUNDS	\$21,413,600	\$23,923,280

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program.

Authority:

HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change from Prior Estimate:

The increase is due to hiring additional Systems Group (IT) staff for the increase in scope of work for new managed care populations and projects.

Methodology:

1. Contract costs are shared between federal funds (FF) and General Fund (GF).
2. Printing and postage line items include costs for all cost reimbursed mailings and the reduced costs from the mailings of Personalized Provider Directories (PPD) in the PPD counties of Sacramento and Los Angeles, in lieu of costs for mailing full county-wide provider directories. The printing and mailing of PPDs in Sacramento and Los Angeles counties in lieu of full county-wide directories is a cost savings to the Department, with total savings to date of \$23,044,048 for the time period of February 2009 through April 2015.

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 64

(Dollars in Thousands)	TF	GF	FF	GF	FF	GF	FF
		Title XIX	Title XIX	Title XXI	Title XXI	Enhanced XXI	Enhanced XXI
FY 2015-16		(50%)	(50%)	(35%)	(65%)	(12%)	(88%)
Postage	\$18,728	\$8,896	\$8,896	\$82	\$152	\$84	\$618
Printing	\$5,511	\$2,618	\$2,617	\$24	\$45	\$25	\$181
Other HCO Informing Materials	\$4,577	\$2,174	\$2,174	\$20	\$37	\$21	\$151
Customer Assistance Telephone	\$1,451	\$689	\$689	\$6	\$12	\$7	\$48
Development of New Informing Mat.	\$166	\$79	\$79	\$1	\$1	\$1	\$5
Translation Services	\$476	\$226	\$226	\$2	\$4	\$2	\$15
Data Access	\$396	\$188	\$188	\$2	\$3	\$2	\$14
Miscellaneous	\$1,106	\$525	\$526	\$5	\$9	\$5	\$36
Special Training Sessions	\$145	\$69	\$69	\$1	\$1	\$1	\$6
PCs, Printers, Copy Machines	\$103	\$49	\$49	\$0	\$1	\$0	\$3
Additional Systems Group Staff	\$1,672	\$794	\$794	\$7	\$13	\$7	\$54
Travel and Per Diem	\$126	\$60	\$60	\$1	\$1	\$1	\$4
Temporary Staff	\$583	\$277	\$277	\$3	\$5	\$3	\$19
Medi-Cal Publications Mailings	\$6,450	\$3,064	\$3,064	\$28	\$52	\$29	\$213
Total	\$41,490	\$19,708	\$19,708	\$181	\$337	\$187	\$1,368

(Dollars in Thousands)	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2016-17		(50%)	(50%)	(12%)	(88%)
Postage	\$20,601	\$9,785	\$9,786	\$124	\$906
Printing	\$6,062	\$2,879	\$2,880	\$36	\$267
Other HCO Informing Materials	\$5,035	\$2,392	\$2,391	\$30	\$222
Customer Assistance Telephone	\$1,596	\$758	\$758	\$10	\$70
Development of New Informing Mat.	\$183	\$87	\$87	\$1	\$8
Translation Services	\$524	\$249	\$248	\$3	\$24
Data Access	\$435	\$207	\$206	\$3	\$19
Miscellaneous	\$1,217	\$578	\$578	\$7	\$54
Special Training Sessions	\$160	\$76	\$76	\$1	\$7
PCs, Printers, Copy Machines	\$114	\$54	\$54	\$1	\$5
Additional Systems Group Staff	\$4,337	\$2,060	\$2,060	\$26	\$191
Travel and Per Diem	\$139	\$66	\$66	\$1	\$6
Temporary Staff	\$641	\$304	\$305	\$4	\$28
Medi-Cal Publications Mailings	\$5,050	\$2,399	\$2,399	\$30	\$222
Total	\$46,094	\$21,894	\$21,894	\$277	\$2,029

Funding:

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

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

FI 88% Title XXI / 12% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO CCI - CAL MEDICCONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1860

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$18,357,000	\$11,665,000
STATE FUNDS	\$9,178,500	\$5,832,500
FEDERAL FUNDS	\$9,178,500	\$5,832,500

DESCRIPTION

Purpose:

This policy change estimates the costs for the specialized call center and informing materials to transition dually eligible and Medi-Cal only beneficiaries into managed care health plans under the Coordinated Care Initiative (CCI).

Authority:

HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the Health Care Options (HCO) program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care institutional services, In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services Program, and other Home and Community-Based Services from fee-for-service into managed care health plans. Notices and packets have been mailed to beneficiaries.

In addition, to ensure a seamless enrollment selection process for beneficiaries impacted by the upcoming CCI programs, costs have been included for a beneficiary-centric specialized call center and specialized informing materials. The beneficiaries covered under this project will have a dedicated toll free number, which directs them to their own specialized team of CCI experts who will guide them through the enrollment process and be able to answer all the Medi-Cal and Medicare questions.

Reason for change from Prior Estimate:

Costs for FY 2015-16 increased due to the addition of telephone call center (TCC) staffing through September 2016.

HCO CCI - CAL MEDICCONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 65

Methodology:

1. Costs are negotiated through a contract amendment with a term through December 31, 2016.
Costs include informing materials development and mailing, CCI telephone call center staffing and equipment, and translations of informing materials into Braille and audio formats.
2. The FY 2015-16 and FY 2016-17 costs are below:

	FY 2015-16	FY 2016-17
Printing/Postage	\$8,103,000	\$2,102,000
Equipment/Non-Equipment	\$1,174,000	\$989,000
Staffing	\$9,080,000	\$8,574,000
Total	\$18,357,000	\$11,665,000

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2015-16	\$18,357,000	\$9,178,000	\$9,179,000

	TF	GF	FF
FY 2016-17	\$11,665,000	\$5,833,000	\$5,832,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1864

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$17,633,000	\$10,262,000
STATE FUNDS	\$8,532,550	\$4,936,440
FEDERAL FUNDS	\$9,100,450	\$5,325,560

DESCRIPTION

Purpose:

This policy change estimates the costs for additional resources for the Health Care Options (HCO) program to provide informing and enrollment assistance to beneficiaries eligible for Medi-Cal.

Authority:

HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

The enrollment contractor will require additional resources in its telephone call center to adequately and effectively provide informing and enrollment assistance functions to the increasing numbers of Medi-Cal beneficiaries for the following changes:

- Effective January 1, 2014, the ACA established a new income eligibility standard for Medi-Cal, based upon a Modified Adjusted Gross Income of 133% of the federal poverty level for adults.
- California enacted legislation to establish eligibility for full scope Medi-Cal benefits for undocumented children under 19 years of age.

Reason for change from Prior Estimate:

The contractor costs for the expansion of full-scope coverage to undocumented children were added to this policy change.

Methodology:

1. Costs are negotiated per agent/person costs through a contract amendment.
2. Contract costs are shared between federal funds (FF) and General Fund (GF).

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 66

	FY 2015-16	FY 2016-17
Telephone Call Center (TCC) Enrollment Operations	\$7,871,000	\$5,970,000
System Group Staff	\$2,404,000	
TCC and Postage and Printing Cost for Undoc. Children	\$7,358,000	\$4,292,000
Total	\$17,633,000	\$10,262,000

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$16,752	\$8,376	\$8,376
Title XXI (65% FF / 35% GF)	\$221	\$77	\$144
Enhanced Title XXI (88% FF / 12% GF)	\$660	\$79	\$581
Total	\$17,633	\$8,532	\$9,101
FY 2016-17	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$9,750	\$4,875	\$4,875
Enhanced Title XXI (88% FF / 12% GF)	\$512	\$62	\$450
Total	\$10,262	\$4,937	\$5,325

Funding:

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

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

FI 88% Title XXI / 12% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1857

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$13,716,000	\$14,013,000
STATE FUNDS	\$6,636,650	\$6,740,120
FEDERAL FUNDS	\$7,079,350	\$7,272,880

DESCRIPTION

Purpose:

This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program.

Authority:

HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for HCO since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

An important goal of the HCO program is to provide every Medi-Cal applicant/ beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

2. Costs are shared between federal funds (FF) and General Fund (GF).
 - 50/50 for Administration,
 - 65/35 for Medicaid Expansion Children's Health Insurance Program (MCHIP), and
 - 88/12 for Medicaid Expansion MCHIP (starting October 2015).
3. The estimated costs for FY 2015-16 and FY 2016-17 are based on 155 ESRs per year.

FY 2015-16	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$13,030,000	\$6,515,000	\$6,515,000
Title XXI (65% FF / 35% GF)	\$171,000	\$60,000	\$111,000
Title XXI (88% FF / 12% GF)	\$515,000	\$62,000	\$453,000
Total	\$13,716,000	\$6,637,000	\$7,079,000

FY 2016-17	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$13,312,000	\$6,656,000	\$6,656,000
Title XXI (88% FF / 12% GF)	\$701,000	\$84,000	\$617,000
Total	\$14,013,000	\$6,740,000	\$7,273,000

Funding:

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

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

FI 88% Title XXI / 12% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 68
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1862

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$727,000	\$0
STATE FUNDS	\$363,500	\$0
FEDERAL FUNDS	\$363,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the informing and enrollment costs for Seniors and Persons with Disabilities (SPD) transitioning into managed care rural counties.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 HCO contract #07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the Health Care Options program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care (GMC), San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Prior to the implementation of AB 1467, managed care was in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

The first phase of expansion was implemented on September 1, 2013, in the eight County Organized Health System (COHS) counties, and was followed by the remaining 20 counties (Two-Plan, GMC-Plan and Single-Plan models) on November 1, 2013. Informing material mailings to beneficiaries (special notices, frequently asked questions, and special packets) started for COHS counties in July 2013. The 20 Two-Plan, GMC-Plan, and Single-Plan model counties will require newly established enrollment presentation sites and the hiring, training, and equipment costs associated with staffing these county enrollment sites. County site staffing started in 2013.

SPDs transitioned from fee-for-service to managed care in the rural counties on December 1, 2014. The enrollment contractor will incur additional costs to provide call center support and special informing and enrollment assistance to this SPD transition population through December 31, 2015.

Reason for change from Prior Estimate:

There is no change.

HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 68

Methodology:

1. Costs are negotiated per agent costs through a contract amendment.
2. Costs are shared between federal funds (FF) and General Fund(GF).

	FY 2015-16
QA Analyst Staff	\$21,000
Customer Service Representatives	\$706,000
Total	\$727,000

	TF	GF	FF
FY 2015-16	\$727,000	\$363,000	\$364,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 69
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1887

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$82,288,000	\$85,134,000
STATE FUNDS	\$26,734,000	\$27,689,250
FEDERAL FUNDS	\$55,554,000	\$57,444,750

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Dental Fiscal Intermediary (FI) contract.

Authority:

Contract #04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Dental Medicaid Management Information System (CD-MMIS). These cost categories consist of:

- General Adjudicated Claim Service Lines (ACSLs) – Lines of service associated with a Medi-Cal dental claim. Payments to FI are based on the number of ACSL's processed.
- Treatment Authorization Requests (TARS) - Prior authorization for treatment in accordance with Medi-Cal dental policy and procedures when prior authorization is required.
- Telephone Service Center (TSC) - Telephone activities to support effective provider and beneficiary service operations and meet all applicable performance standards.

Delta has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

DENTAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 69

Reason for change from Prior Estimate:

FY 2015-16 costs increased slightly due to updated estimates based on actual ACSL, TAR, and TSC minute volumes and caseload adjustments. Additionally, per the FI contract, processing rates are currently increased annually by the California Consumer Price Index.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the Dental FI contract.
2. ACSL/TAR volumes determine the Dental Administration/Operations costs. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.
 - a. Provider Enrollment costs:
 - i. 69% of costs are funded at 50% FF and 50% GF
 - ii. 31% of costs are funded at 75% FF and 25% GF
 - b. Remaining costs are funded at 75% FF and 25% GF
3. TSC costs:
 - a. 69% of costs are funded at 50% FF and 50% GF
 - b. 31% of costs are funded at 75% FF and 25% GF

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$46,567	\$11,642	\$34,925
Provider Enrollment (50% FF / 50% GF and 75% FF / 25% GF)	\$8,217	\$3,472	\$4,745
Total ACSL/TAR	\$54,784	\$15,114	\$39,670
TSC - Provider (50% FF / 50% GF and 75% FF / 25% GF)	\$18,080	\$7,638	\$10,442
TSC - Beneficiary (50% FF / 50% GF and 75% FF / 25% GF)	\$9,424	\$3,982	\$5,442
Total TSC	\$27,504	\$11,620	\$15,884
Total Operations Costs	\$82,288	\$26,734	\$55,554

DENTAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 69

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$47,999	\$12,000	\$35,999
Provider Enrollment (50% FF / 50% GF and 75% FF / 25% GF)	\$8,471	\$3,579	\$4,892
Total ACSL/TAR	\$56,470	\$15,579	\$40,891
TSC – Provider (50% FF / 50% GF and 75% FF / 25% GF)	\$18,855	\$7,966	\$10,889
TSC – Beneficiary (50% FF / 50% GF and 75% FF / 25% GF)	\$9,809	\$4,144	\$5,665
Total TSC	\$28,664	\$12,110	\$16,554
Total Operations Costs	\$85,134	\$27,689	\$57,445

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1888

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$12,334,000	\$12,769,000
STATE FUNDS	\$3,083,500	\$3,192,250
FEDERAL FUNDS	\$9,250,500	\$9,576,750

DESCRIPTION

Purpose:

This policy change estimates the hourly reimbursement costs of the Dental Fiscal Intermediary (FI) contract.

Authority:

Contract #04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities. Hourly reimbursed areas consist of the Systems Group (SG), Surveillance and Utilization Review (SURS) unit, and computer support. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the California Dental Medicaid Management Information Systems. The SURS staff consists of dental consultants, manager/supervisors, liaisons, and analysts that monitor the provider and beneficiary claims to prevent potential fraud and abuse.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. SG costs are based on the Contract Bid Price for SG Hourly Reimbursements.
2. SURS costs are based on the Contract Bid Price for SURS Hourly Reimbursements.

DENTAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 70

3. Costs are shared between federal funds (FF) and General Fund(GF).

FY 2015-16	TF	GF	FF
Systems Group (SG)	\$6,816,000	\$1,704,000	\$5,112,000
HIPAA SG	\$840,000	\$210,000	\$630,000
SURS	\$4,678,000	\$1,169,000	\$3,509,000
Total	\$12,334,000	\$3,083,000	\$9,251,000

FY 2016-17	TF	GF	FF
Systems Group (SG)	\$6,986,000	\$1,746,000	\$5,240,000
HIPAA SG	\$940,000	\$235,000	\$705,000
SURS	\$4,843,000	\$1,211,000	\$3,632,000
Total	\$12,769,000	\$3,192,000	\$9,577,000

Funding:

FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1889

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$7,369,000	\$7,444,000
STATE FUNDS	\$3,504,250	\$3,541,750
FEDERAL FUNDS	\$3,864,750	\$3,902,250

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Dental Fiscal Intermediary (FI) contract.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the FI services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

The terms of the contract require Delta to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Printing,
2. Data center access,
3. Postage, parcel services, and common carriers,
4. Special training sessions, convention, and travel,
5. Audits and research,
6. Facilities improvement,
7. Telephone toll charges,
8. Knox Keene License Annual Assessment, and
9. Miscellaneous.

DENTAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 71

Costs under these categories consist of direct costs, or a subset thereof, which can be specifically identifiable with the particular cost objective.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. Costs are shared between federal funds (FF) and General Fund (GF).

FY 2015-16	TF	GF	FF
Printing (50% FF / 50% GF)	\$1,300,000	\$650,000	\$650,000
Data Center Access (75% FF / 25% GF)	\$1,000	\$250	\$750
Postage/Parcel Service (50% FF / 50% GF)	\$1,500,000	\$750,000	\$750,000
Special Training, Conf., Travel (50% FF / 50% GF)	\$130,000	\$65,000	\$65,000
Audits (50% FF / 50% GF)	\$170,000	\$85,000	\$85,000
Facilities Improvement (75% FF / 25% GF)	\$110,000	\$27,500	\$82,500
Toll Free Phone Charges (75% FF / 25% GF)	\$610,000	\$152,500	\$457,500
Knox-Keene Annual Assess. (50% FF / 50% GF)	\$2,898,000	\$1,449,000	\$1,449,000
Misc. (50% FF / 50% GF)	\$650,000	\$325,000	\$325,000
Total*	\$7,369,000	\$3,504,000	\$3,865,000

FY 2016-17	TF	GF	FF
Printing (50% FF / 50% GF)	\$1,300,000	\$650,000	\$650,000
Data Center Access (75% FF / 25% GF)	\$1,000	\$250	\$750
Postage/Parcel Service (50% FF / 50% GF)	\$1,500,000	\$750,000	\$750,000
Special Training, Conf., Travel (50% FF / 50% GF)	\$130,000	\$65,000	\$65,000
Audits (50% FF / 50% GF)	\$170,000	\$85,000	\$85,000
Facilities Improvement (75% FF / 25% GF)	\$110,000	\$27,500	\$82,500
Toll Free Phone Charges (75% FF / 25% GF)	\$610,000	\$152,500	\$457,500
Knox-Keene Annual Assess. (50% FF / 50% GF)	\$2,898,000	\$1,449,000	\$1,449,000
Misc. (50% FF / 50% GF)	\$725,000	\$363,000	\$362,000
Total*	\$7,444,000	\$3,542,000	\$3,902,000

*Totals may differ due to rounding.

Funding:

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

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI FEDERAL RULE - REVALIDATION

OTHER ADMIN. POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1893

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,438,000	\$1,438,000
STATE FUNDS	\$719,000	\$719,000
FEDERAL FUNDS	\$719,000	\$719,000

DESCRIPTION

Purpose:

This policy change estimates the cost of additional workload of the Dental Fiscal Intermediary (FI) contract as a result of the CMS mandated federal rules that apply to the Medi-Cal Dental Program. The additional workload includes the revalidation of the enrollment of all providers at least once every five years.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the fiscal intermediary (FI) services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

Effective March 2011, CMS mandated federal rules that apply to the Medi-Cal Dental Program. The current CMS rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

The Department must revalidate the enrollment all providers regardless of provider type at least once every 5 years. The Department is allowed to use the results of the provider screening performed by Medicare contractors and has delegated this to the FI. To work towards compliance, Delta hired additional staff to complete the increased workload.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. Costs are estimated based on the number of completed packets received from current providers revalidating their enrollment information.
2. The average monthly number of revalidations is 258.25 and the rate per revalidation is \$464. The annual cost impact based on the number of completed revalidation packets received is estimated at \$1,438,000 TF (\$719,000 GF).

DENTAL FI FEDERAL RULE - REVALIDATION

OTHER ADMIN. POLICY CHANGE NUMBER: 72

FY 2015-16: 258.25 revalidations x \$464 per revalidation x 12 months = **\$1,438,000 TF****FY 2016-17:** 258.25 revalidations x \$464 per revalidation x 12 months = **\$1,438,000 TF**

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2015-16	\$1,438,000	\$719,000	\$719,000

	TF	GF	FF
FY 2016-17	\$1,438,000	\$719,000	\$719,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI FEDERAL RULE - DATABASE CHECKS

OTHER ADMIN. POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1894

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$375,000	\$375,000
STATE FUNDS	\$187,500	\$187,500
FEDERAL FUNDS	\$187,500	\$187,500

DESCRIPTION

Purpose:

This policy change estimates the cost of additional workload of the Dental Fiscal Intermediary (FI) contract as a result of the CMS mandated federal rules that apply to the Medi-Cal Dental Program. This additional workload is due to the Department checking specified federal databases for enrollment and reenrollment to confirm the identity and exclusion status of providers and any person with a controlling interest.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the fiscal intermediary (FI) services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

Effective March 2011, CMS mandated federal rules that apply to the Medi-Cal Dental Program. The current CMS rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

The Department must confirm the identity upon enrollment and reenrollment and determine the exclusion status of providers, and any person with an ownership or controlling interest, or who is an agent or managing employee of the provider through routine database checks. This includes checking specific federal databases and checking at least the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) monthly. To work towards compliance, Delta hired additional staff to complete the increased workload.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. Costs are estimated based on Federal Database Checks which are required monthly from the LEIE and EPLS databases.

DENTAL FI FEDERAL RULE - DATABASE CHECKS

OTHER ADMIN. POLICY CHANGE NUMBER: 73

2. The average monthly number of Federal Database Checks performed is 20,292 and the rate per Database Check is \$1.54. The annual cost impact based on the number of Federal Database Checks performed is estimated at \$375,000 TF (\$187,500 GF).

FY 2015-16: 20,292 checks x \$1.54 per check x 12 months = **\$375,000 TF**

FY 2016-17: 20,292 checks x \$1.54 per check x 12 months = **\$375,000 TF**

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2015-16	\$375,000	\$187,500	\$187,500

	TF	GF	FF
FY 2016-17	\$375,000	\$187,500	\$187,500

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 74
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1892

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$320,000	\$320,000
STATE FUNDS	\$80,000	\$80,000
FEDERAL FUNDS	\$240,000	\$240,000

DESCRIPTION

Purpose:

This policy change budgets the cost of establishing the Department's implementation plan designed to comply with the controls required by the National Institute of Standards and Technology (NIST). The Department implements the Health Insurance Portability and Accountability Act's (HIPAA) Security Rule based on the latest NIST guidelines.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the fiscal intermediary services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

HIPAA's Security Rule covers the steps in the Risk Management Framework that address security control selection for federal information systems in accordance with the security requirements in Federal Information Processing Standard 200. Compliance with the NIST controls will result in increased requirements to the Security and Privacy Laws and regulations required by Contract 04-35745, Exhibit H, the HIPAA Business Associate Addendum. This policy change establishes the Department's implementation plan to comply with NIST to continue the security risk assessment process for all current and future projects.

Reason for change from Prior Estimate:

There is no change.

Methodology:

1. The security risk assessment process costs are based upon the hours required to ensure compliance with the controls required by NIST.

DENTAL FI HIPAA ADDENDUM SECURITY RISK ASSESSMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 74

2. The cost break down for billable hours for the security risk assessment process is projected at 114 hours per month billed at \$234 per hour for a monthly estimated total of \$26,676, resulting in estimated yearly costs of \$320,000 TF (\$80,000 GF).

FY 2015-16: 114 hours/month x \$234/hour x 12 months = **\$320,000 TF**

FY 2016-17: 114 hours/month x \$234/hour x 12 months = **\$320,000 TF**

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2015-16	\$320,000	\$80,000	\$240,000

	TF	GF	FF
FY 2016-17	\$320,000	\$80,000	\$240,000

Funding:

FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER: 75
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1891

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$195,000	\$195,000
STATE FUNDS	\$97,500	\$97,500
FEDERAL FUNDS	\$97,500	\$97,500

DESCRIPTION

Purpose:

This policy change estimates the cost of additional workload of the Dental Fiscal Intermediary (FI) contract as a result of the *Conlan, Schwarzmer, Stevens v. Bontá* case ruling.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the fiscal intermediary (FI) services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

In the case of *Conlan, Schwarzmer, Stevens v. Bontá*, the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can be reimbursed for their out-of-pocket expenses for health care received during their period of retroactive eligibility and during the period between their application for Medi-Cal and their determination of eligibility. The Court held that the Department's system of relying upon the beneficiaries to obtain reimbursement from the providers for these expenses is insufficient, because it violates the comparability provisions of the Medicaid law.

The Department has developed and implemented new processes through the Dental FI to ensure prompt reimbursement to beneficiaries. The Dental FI is required to hire, train, and oversee appropriate staff to address this new workload.

Reason for change from Prior Estimate:

There is no change.

Methodology:

- 1) Costs are estimated based on the number of Correspondence Counts which include the Conlan Mailed Beneficiary Claim Packets and related documents. These include the initial paperwork that beneficiaries complete and Dental FI's status letters that are sent to beneficiaries and providers.

DENTAL FI CONLAN, SCHWARZMER, STEVENS V. BONTA

OTHER ADMIN. POLICY CHANGE NUMBER: 75

- 2) The average monthly number of Correspondence Counts is 120 and the rate per Correspondence Counts is \$135.14. The annual cost impact based on the number of Correspondence Counts is estimated at \$195,000 TF (\$97,500 GF).

FY 2015-16: 120 counts x \$135.14 per count x 12 months = **\$195,000 TF**

FY 2016-17: 120 counts x \$135.14 per count x 12 months = **\$195,000 TF**

- 3) Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2015-16	\$195,000	\$97,500	\$97,500

	TF	GF	FF
FY 2016-17	\$195,000	\$97,500	\$97,500

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 76
IMPLEMENTATION DATE: 12/2015
ANALYST: Sandra Bannerman
FISCAL REFERENCE NUMBER: 1890

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$77,000	\$20,000
STATE FUNDS	\$19,250	\$5,000
FEDERAL FUNDS	\$57,750	\$15,000

DESCRIPTION

Purpose:

This policy change estimates the cost of the base California Dental Medicaid Management Information System's (CD-MMIS) additional contractual services of the Dental Fiscal Intermediary (FI) contract.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental of California (Delta) was awarded a multi-year contract in 2004. Delta is responsible for all the fiscal intermediary (FI) services, including claims processing, provider enrollment, outreach, and the underwriting of the Medi-Cal Dental Program. The Department has acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2015 through September 30, 2016. The Department will seek approval for an additional one-year extension of the contract for the period October 1, 2016 through June 30, 2017.

The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers.

In February 2012, the new dental FI began takeover activities. However, the Centers for Medicare and Medicaid Services (CMS) determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the current Dental FI contract for the period of July 1, 2013 through June 30, 2015. The Department instructed the FI contractor to stop all takeover activities. The FI contractor filed a Notification of Claim to recoup costs already expended for takeover activities. The Department has determined that the FI contractor should be reimbursed and is currently working with CMS to determine if federal funding will be available for these costs.

The Department has instructed the current FI contractor to resume turnover support services and all activities in accordance with the contract requirements. Due to contracting issues with CMS in executing the new contract, turnover activities will need to commence again. The turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 76

required data and documentation was included in the Office of Medi-Cal Procurement's data library. As a result, the turnover bid price has been renegotiated. The amendment to implement this change was approved by CMS on June 29, 2015.

Reason for change from Prior Estimate:

There is no material change. The turnover bid price has been renegotiated and approved by CMS.

Methodology:

1. Costs are estimated based on actual expenses for the turnover services already performed.
2. Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2015-16	\$77,000	\$19,000	\$58,000

	TF	GF	FF
FY 2016-17	\$20,000	\$5,000	\$15,000

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 77
 IMPLEMENTATION DATE: 4/1993
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 236

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$298,575,000	\$297,785,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$298,575,000	\$297,785,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP), and IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:

Interagency Agreement (IA) 03-75676
 IA 14-90483
 IA 09-86307 IPO

Interdependent Policy Changes:

Not Applicable

Background:

The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

Reason for Change from Prior Estimate:

Updated expenditure data was provided by CDSS.

Methodology:

The estimates, on a cash basis, were provided by CDSS.

PERSONAL CARE SERVICES
OTHER ADMIN. POLICY CHANGE NUMBER: 77

(Dollars in Thousands)

FY 2015-16	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$498,150	\$249,075	\$249,075
CMIPS II	\$99,000	\$49,500	\$49,500
Total	\$597,150	\$298,575	\$298,575
FY 2016-17	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$503,870	\$251,935	\$251,935
CMIPS II	\$91,700	\$45,850	\$45,850
Total	\$595,570	\$297,785	\$297,785

Totals may differ due to rounding.

Funding:

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 233

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$260,425,000	\$319,875,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$260,425,000	\$319,875,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

This policy change reflects the 100% FFP provided to CDSS.

Authority:

Interagency Agreements:

CWS 01-15931

CWS/CMS 06-55834

CSBG/APS 01-15931

Interdependent Policy Changes:

Not Applicable

Background:

The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); and 4) Adult Protective Services (APS).

Reason for Change from Prior Estimate:

Updated expenditure data received from CDSS.

Methodology:

The estimates, on a cash basis, were provided by CDSS.

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 78

(Dollars in Thousands)

FY 2015-16	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$289,208	\$154,604	\$154,604
CWS/CMS	\$11,130	\$5,565	\$5,565
CSBG/APS	\$220,512	\$100,256	\$110,256
TOTAL	\$520,850	\$260,425	\$260,425

FY 2016-17	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$428,190	\$214,095	\$214,095
CWS/CMS	\$11,060	\$5,530	\$5,530
CSBG/APS	\$200,500	\$100,250	\$100,250
TOTAL	\$639,750	\$319,875	\$319,875

Funding:

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 6/2012
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1679

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$142,998,000	\$129,171,000
STATE FUNDS	\$31,594,800	\$25,568,050
FEDERAL FUNDS	\$111,403,200	\$103,602,950

DESCRIPTION

Purpose:

This policy change estimates the cost for the development, implementation, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This policy change also includes the cost for contractors to integrate the Medi-Cal Eligibility Data System (MEDS) into the CalHEERS.

Authority:

Affordable Care Act (ACA) of 2010
 AB 1602, Statute of 2010, Chapter 655
 SB 900, Statute of 2010, Chapter 659
 Interagency Agreement #12-89551
 Contract # 73031236

Interdependent Policy Changes:

Not Applicable

Background:

California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this "one-stop-shop" experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone, or with the Medicaid and Children's Health Insurance Program agency. To meet this requirement, the Department and Covered California have formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop-shopping, making health insurance eligibility purchasing easier and more understandable.

The department is responsible for the coordination, clarification and implementation of Medi-Cal regulations, policies and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. The Department also works with the county welfare department consortiums to develop the business rules necessary to implement eligibility policy and maintain the records of beneficiaries in the county systems and the Medi-Cal Eligibility Data System (MEDS).

CalHEERS was programmed to provide Modified Adjusted Gross Income eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. In order to provide seamless integration with the new CalHEERS system, the Department designed and implemented the technology solutions for ongoing maintenance of MEDS changes and integration with CalHEERS.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 79

ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department will also receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS. Medi-Cal's associated cost for the one-time development and implementation (D&I) of CalHEERS is 10/90 FFP, 50/50 FFP, and 35/65 FFP. CalHEERS ongoing Operations and Maintenance (O&M) cost is 25/75 FFP and 35/65 FFP. CalHEERS' costs are shared between Covered California and Medi-Cal. Covered California will reimburse the Department for their share.

Reason for Change from Prior Estimate:

Project expenditures have been revised based on updated work plan.

Methodology:

1. Contractors began D&I work in July 2012 with payments beginning in August 2012. O&M started in January 2015.
2. In FY 2015-16 and FY 2016-17, costs will be shared based on estimated enrollment for shared costs at a rate of 13.5% Covered California and 86.5% to the Department. Costs directly attributable to the Department will be 100%.
3. In FY 2015-16 and 2016-17, costs incurred are for CalHEERS' D&I and O&M. The design, development, and implementation period is eligible for:
 - 86% at 90% federal reimbursement
 - 14% at 65% federal reimbursement

The maintenance and operations period is eligible for:

 - 86% at 75% federal reimbursement
 - 14% at 65% federal reimbursement
4. Effective FY 2016-17, the Department will submit a separate Implementation Advance Planning Document (IAPDU) for CMS approval for the Department's Enterprise Innovation and Technology Services (EITS) contractor costs that will no longer be included in the CalHEERS IAPDU.

FY 2015-16:	TF	GF	FF	Reimbursements
Title XIX (50% FF / 50% GF)	\$3,520,000	\$1,760,000	\$1,760,000	\$0
Title XXI (65% FF / 35% GF)	\$4,731,000	\$1,656,000	\$3,075,000	\$0
Title XXI (88% FF / 12% GF)	\$14,195,000	\$1,703,000	\$12,492,000	\$0
Title XIX (75% FF / 25% GF)	\$84,787,000	\$21,197,000	\$63,590,000	\$1,627,000
Title XIX (90% FF / 10% GF)	\$30,598,000	\$3,060,000	\$27,538,000	\$592,000
Title XIX (100% FF)	\$2,948,000	\$0	\$2,948,000	\$0
Total	\$142,998,000	\$29,376,000	\$111,403,000	\$2,219,000

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 79

FY 2016-17:	TF	GF	FF	Reimbursements
Title XIX (75% FF / 25% GF)	\$81,975,000	\$20,494,000	\$61,481,000	\$0
Title XXI (88% FF / 12% GF)	\$17,735,000	\$2,128,000	\$15,607,000	\$0
Title XIX (90% FF / 10% GF)	\$29,461,000	\$2,946,000	\$26,515,000	\$0
Sub Total	\$127,146,000	\$25,333,000	\$102,086,000	\$0
DHCS EITS contractor costs	\$2,025,000	\$235,000	\$1,517,000	\$273,000
Total	\$129,171,000	\$25,568,000	\$103,603,000	\$273,000

Funding:

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

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

75% Title XIX / 25 % GF (4260-101-0001/0890)

88% Title XIX / 12 % GF (4260-101-0001/0890)

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 7/1997
ANALYST: Jason Moody
FISCAL REFERENCE NUMBER: 243

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$50,873,000	\$44,254,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$50,873,000	\$44,254,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

CDDS administrative costs are comprised of Developmental Centers (DC)/State Operated Community Facility (SOCF) Medi-Cal Administration, Developmental Centers Medi-Cal Eligibility Contract, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

The General Fund is included in the CDDS budget on an accrual basis and the federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The changes are due to updated expenditures.

Methodology:

1. CDDS provides the following cash estimates of its administrative cost components:

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80

FY 2015-16		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$12,174,000	\$12,174,000	03-75282/83
	DC/SOCF HIPAA*	\$163,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$550,000	\$550,000	01-15378
3	HCBS Waiver Admin.	\$18,471,000	\$18,471,000	01-15834
4	RC Medicaid Admin.	\$12,237,000	\$4,079,000	03-75734
5	NHR Admin.	\$441,000	\$441,000	03-75285
6	TCM Headquarters Admin.	\$425,000	\$425,000	03-75284
	TCM RC Admin.	\$5,774,000	\$5,774,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$50,873,000	\$41,914,000	

FY 2016-17		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$6,385,000	\$6,385,000	03-75282/83
	DC/SOCF HIPAA*	\$163,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$550,000	\$550,000	01-15378
3	HCBS Waiver Admin.	\$18,071,000	\$18,071,000	01-15834
4	RC Medicaid Admin.	\$12,551,000	\$4,184,000	03-75734
5	NHR Admin.	\$595,000	\$595,000	03-75285
6	TCM Headquarters Admin.	\$349,000	\$349,000	03-75284
	TCM RC Admin.	\$4,952,000	\$4,952,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$44,254,000	\$35,086,000	

Funding:

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)*

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 81
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 234

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$29,965,000	\$29,893,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$29,965,000	\$29,893,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child and Adolescent Health (MCAH) programs.

Authority:

Interagency agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

The MCAH includes the following programs:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African-American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants.
- Comprehensive Perinatal Services Program (CPSP): Provides a wide range of services to Medi-Cal pregnant women, from conception through 60 days postpartum.
- Prenatal Care Guidance (PCG): Case management services for improved access to early obstetrical care for Medi-Cal eligible pregnant women.
- Scope of Work (SOW) Local Program Activities: Perinatal education, services, and referral provided to Medi-Cal eligible women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant teens including education and prevention of subsequent pregnancies.
- Effective July 1, 2014, SB 852 (Chapter 25, Statutes of 2014) restored the General Fund for the Black Infant Health Program.

Reason for Change from Prior Estimate:

The changes are due to updated expenditures and to the restoration of the General Fund for the Black Infant Health Program.

Methodology:

1. The Department claims Title XIX federal funds with Certified Public Expenditures (CPE) from local

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 81

agencies.

2. Annual expenditures on the accrual basis are \$29,954,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
3. The FY 2015-16 budgeted amounts include \$9,540,000 for FY 2014-15 and \$20,425,000 for FY 2015-16.
4. The FY 2016-17 budgeted amounts include \$1,298,000 for FY 2014-15, \$8,753,000 for FY 2015-16, and \$19,842,000 for FY 2016-17.
5. The following estimates have been provided on a cash basis by CDPH.

FY 2015-16	DHCS FFP	CDPH GF	County Match
BIH	\$4,802	\$2,375	\$1,521
CPSP, PCG & SOW	\$23,264		\$15,456
AFLP	\$1,899		\$1,426
Total	\$29,965	\$2,375	\$18,404

FY 2016-17	DHCS FFP	CDPH GF	County Match
BIH	\$3,687	\$1,534	\$1,383
CPSP, PCG & SOW	\$23,890		\$16,017
AFLP	\$2,316		\$1,703
Total	\$29,893	\$1,534	\$19,103

Funding:

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 82
 IMPLEMENTATION DATE: 7/2002
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 256

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$28,803,000	\$29,998,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$28,803,000	\$29,998,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:

Interagency Agreements (IA):

IHSS PCSP	03-75676
IHSS Health Related	01-15931
CWS/CMS for Medi-Cal	06-55834
IHSS Plus Option Sec. 1915(j)	09-86307
SAWS	04-35639
Medi-Cal State Hearings	10-87031 and 12-89543
Public Inquiry and Response	10-87023 and 13-90113
Medicaid Disability Evaluation Services	10-87027 and 13-90112
Licensing Related Activities for Mental Health Facilities	12-89443

Interdependent Policy Changes:

Not Applicable

Background:

These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Coordinated Care Initiative (CCI) IA, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change from Prior Estimate:

The estimated costs have changed due to revised expenditure data provided by CDSS.

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 82

Methodology:

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

FY 2015-16	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$14,027,000	\$7,014,000	\$7,013,000
IHSS Health Related	\$112,000	\$56,000	\$56,000
CWS/CMS for Medi-Cal	\$570,000	\$285,000	\$285,000
IHSS Plus Option Sec. 1915(j)	\$3,694,000	\$1,847,000	\$1,847,000
SAWS	\$508,000	\$254,000	\$254,000
Medi-Cal State Hearings	\$11,704,000	\$10,201,000	\$10,202,000
Public Inquiry and Response	\$298,000	\$149,000	\$149,000
Medicaid Disability Evaluation Services	\$17,994,000	\$8,997,000	\$8,997,000
TOTAL	\$48,907,000	\$28,803,000	\$28,803,000
FY 2016-17	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$14,030,000	\$7,015,000	\$7,015,000
IHSS Health Related	\$112,000	\$56,000	\$56,000
CWS/CMS for Medi-Cal	\$570,000	\$285,000	\$285,000
IHSS Plus Option Sec. 1915(j)	\$3,620,000	\$1,810,000	\$1,810,000
SAWS	\$510,000	\$255,000	\$255,000
Medi-Cal State Hearings	\$19,600,000	\$9,800,000	\$9,800,000
Public Inquiry and Response	\$480,000	\$240,000	\$240,000
Medicaid Disability Evaluation Services	\$21,073,000	\$10,537,000	\$10,536,000
TOTAL	\$59,995,000	\$29,998,000	\$29,997,000

*Totals may differ due to rounding.

Funding:

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

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 83
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 246

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$25,143,000	\$24,879,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$25,143,000	\$24,879,000

DESCRIPTION

Purpose:

This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

Authority:

Welfare & Institutions Code, Section 16501.3
 AB 1111 (Chapter 147, Statutes of 1999)
 SB 1013 (Chapter 35, Statutes of 2012)
 Interagency Agreement (IA) 14-2002

Interdependent Policy Change:

Not Applicable

Background:

On January 1, 2010, the Department, in collaboration with CDSS, implemented the following requirements of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access, and
- Improve incentives for adoption.

CDSS and the Department implemented the HCPCFC through the existing Child Health and Disability Prevention (CHDP) program so counties can employ public health nurses to help foster care children access health-related services.

The responsibility for HCPCFC was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

Reason for Change from Prior Estimate:

There is no change.

**HEALTH OVERSIGHT & COORD. FOR FOSTER CARE
CHILDREN**

OTHER ADMIN. POLICY CHANGE NUMBER: 83

Methodology:

1. CDSS provides the annual Local Revenue Fund of \$8,381,000 for FY 2015-16 and \$8,293,000 for FY 2016-17.

(Dollars in Thousands)

FY 2015-16	TF	CDSS GF	DHCS FFP
	\$33,524	\$8,381	\$25,143

FY 2016-17	TF	CDSS GF	DHCS FFP
	\$33,172	\$8,293	\$24,879

Funding:

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

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER: 84
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1820

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$15,978,000	\$9,950,000
STATE FUNDS	\$7,989,000	\$4,975,000
FEDERAL FUNDS	\$7,989,000	\$4,975,000

DESCRIPTION

Purpose:

This policy change estimates the costs for outreach, enrollment and renewal activities related to targeted Medi-Cal populations who are eligible as result of the Affordable Care Act (ACA).

Authority:

SB 101 (Chapter 361, Statutes of 2013)
 SB 18 (Chapter 551, Statutes of 2014)
 AB 82, Sections 70 and 71 (Chapter 23, Statutes of 2013)
 SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:

Not Applicable

Background:

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

The Department partnered with Covered California to certify enrollment counselors and provide outreach, enrollment, renewal assistance and marketing activities related to the ACA. This policy change estimates the costs for the outreach and enrollment of targeted Medi-Cal populations as well as renewal assistance for current Medi-Cal beneficiaries. Also included in this policy change are costs to compensate Medi-Cal enrollment counselors and insurance agents for providing in-person application assistance. There will be special emphasis on targeting of the following populations for outreach and enrollment:

- Persons with mental health disorder needs,
- Persons with substance use disorder needs,
- Persons who are homeless,
- Young men of color,
- Persons who are in county jail, in state prison, on state parole, on county probation, or under post release community supervision,
- Families of mixed-immigration status; and,
- Persons with limited English proficiency.

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER: 84

The Department established a special Healthcare Outreach and Medi-Cal Enrollment Account within a Special Deposit Fund to collect and allocate public or private grants to fund these activities.

Reason for Change from Prior Estimate:

- The Department adjusted FY 2015-16 funding based on actual expenditures and reforecasting amounts pursuant to SB 75's program extensions through FY 2017-18.
- The Department added \$750,000 in remaining funds from the application assistance program to county outreach grants, pursuant to SB 75.

Methodology:

1. The Department estimates \$25,928,000 will be spent on these activities in FY 2015-16 and FY 2016-17. It is assumed the remaining \$12,708,000 will be spent on these outreach, enrollment, and renewal assistance activities in FY 2017-18.
2. Per SB 75, Section 48(f) (amendment to Section 70 of Chapter 23 of the Statutes of 2013), after all enrollment assistance payments have been made for applications received through June 30, 2015, any remaining funds shall be allocated to the county outreach and enrollment grants under Section 71 of Chapter 23 of the Statutes of 2013.
3. Per SB 101 (Chapter 361, Statutes of 2013) Section 5(d), the Department has authority to expend in aggregate up to \$500,000 annually to administer the activities budgeted in this policy change. The Department has included the administrative funding in the Department's support budget (4260-501-0942 (285)).
4. The funds will be spent as follows:

(Dollars in Thousands)

FY 2015-16	TF	Special Fund	FF
Enrollment Counselors	\$6,028	\$3,014	\$3,014
Outreach and Enrollment	\$6,450	\$3,225	\$3,225
Renewal Assistance	\$4,000	\$2,000	\$2,000
Support Adjustment (4260-501-0942)	(\$500)	(\$250)	(\$250)
Total	\$15,978	\$7,989	\$7,989

(Dollars in thousands)

FY 2016-17	TF	Special Fund	FF
Enrollment Counselors	\$0	\$0	\$0
Outreach and Enrollment	\$6,450	\$3,225	\$3,225
Renewal Assistance	\$4,000	\$2,000	\$2,000
Support Adjustment (4260-501-0942)	(\$500)	(\$250)	(\$250)
Total	\$9,950	\$4,975	\$4,975

Funding:

50% Title XIX FFP (4260-101-0890)

50% Healthcare Outreach Fund (4260-601-0942285)

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 85
 IMPLEMENTATION DATE: 7/2007
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1192

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$11,671,000	\$11,463,000
STATE FUNDS	\$3,560,000	\$3,560,000
FEDERAL FUNDS	\$8,111,000	\$7,903,000

DESCRIPTION

Purpose:

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to services provided to Medi-Cal beneficiaries.

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into an IA with CDPH to allow for the provision of Title XIX federal funds as a reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following programs support costs:

- Maternal, Child and Adolescent Health (MCAH)
- Office of AIDS
- Childhood Lead Prevention Program (CLPP)
- Center for Health Statistics and Informatics (CHSI)
- Licensing and Certification (L&C)
- Skilled Nursing Facilities (SNF)

Skilled Nursing Facility: SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payment program (QASP) for nursing facilities (NF-Bs). The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund.

Licensing and Certification: Previous estimates included only the projected reimbursements for the Provider Certification Unit. This estimate also includes the projected reimbursements of the Nurse Aide Registry and the Nurse Aide Training and Competency Evaluation Program (NAR/NATCEP) and the Central Application Unit which were not included in prior years. CHSI is currently negotiating the amendment of the contract with the Department to include the reimbursement for the NAR/NATCUP, the Central Applications Unit, and the Provider Certification Unit.

CHSI cost estimates the California Health Interview Survey (CHIS) contract services costs. CHIS is conducted by the University of California, Los Angeles (UCLA) Center for Health Policy Research in collaboration with the California Department of Public Health (CDPH) and the Department. The Department no longer has a shared contract with CDPH to provide federal funding for CHIS. The

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 85

Department's contract with CDPH ended on June 30, 2015.

Effective July 1, 2015, the Department will contract directly with UCLA to utilize CHIS for program needs and performance. FY 2015-16 Federal Financial Participation (FFP) costs for the new contract will be budgeted in Other Administrative policy change titled California Health Interview Survey; the non-federal share will be paid through certified public expenditures (CPEs).

Reason for Change from Prior Estimate:

The changes are due to the following:

- SNF costs reflect updated actual expenditures.
- L&C costs reflect updated actual expenditures, as well as the addition of projected reimbursements for NAR/NATCEP and the Central Applications Unit.
- For CLPP, FY 2015-16 changes reflect updated expenditures and realignment with appropriation authority.
- For CHSI, FY 2015-16 costs reflect remaining expenditures for FY 2014-15. FY 2015-16 contract cost is now budgeted in Other Administrative policy change titled California Health Interview Survey.

Methodology:

1. CDPH provides the General Fund match.
2. For Maternal, Child and Adolescent Health, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs.
3. CDPH provided the following estimates.

FY 2015-16 (Cash Basis)	DHCS FFP*	DHCS SP**	CDPH GF	Other Match
MCAH	\$1,900,000		\$1,900,000	
Office of AIDS	\$463,000		\$463,000	
CLPP	\$1,770,000			\$1,770,000
CHSI	\$135,000			\$135,000
Licensing and Certification	\$3,843,000			\$3,843,000
Skilled Nursing Facilities	\$3,560,000	\$3,560,000		
Total	\$11,671,000	\$3,560,000	\$2,363,000	\$5,748,000

FY 2016-17 (Cash Basis)	DHCS FFP*	DHCS SP**	CDPH GF	Other Match
MCAH	\$1,900,000		\$1,900,000	
Office of AIDS	\$390,000		\$390,000	
CLPP	\$1,770,000			\$1,770,000
Licensing and Certification	\$3,843,000			\$3,843,000
Skilled Nursing Facilities	\$3,560,000	\$3,560,000		
Total	\$11,463,000	\$3,560,000	\$2,290,000	\$5,613,000

Funding:

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

SNF Quality & Accountability (non-GF) (4260-605-3167)**

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 86
 IMPLEMENTATION DATE: 7/1997
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 239

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$5,596,000	\$4,200,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,596,000	\$4,200,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement (IA) #07-65689

Interdependent Policy Changes:

Not Applicable

Background:

The CLPP Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments which provide the case management services. Some of these services are provided to Medi-Cal eligibles. To the extent that local governments have administrative costs associated with case management services to Medi-Cal eligibles, federal matching funds can be claimed. The federal match is provided to CDPH through an Interagency Agreement.

Reason for Change from Prior Estimate:

There are prior year costs to be incurred in the current year due to delay in local jurisdictions invoicing to the state.

Methodology:

1. Annual expenditures on the accrual basis are \$8,400,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

FY 2015-16	DHCS FFP	CDPH CLPP Fee Funds
Administrative Costs	\$5,596	\$5,596

FY 2016-17	DHCS FFP	CDPH CLPP Fee Funds
Administrative Costs	\$4,200	\$4,200

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 86

Funding:

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 7/1984
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 253

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
TOTAL FUNDS	\$3,584,000	\$4,085,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,584,000	\$4,085,000

DESCRIPTION

Purpose:

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). Enhanced federal funding is also provided to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).

Authority:

Interagency Agreements:

CBAS 03-76137
MSSP 01-15976

Interdependent Policy Changes:

Not Applicable

Background:

The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change from Prior Estimate:

Estimated projections were updated by CDA.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 87

Methodology:

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

(Dollars in Thousands)

	FY 2015-16		FY 2016-17	
	CDA GF	FFP	CDA GF	FFP
CBAS Support				
FY 2014-15 DOS	\$4	\$3		
FY 2015-16 DOS	\$1,560	\$1,806	\$48	\$56
FY 2016-17 DOS			\$1,872	\$2,184
Total CBAS	\$1,564	\$1,809	\$1,920	\$2,240
MSSP Support				
FY 2014-15 DOS	\$4	\$4		
FY 2015-16 DOS	\$1,256	\$1,450	\$39	\$45
FY 2016-17 DOS			\$1,259	\$1,452
Total MSSP	\$1,260	\$1,454	\$1,298	\$1,497
ADRC Support*				
FY 2015-16 DOS		\$321		\$10
FY 2016-17 DOS				\$338
Total ADRC		\$321		\$348
Grand Total	\$2,824	\$3,584	\$3,218	\$4,085

Funding:

100% Title XIX (4260-101-0890)

100% MFP Federal Grant (4260-106-0890)*

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 88
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 257

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,215,000	\$840,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,215,000	\$840,000

DESCRIPTION

Purpose:

This policy change estimates and reimburses the California Health and Human Services (CHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:

Interagency Agreement (IA) 14-90234

Interdependent Policy Changes:

Not Applicable

Background:

A HIPAA office has been established at the CHHS Agency to coordinate implementation and set policy requirements for departments utilizing Title XIX funding. This funding supports State positions and contracted staff to assist in the implementation of HIPAA rules at the Agency level. These staff provide oversight and subject matter expertise in HIPAA rules.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
FY 2015-16	\$1,215,000	\$1,215,000
FY 2016-17	\$840,000	\$840,000

Funding:

100% HIPAA (4260-117-0890)

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 249

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,119,000	\$1,119,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,119,000	\$1,119,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing "Welcome Kits" to parents of Medi-Cal eligible newborns.

Authority:

Interagency Agreement (IA) #03-76097

Interdependent Policy Changes:

Not Applicable

Background:

In November 2001, CCFC and the Department entered into an IA to allow the Department to claim Title XIX federal funds (FF) for the "Welcome Kits" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. CCFC will distribute an estimated 370,000 kits in FY 2015-16 and FY 2016-17, of these kits, 46% are expected to be distributed to Medi-Cal eligible newborns.

$$370,000 \text{ kits} \times 46\% = 170,200 \text{ Medi-Cal kits}$$

2. Approximately 51% of the kits distributed will be basic kits and 49% will be custom kits. The basic kit costs \$13.10 and the customized kit, which contains an additional item specific to the county of birth, costs \$13.19.

$$\begin{aligned}
 170,200 \text{ Medi-Cal kits} \times 51\% &= 86,802 \text{ basic kits} \times \$13.10 &= \$1,137,000 \\
 170,200 \text{ Medi-Cal kits} \times 49\% &= 83,398 \text{ custom kits} \times \$13.19 &= \underline{\$1,100,000} \\
 \text{Total} &&= \$2,237,000
 \end{aligned}$$

3. For the FY 2015-16 expenditures, \$559,000 of the costs are from the last quarter of FY 2014-15 and \$1,678,000 of the costs are from the first three quarters of FY 2015-16.
4. For the FY 2016-17 expenditures, \$559,000 of the costs are from the last quarter of FY 2015-16 and \$1,678,000 of the costs are from the first three quarters of FY 2016-17.

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89

Cash Basis	FY 2015-16	FY 2016-17
FY 2014-15	\$ 559,000	\$0
FY 2015-16	\$1,678,000	\$ 559,000
FY 2016-17	\$0	\$1,678,000
Total	\$2,237,000	\$2,237,000
FFP Total	\$1,119,000	\$1,119,000

Funding:

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 90
 IMPLEMENTATION DATE: 3/2011
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1665

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,017,000	\$1,017,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,017,000	\$1,017,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR) for administrative costs related to the Inmate Eligibility Program.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)
 SB 1399 (Chapter 405, Statutes of 2010)
 AB 396 (Chapter 394, Statutes of 2011)
 Interagency Agreement #10-87275

Interdependent Policy Changes:

Not Applicable

Background:

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

- Claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties. As part of these provisions, CDCR is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to CDCR are included in the Medi-Cal inpatient hospital costs for inmates and LIHP inpatient hospital costs for CDCR inmates policy changes respectively.

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.

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by CDCR or the county. Policy Change CA 1 County Administration Base covers the county FFP for county inmates.

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 90

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Implementation of the Inmate Eligibility Program began April 1, 2011.
2. Reimbursements for CDCR's administrative costs began in March 2011.
3. The federal share of ongoing administrative costs is \$1,017,000 in FY 2015-16 and FY 2016-17.

Funding:

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

TOBACCO QUITLINE ADMINISTRATIVE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 91
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1680

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,000,000	\$1,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,000,000	\$1,000,000

DESCRIPTION

Purpose:

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to Tobacco Quitline Services provided to Medi-Cal beneficiaries.

Authority:

Interagency Agreement (IA) 13-90417

Interdependent Policy Change:

Not Applicable

Background:

The Tobacco Quitline is the California Smokers' Helpline, operated by the University of California, San Diego. Tobacco Quitline provides a free telephone-based counseling program to provide advice, education, and support to callers who currently smoke or have recently quit smoking.

The Department executed an IA with CDPH to enable the State to receive 50% FFP for Tobacco Quitline Services administrative costs beginning July 1, 2013.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Total Tobacco Quitline Services administration costs are \$4 million annually.
2. Assume 50% of callers are Medi-Cal beneficiaries and the State receives 50% FFP.
3. The estimated annual FFP is \$1,000,000.

Funding:

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 92
 IMPLEMENTATION DATE: 12/1988
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 232

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$956,000	\$956,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$956,000	\$956,000

DESCRIPTION

Purpose:

This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:

AB 1807(Chapter 1424, Statutes of 1987)
 California Military & Veterans Code 972.5
 Interagency Agreement 15-92032

Interdependent Policy Changes:

Not Applicable

Background:

Assembly Bill (AB) 1807 permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the CDVA. CVSO's help identify additional veterans' benefits and refers the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- The contract amounts for FY 2015-16 and FY 2016-17 are estimated to be \$956,000. The non-federal match is budgeted at CDVA.

(Dollars in Thousands)

FY	FY 2015-16			FY 2016-17		
	Cash Basis	TF	CDVA GF	DHCS FF	TF	CDVA GF
Administrative	\$436	\$218	\$218	\$436	\$218	\$218
Workload Units	\$1,476	\$738	\$738	\$1,476	\$738	\$738
Total	\$1,912	\$956	\$956	\$1,912	\$956	\$956

Funding:

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 93
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 261

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$994,000	\$946,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$994,000	\$946,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for the Information and Education (I&E) program to establish and implement clinical linkages to the Family Planning, Access, Care and Treatment (Family PACT) program.

Authority:

Interagency Agreement (IA) 07-65592
 AB 1762 (Chapter 230, Statutes of 2003)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1762 authorized the Department to require contractors and grantees under the Office of Family Planning (OFP) and the I&E program to establish and implement clinical linkages to the Family PACT program. This linkage includes planning and development of a referral process for program participants to ensure access to family planning and other reproductive health care services, including technical assistance, training, and an evaluation component for grantees.

CDPH budgets the I&E program under the Maternal, Child and Adolescent Health Division.

Reason for Change from Prior Estimate:

The changes are due to updated actual claims data.

Methodology:

1. CDPH budgets the non-federal matching funds.
2. CDPH provides the estimated costs on a cash basis.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 93

FY 2015-16	TF	CDPH GF	DHCS FF
FY 2014-15	\$663,000	\$332,000	\$332,000
FY 2015-16	\$1,324,000	\$662,000	\$662,000
Total	\$1,987,000	\$994,000	\$994,000

FY 2016-17	TF	CDPH GF	DHCS FF
FY 2015-16	\$568,000	\$284,000	\$284,000
FY 2016-17	\$1,324,000	\$662,000	\$662,000
Total	\$1,892,000	\$946,000	\$946,000

Funding:

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

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 8/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1774

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$900,000	\$883,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$900,000	\$883,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) for the California Department of Public Health (CDPH) to improve delivery of Vital Records data.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

California birth, death, fetal death, still birth, marriage and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA—a Centers for Medicare and Medicaid Services (CMS) initiative—fosters an integrated business and information technology (IT) transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH.

Reason for Change from Prior Estimate:

Due to delays in approvals of the contract, the start date changed from March 2015 to August 2015 with first records being exchanged in August 2015.

Methodology:

1. Assume the Department and CDPH will receive MITA 90% FFP for Design, Development, and Installation activities and 75% FFP for ongoing costs to deliver data in an automated fashion.
2. Assume CDPH will provide the match for FFP from the Health Statistics Special Fund (HSSF).
3. Assume that establishing an automated data interchange will cost \$100,000 with 90% FFP in FY 2015-16.
4. Assume a data flow based on a monthly average of 20,000 death records and 45,000 birth records.

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 94

5. Assume that ongoing cost for each record will be \$1.51 to reimburse the cost associated with preparing the record for transfer and transferring the record to the Department.

FY 2015-16

\$1.51 per record x (20,000 death records + 45,000 birth records) x 11 months = \$1,080,000 TF
(\$810,000 FFP)

FY 2016-17

\$1.51 per record x (20,000 death records + 45,000 birth records) x 12 months = \$1,178,000 TF
(\$883,000 FFP)

FY 2015-16	TF	HSSF	FFP
Data Interchange Development	\$100,000	\$10,000	\$90,000
Data Provision	\$1,080,000	\$270,000	\$810,000
Total	\$1,180,000	\$280,000	\$900,000

FY 2016-17	TF	HSSF	FFP
Total	\$1,178,000	\$295,000	\$883,000

Funding:

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

CDDS DENTAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 95
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1631

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$308,000	\$120,000
STATE FUNDS	\$308,000	\$120,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost related to processing the California Department of Developmental Services (CDDS) dental claims.

Authority:

Interagency Agreement 10-87244

Interdependent Policy Changes:

Not Applicable

Background:

The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covered most dental services for adults 21 years of age and older, CDDS entered into an interagency agreement with the Department to have the Medi-Cal dental Fiscal Intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of processing claims and benefits will be reimbursed by CDDS. Select adult optional dental services were reinstated May 1, 2014.

This policy change estimates the reimbursement of administration costs. The reimbursement of benefit costs is budgeted in the CDDS Dental Services policy change.

Reason for Change from Prior Estimate:

FY 2015-16 costs increased due to errors in invoicing CDDS, resulting in an updated estimated annual cost for processing claims. FY 2015-16 costs also include outstanding invoice amounts from FY 2013-14 and FY 2014-15.

Methodology:

1. Assume the cost of processing claims is \$120,000 annually.
2. Outstanding invoices from prior years will be paid in FY 2015-16.
3. All costs are reimbursed by CDDS.

Funding:

Reimbursement GF (4260-610-0995)

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 96
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 263

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$195,000	\$195,000
STATE FUNDS	\$97,500	\$97,500
FEDERAL FUNDS	\$97,500	\$97,500

DESCRIPTION

Purpose:

This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:

IA #12-89476

Interdependent Policy Changes:

Not Applicable

Background:

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meet current state regulations. The Merit System Services Program was established under the State Personnel Board and is now administered by the CalHR to administer personnel services for the counties that do not have one. In addition, the CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses the CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. CalHR provided the estimates on a cash basis.
2. The estimated reimbursement is \$195,000 TF (\$97,500 GF) in FY 2015-16 and \$195,000 TF (\$97,500 GF) in FY 2016-17.

Funding:

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 97
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1114

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$305,000	\$382,000
STATE FUNDS	\$152,500	\$191,000
FEDERAL FUNDS	\$152,500	\$191,000

DESCRIPTION

Purpose:

This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:

Interagency Agreement (IA) #13-90175

Interdependent Policy Changes:

Not Applicable

Background:

The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services.

Reason for Change from Prior Estimate:

The estimated expenditures for FY 2015-16 were reduced based on fewer packages shipped in FY 2014-15 and FY 2015-16.

Methodology:

1. The contract with State Delivery Service Inc. expired at the end of FY 2014-15. Their cost per package was \$1.375 plus three percent fuel surcharge. The new contract with Unity Courier Service charges \$1.75 per package rate and no fuel surcharge.
2. The number of shipped packages is 187,000 for FY 2014-15. The number of estimated packages to be shipped is 216,000 for FY 2015-16 and 220,000 in FY 2016-17.

FY 2014-15	$\$1.375 \times 1.03 \times 187,000 = \$265,000$
FY 2015-16	$\$1.375 \times 1.03 \times 36,000 = \$ 51,000$ $+ \$1.75 \times 180,000 = \$315,000$ Total packages 216,000 = \$366,000
FY 2016-17	$\$1.75 \times 220,000 = \$385,000$

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 97

3. Payments for the third and fourth quarter of FY 2014-15 services were made in FY 2015-16.

Cash Basis	FY 2015-16	FY 2016-17
FY 2014-15 Services	\$128,000	\$0
FY 2015-16 Services	\$177,000	\$189,000
FY 2016-17 Services	\$0	\$193,000
Total	\$305,000	\$382,000

Funding:

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

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 99
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1948

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$0	\$23,748,000
STATE FUNDS	\$0	\$11,874,000
FEDERAL FUNDS	\$0	\$11,874,000

DESCRIPTION

Purpose:

This policy change estimates the cost to reimburse mental health plans the cost of capturing and reporting new functional assessment data. County mental health plans will collect, manage, use, and report additional functional assessment data as part of the Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services.

Authority:

Welfare & Institutions Code 14707.5

Interdependent Policy Changes:

Not Applicable

Background:

W&I Code, Section 14707.5 requires the Department to develop a POS for EPSDT mental health services that will improve outcomes at the individual and system levels and to inform fiscal decision-making related to the purchase of services.

Through implementation of the POS, California will have a coordinated method for data collection, be able to evaluate specific measures of mental health services, and establish an ongoing process for quality improvement. The POS implementation plan consists of the following:

- Establishing the POS methodology,
- Initial performance outcomes reporting from existing Department databases,
- Functional assessment data reporting,
- Continuous quality improvement, and
- Tracking the continuum of care for children/youth.

In order to meet the POS project milestones, a Quality Assurance/Improvement team will be needed at the county level to collect, manage, use and report information obtained from the additional functional assessment data collected. This will require modifying existing data systems and increasing staff time or enhancing current staffing levels to implement the Quality Improvement Plan.

The responsibility for Specialty Mental Health child welfare and protective services was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of service required by legislation, above the level for

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 99

which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. County personnel costs are based on estimated costs for:
 - Clerical staff for data collection, and
 - Training for county clinicians.
2. Assume annual personnel costs are \$16,890,000 and 45.296% benefit rate for personnel costs.

$$\$16,890,000 \times 1.45296 = \$24,540,000$$

3. Assume county staff will begin the hiring process July 2016. This hiring effort will be for all staff. Assume a six-month phase-in.

$$\$24,540,000 \times 77.9\% \text{ lag factor} = \$19,117,000$$

4. Assume training costs are \$4,631,000 for 14,842 county clinicians to receive eight hours of training to implement the tools for data collection. The costs are based on the number of estimated number of clinicians with an hourly wage of \$39.
5. Assume the personnel and training costs are eligible for reimbursement at 50%.
6. The estimated total FY 2016-17 costs including ongoing personnel costs and training costs are:

	TF	FF	GF
Ongoing Personnel Costs	\$19,117,000	\$9,558,500	\$9,558,500
Training Costs	\$4,631,000	\$2,315,500	\$2,315,500
Total FY 2016-17	\$23,748,000	\$11,874,000	\$11,874,000

Funding:

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

DENTAL FI -BENEFICIARY OUTREACH & ED PROGRAM- ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 1/2016
 ANALYST: Jerrold Anub
 FISCAL REFERENCE NUMBER: 1949

	FY 2015-16	FY 2016-17
TOTAL FUNDS	\$1,046,000	\$3,067,000
STATE FUNDS	\$447,500	\$1,307,000
FEDERAL FUNDS	\$598,500	\$1,760,000

DESCRIPTION

Purpose:

The policy change estimates the administrative 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:

PC 46 Beneficiary Outreach and Education Program

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. Certain administrative activities related to this effort are payable under the contract.

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 for Telephone Service Center (TSC) costs, 69% is funded at 50% FF and 50% GF; 31% is funded at 75% FF and 25% GF. TSC costs are \$975,000 (TF) in FY 2015-16 and \$2,922,000 (TF) in FY 2016-17.
3. Assume cost reimbursable items (brochures, banners, newspaper ads, etc...) are funded at 50% FF and 50% GF. These costs are \$72,000 (TF) in FY 2015-16 and \$145,000 in FY 2016-17.
4. The increase in administrative costs for FY 2015-16 and FY 2016-17 will be:

**DENTAL FI -BENEFICIARY OUTREACH & ED PROGRAM-
ADMIN**
OTHER ADMIN. POLICY CHANGE NUMBER: 100

FY 2015-16	TF	GF	FF
Title XIX (50/50)	\$ 744,000	\$ 372,000	\$ 372,000
Title XIX (75/25)	\$ 302,000	\$ 75,500	\$ 226,500
Total	\$ 1,046,000	\$ 447,500	\$ 598,500

FY 2016-17	TF	GF	FF
Title XIX (50/50)	\$ 2,161,000	\$1,080,500	\$1,080,500
Title XIX (75/25)	\$906,000	\$226,500	\$679,500
Total	\$3,067,000	\$1,307,000	\$1,760,000

(Numbers may vary due to rounding)

Funding:

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

FI 75% Title XIX FF / 75% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

MEDI-CAL INFORMATION ONLY
November 2015
FISCAL YEARS 2015-16 & 2016-17

INTRODUCTION

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction, and is derived from a 36 month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Estimate.

FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and \$/claim or \$/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

$$\begin{aligned} \text{USERS} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}, \text{Eligibles}) \\ \text{CLAIMS/USER} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \\ \text{\$/CLAIM} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \end{aligned}$$

WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\\$/CLAIM	= Total monthly \$ divided by total monthly claims or units by service and aid category.
	TND	= Linear trend variable.
	S.DUM	= Seasonally adjusting dummy variable.
	O.DUM	= Other dummy variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)

Eligibles = Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and \$/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA establishes a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplifies the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The new standard allows current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

The ACA also imposes a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled in Medi-Cal to enroll in the program. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA will increase the Children's Health Insurance Program (CHIP) FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows the Department to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

HOME AND COMMUNITY BASED SERVICES

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment
- Development of an individualized service plan
- Linkage and consultation
- Assistance with accessing services
- Crisis assistance planning
- Periodic review

Waivers

Medi-Cal operates and administers various home and community-based services (HCBS) waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary State Plan services are less than the total cost incurred at the otherwise appropriate facility plus State Plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS), Assisted Living (ALW), In-Home Operations (IHO), **Nursing Facility/Acute Hospital Waivers**, Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with Developmental Disabilities, San Francisco Community Living Support Benefit (CLSB), and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, Santa Clara and Orange.) Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF) or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 3,700. CMS approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019.

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A lawsuit was filed challenging elimination of ADHC (*Darling et al. v. Douglas et al.*), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it

HOME AND COMMUNITY BASED SERVICES

with a new program called CBAS. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became a managed care benefit effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver; the CBAS portion continues through the life of the 1115 Demonstration. Eligible participants who meet the more stringent CBAS eligibility standards receive CBAS in approved CBAS centers. CBAS has been provided to all eligible participants since April 1, 2012. There is no cap on enrollment into this waiver service.

In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC.* ~~The waiver is approved*~~ **CMS approved the IHO waiver renewal** from January 1, ~~*2010*~~ **2015** through December 31, ~~*2014*~~ **2019***. ~~CMS approved a temporary extension for the IHO Waiver Renewal through March 30, 2015. The IHO Waiver Renewal period from January 1, 2015 through December 31, 2019 is pending CMS approval.*~~

Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver

Effective December 1, 2012, the Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver was merged with the Nursing Facility/Acute Hospital (NF/AH) Waiver, based on CMS approval. The newly merged waiver was renamed the Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver. Under the NF/AH – Transition and Diversion Waiver, current DD/CNC participants will continue receiving their existing services and the DD/CNC providers will continue to be reimbursed at the pre-existing DD/CNC daily per diem rates.

The NF/AH – Transition and Diversion Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute, nursing facility, distinct-part nursing facility (NF) Level of Care, with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization.

The waiver is approved from January 1, 2012 through December 31, 2016.

NF/AH Waiver Renewal

The NF/AH waiver offers services in the home or in the community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Eligibility into the NF/AH is based on skilled nursing levels of care. The level of care per waiver participant is determined by the Medi-Cal beneficiary's medical need and substantiated by a physician via a completed Plan of Treatment and a home evaluation conducted by the Department's Long-Term Care Division (LTCD) employed program nurse. The waiver is held to the principle of federal cost neutrality thus services are arranged based on an annual cost limitation per participant. In order to maintain cost neutrality, the overall total costs for the Waiver and Medi-Cal State Plan services

HOME AND COMMUNITY BASED SERVICES

cannot exceed the costs of facilities offering equivalent levels of care. The cost neutrality limit requirements are applied individually to each NF/AH Waiver participant therefore limiting access to critically needed services and risking unnecessary institutionalization on a case by case basis.

The waiver will be renewed on January 1, 2017. The Department is engaging in a stakeholder process, beginning October 2014, before finalizing the details of the renewal. Therefore, the fiscal impact is indeterminate at this time.

San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements AB 2968 (Chapter 830, Statutes of 2006) which allows the San Francisco Department of Public Health (SFDPH) to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco.
- Be at least age 21 years or over.
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations.
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting.
- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home-Delivered Meals in DAH sites.

The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, CMS approved a waiver amendment on September 23, 2013, which adjusted enrollment estimates. The waiver is approved from July 1, 2012, through June 30, 2017.

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization.

HOME AND COMMUNITY BASED SERVICES

Services provided include:

- Administrative Expenses
- Attendant care
- Case management
- Financial supplements for foster care
- Home-delivered meals
- Homemaker services
- In-home skilled nursing care
- Minor physical adaptations to the home
- Non-emergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Psychotherapy

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Approved capacity of unduplicated recipients for this waiver is 4,490 in 2014, 4,570 in 2015 and 4,660 in 2016. The waiver is approved from January 1, 2012 through December 31, 2016. **The Department plans to initiate the waiver renewal process in FY 2015-16.**

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are ~~*certifiable for*~~ **at risk of** placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and **can** be certified ~~or certifiable~~ for placement in a nursing facility. Services provided by MSSP include: adult day care / support center, housing assistance, ~~*ehore*~~ **household** and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Under the approved waiver, beginning July 1, 2014 through June 30, 2019, capacity of unduplicated recipients is as follows:

HOME AND COMMUNITY BASED SERVICES

- Waiver Year 1: 12,000
- Waiver Year 2: ~~40,932~~ **12,000**
- Waiver Year 3: ~~6,011~~ **12,000**
- Waiver Years 4 & 5: ~~5,624~~ **8,812**
- **Waiver Year 5: 5,624**

The decrease in Waiver capacity is a result of the Coordinated Care Initiative (CCI), which will phase out the MSSP Waiver by ~~March~~ **December 31, 2017** and integrate as a managed care benefit in the seven CCI counties.

Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)

The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the mentally retarded; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is 110,000 in 2013, 115,000 in 2014 and 120,000 in 2015. The waiver is approved from March 29, 2012 through March 28, 2017.

Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to State Plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009, through March 31, 2012. ~~The~~ CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective April 1, 2012, through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800. **The PPC Waiver is expected to be renewed prior to the March 31, 2017 expiration.**

Managed Care Programs

Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical long-term services and supports, dental, vision and other specialty services, allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place. The Department has statutory authority to contract with up to 15 PACE organizations.

HOME AND COMMUNITY BASED SERVICES

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. ~~*The Department has renewed the SCAN contract through December 31, 2015.*~~ **The Department negotiates this contract on an annual basis.**

Special Grant

California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. Grant funds may be requested from January 1, 2007, through September 30, ~~*2016*~~ **2018**. The Department is pursuing the continuation of grant funds through September 30, 2020. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal beneficiaries who have resided continuously in health care facilities for three months or longer back to a federally-qualified residence.

1115 WAIVER-MH/UCD & BTR

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) was approved effective November 1, 2010, for five years. This Demonstration extends and modifies the previous MH/UCD. Many of the features of the previous Demonstration have been continued with modifications as noted in the individual assumptions. There is no new funding for the South LA Preservation Fund and the Distressed Hospital Fund. Other significant changes in the Demonstration are:

- Expansion of the state-only programs that may be federalized up to a maximum of \$400 million in each year of the waiver;
- Creation of a Delivery System Reform Incentive Pool (DSRIP) fund to support public hospital efforts in enhancing quality of care and health of patients;
- Expansion of the current Health Care Coverage Initiative (HCCI) by creating a separate Medicaid Coverage Expansion (MCE) program using new funding for those eligibles that have family income at or below 133% of the Federal Poverty Level.

The BTR ~~will~~ **was scheduled to** end on October 31, 2015. The Department ~~plans to work with CMS to extend this Demonstration and/or submit a waiver renewal concept for 2015-16 and beyond. The Department assumes that all existing BTR Demonstration funding for designated public hospitals will continue. At this time, the Department is not assuming the continuation of the \$400 million for designated state~~ ***announced a conceptual agreement with CMS on October 31, 2015 that outlined the major components of the Waiver renewal, along with a temporary extension to December 31, 2015 of the existing BTR waiver while the official Special Terms and Conditions (STCs) were completed.** *

~~The Department intends to seek a new five-year waiver valued between \$15 billion to \$20 billion to accomplish various system transformation initiatives.~~

~~The new Waiver design has three core components:~~

- ~~Shared savings with the federal government of Waiver savings to be reinvested into the Medi-Cal Program;~~
- ~~A redesign of Disproportionate Share Hospital (DSH) and Safety Net Care Pool Uncompensated Care funding under a global payment model to provide care to the remaining uninsured; and~~
- ~~A set of delivery system transformation and alignment incentives that leads to the achievement of Waiver goals.~~

~~Under the rubric of delivery system transformation and alignment incentives there are six concepts:~~

- ~~Incentives that foster partnerships and quality improvements in and among managed care plans, behavioral health systems, and providers;~~
- ~~Fee-for-service quality improvement incentives in areas such as dental and maternity care where FFS continues to play a critical role in the delivery system;~~

1115 WAIVER-MH/UCD & BTR

- A successor to the DSRIP at California's public hospital systems
- Workforce development strategies;
- Incentives to promote access to housing and supportive services; and
- In places that are ready, the opportunity for counties and Medi-Cal plans to partner in local pilots, with providers and entities across the spectrum, that combine the aforementioned approaches of delivery system transformation and alignment.

The total initial federal funding in the renewal is \$6.218 billion, with the potential for additional federal funding in the global payment program to be determined after the first year.

The conceptual agreement includes the following core elements:

- **Global Payment Program (GPP) for services to the uninsured in designated public hospital systems (DPH). The GPP converts existing Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding – which is hospital-focused and cost-based – to a system focused on value and improved care delivery. The funding of the GPP will include five years of the DSH funding that otherwise would have been allocated to Designated Public Hospitals (DPHs) along with \$236 million in initial federal funding for one year of the SNCP component. SNCP component funding for years two through five would be subject to an independent assessment of uncompensated care.**
- **Delivery system transformation and alignment incentive program for DPHs and district/municipal hospitals (DMPH), known and PRIME (Public Hospital Redesign and Incentives in Medi-Cal). The federal funding of PRIME for the DPHs is a total of \$3.2655 billion over the five years of the Waiver, which includes \$700 million for each of the first three years, \$630 million in year four, and \$535.5 million in year five. The federal funding for the DMPHs is a total of \$466.5 million over the five years of the Waiver, which includes \$100 million for each of the first three years, \$90 million in year four, and \$76.5 million in year five.**
- **Dental Transformation Incentive program. The funding of this program is \$750 million in total funding over five years.**
- **Whole Person Care Pilot (WPC) program, which would be a county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations. The funding of this program would be up to \$1.5 billion in federal funds over five years.**
- **Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries.**
- **Independent studies of uncompensated care and hospital financing.**

MANAGED CARE

Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months and plans' self-reported utilization and encounters by category of service (i.e., Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc.) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Family/Adult, and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment.

Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.

A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.

The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult/Family and Disabled Medi-Cal Only capitation rates.

Prior to July 1, 2014, rates for the Family category of aid (COA) were paid as one blended rate. Effective July 1, 2014, the department has split the Family COA in 2 groups: "Child (Under 19)" and "Family/Adult (19 and Over)".

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates are risk adjusted in the Family/Adult and Aged/Disabled/Medi-Cal Only Categories of Aid (COAs).

Risk Adjustment and County Averaging is prepared with plan specific pharmacy data (with NDC Codes) gathered for Managed Care and FFS enrollment data for the most recent 12 month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for at least 6 out of 12 months, (not necessarily consecutive) then the beneficiary will be counted in the plan's risk scoring calculation.

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or

MANAGED CARE

SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the ~~2014-15~~ **2015-16** rates, ~~60%~~ **50%** of this county specific rate was taken and multiplied by each plan's respective risk score and ~~40%~~ **50%** of each plan's plan specific rate was retained and added to the ~~60%~~ **50%** risk adjusted rate to establish a risk adjusted plan specific rate. The risk adjustment policy will be examined in future years and adjusted if determined necessary.

For County Organized Health Systems, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and GMC models.

Fee-for-Service Expenditures for Managed Care Beneficiaries

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC/RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

For further information, see policy change FFS Costs for Managed Care Enrollees.

2014-15 and 2015-16 and 2016-17 Rates

Overall, the rates represent a ~~3.5%~~ **2.3%** increase in FY ~~2014-15~~ **2015-16** over the previous fiscal year rates (based on a fiscal year comparison). Rates for FY ~~2015-16~~ **2016-17** represent a ~~1.9%~~ **2.5%** increase over the ~~2014-15~~ **2015-16** fiscal year rates.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent **audited** cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personal activities. Costs are limited to the 90th percentile of each facility's peer group.
- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

In the absence of legislation, the AB 1629 facility-specific rate methodology, QAF, and QASP are scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date with a 3.62% total annual rate increase. **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. The Department has proposed Trailer Bill Language to extend the program until July 31, 2020. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.**

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

PROVIDER RATES

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective June 2014, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65th percentile.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

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REVENUES

1. Revenues

The State is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2014-15: \$	27,409,000	ICF-DD Quality Assurance Fee
\$	522,095,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$	9,120,000 <u>9,219,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
\$	1,862,000	Freestanding Pediatric Subacute Quality Assurance Fee
\$	1,407,405,000	MCO Tax
\$	3,991,796,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$	9,867,000 <u>8,750,000</u>	Emergency Medical Air Transportation Fund (EMATA)
\$	5,811,758,000 <u>5,968,536,000</u>	Total
FY 2015-16: \$	27,886,000 <u>26,705,000</u>	ICF-DD Quality Assurance Fee
\$	540,994,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$	6,847,000 <u>9,244,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
\$	1,862,000	Freestanding Pediatric Subacute Quality Assurance Fee
\$	1,733,235,000 <u>1,744,753,000</u>	MCO Tax
\$	4,600,535,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$	9,867,000 <u>10,000,000</u>	Emergency Medical Air Transportation (EMATA) Fund
\$	6,390,017,000 <u>6,934,093,000</u>	Total
FY 2016-17: \$	<u>26,993,000</u>	ICF-DD Quality Assurance Fee
\$	<u>560,578,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$	<u>9,244,000</u>	ICF-DD Transportation/Day Care Quality Assurance Fee
\$	<u>1,862,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
\$	<u>1,583,986,000</u>	MCO Tax
\$	<u>2,575,289,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$	<u>10,000,000</u>	Emergency Medical Air Transportation (EMATA) Fund
\$	<u>4,767,952,000</u>	Total

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Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee for AB 1629 facilities is assessed, to include Medicare.

The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of \$22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated \$6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

SB 78 (Chapter 33, Statutes of 2013) provides for a statewide tax on the total operating revenue of Medi-Cal Managed Care Plans. Although this tax is effective through June 2016, it has been deemed out of compliance with federal regulations and will be replaced with a new tax beginning July 1, 2016. Proposed legislation provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least \$320 million.

SB 335 (Chapter 286, Statutes of 2011) authorized the implementation of a new Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This extension authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased

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capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

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 FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

2. Redevelopment Agency and Local Government Funds

~~The amended 2009 Budget Act included a \$3.6 billion expenditure transfer of Redevelopment Agency and local government funds to the General Fund to offset General Fund expenditures. Of the \$3.6 billion transfer, \$572,638,000 has been attributed to the Medi-Cal program for accounting purposes. The transfer provides funds directly to the General Fund, and cash does not flow through the Department of Health Care Services. The transfer does not affect Medi-Cal payments or the estimate.~~

ELIGIBILITY

1. County Administration Base

The Department is in the process of finalizing a Request for Offer (RFO) for approval to hire a contractor to begin evaluating county processes and time-studies associated with the new budgeting methodology. The Department anticipates the workgroup to begin meeting in the spring of 2015 ~~FY 2015-16~~.

2. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the

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premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to March 31, 2015, by HR 4302, the Protecting Access to Medicare Act of 2014. **The Medicare Access and CHIP Reauthorization Act of 2015 provides a permanent allotment of the QI-1 program.**

3. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended March 31, 2015, by HR 4302, the Protecting Access to Medicare Act of 2014.

4. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

5. Ledezma v. Shewry Lawsuit

~~The Department negotiated a settlement of the *Ledezma v. Shewry* lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not significant. The parties determined the scope of the Department's liability by contacting beneficiaries who may have incurred out-of-pocket expenses. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.~~

6. Electronic Asset Verification Program

Due to the requirements imposed by HR 2642 of 2008, the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to financial institutions. The Department

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will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The financial vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. There will be undetermined costs for a third party contract as well as reimbursements to financial institutions. Although savings from asset and eligibility verification are currently indeterminate, savings/cost avoidance will be achieved when supplemental data increases the accuracy of eligibility determinations for the ABD population. The implementation date of this program is currently unknown.

7. Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements. If eligible for Medi-Cal, residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system. ~~It is not known when the transitions will begin.~~
All residents were transitioned out of Lanterman Development Center by December 31, 2014.

8. Medi-Cal Inpatient Services for Inmates

AB 720 (Chapter 646, Statutes of 2013) requires the suspension of Medi-Cal benefits for all Medi-Cal eligible inmates, regardless of age. This new state law authorizes county boards of supervisors, in consultation with the county sheriff, to designate an entity or entities to act on behalf of county inmates and assist county jail inmates to apply for a health insurance affordability program.

9. Refugee Resettlement Program

The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, the majority of refugees are expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

10. Proposal for Glendale Adventist Medical Center

The Department of State Hospitals (DSH) is pursuing a contract with Glendale Adventist Medical Center, for up to a 40-bed program in a secure facility located in a non-DSH hospital at a daily rate of \$300 per bed. This equates to an estimated cost of

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\$109,500 per bed, per year. The program will be licensed as a Skilled Nursing Facility (SNF) and will serve SNF patients transferred primarily from DSH-Metropolitan. The patients eligible for this transfer would be committed as either: Not Guilty by Reason of Insanity (NGI), Mentally Disordered Offenders (MDO), or Lanterman-Petris-Short (LPS) patients in need of treatment on a SNF unit. DSH-Metropolitan is currently able to transfer up to 40 patients to Glendale and backfill those beds with low-security forensic patients who are able to receive treatment outside of the Secure Treatment Area (STA) and who are in need of SNF care. This will, in turn, free additional beds in the STA and allow DSH to admit additional forensic patients.

AFFORDABLE CARE ACT**1. Realignment**

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be \$724.9 million in FY 2014-15 and \$743.158 million in ~~FY 2015-16~~ **\$741.9 million for FY 2015-16 and \$564.5 million for FY 2016-17.** **Final reconciliation for FY 2013-14 are estimated to cost \$151.7 million to be paid in FY 2016-17.**

2. Disproportionate Share Hospital Reduction

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The ACA reduction in the Disproportionate Share Hospital (DSH) allotments was to have gone into effect on October 1, 2013; instead, HR 2 (2015) was enacted on April 16, 2015, which delays the reduction ~~start of the reductions~~ until October 1, 2017. The ACA nationwide reduction of State DSH allotments will begin to occur in FY 2017-18. The reduction for each state will be determined by CMS.

For federal fiscal year 2018, an aggregate of \$2 billion in reduction for all states has been determined, but state specific reductions have not been released by CMS.

3. IRS Reporting for Medi-Cal Minimum Essential Coverage

~~Beginning in 2014, the Affordable Care Act (ACA) required most U.S. citizens and legal residents to have qualifying health insurance coverage or pay a tax for not carrying insurance, known as the individual mandate. Internal Revenue Code Section 6055 finalized and published by the Internal Revenue Service (IRS) on March 10, 2014 requires that all State Medicaid Agencies meet the information reporting requirements to support the individual mandate reporting. The Department is required to comply with the minimum essential coverage (MEC) reporting requirements for tax year 2015. The state will be subject to a penalty if it does not show good faith in attempting to implement these new reporting requirements. The Department will develop a system to report information about Medi-Cal consumers with MEC to the IRS. The Department is still researching the fiscal impact and options on the best way to implement/leverage a system for this new reporting requirement.~~

BENEFITS

1. State-Only Anti-Rejection Medicine Benefit Extension

Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.

2. Adrenoleukodystrophy (ALD) as a CCS Eligible Condition

AB 1559, statutes of 2014, requires that statewide newborn screening be expanded to include Adrenoleukodystrophy (ALD), "as soon as ALD is adopted by the federal Recommended Uniform Screening Panel (RUSP)." The Genetic Disease Screening Program anticipates initiation of universal screening of all newborns for ALD beginning in July of 2016. Newborn screening for ALD will identify all children with the genetic disorder. Adrenal insufficiency occurs in 90 percent of males, with onset as early as 6 months of age. Nearly all female carriers develop symptoms in adulthood, so would not typically be age eligible for CCS but may be covered by Medi-Cal.

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With universal screening for ALD, the protocols for the medical management of the condition can be expected to evolve quickly as more individuals with the condition are identified. It is likely medical management protocols will place greater emphasis on early monitoring, prevention, and timely diagnosis and treatment in response to the emergence of signs of disease progression. A broad array of services are expected to be used ranging from laboratory, physician, and inpatient services to occupational and physical therapy, durable medical equipment, and bone marrow/stem cell transplant. More case by case research is required to estimate correctly.

HOME & COMMUNITY BASED-SERVICES

1. AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project. In conjunction with DOR, the Department has explored serving this population through other HCBS waivers.

2. Medicaid Health Home Services Benefits

This assumption has been deleted and is now located in PC 213.

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

1. Average Acquisitions Cost as the New Drug Reimbursement Benchmark

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source ceased publishing AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new methodology for Medi-Cal drug reimbursement that is based on average acquisition cost (AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

2. Federal Upper Limit

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS

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had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs. On May 23, 2011, CMS reported that a notice of proposed rulemaking (NPRM) implementing the changes to AMP had been drafted and was under review. The Department plans to implement the FULs, after federal regulations have been published and/or final FULs are provided by CMS.

3. State Supplemental Drug Rebates – Managed Care

State supplemental rebates for drugs are negotiated by the Department with drug manufacturers to provide rebates in addition to the mandatory federal rebates already collected. SB 870 (Chapter 40, Statute of 2014) authorizes the Department to include utilization data from MCOs to determine and collect state supplemental rebates for prescription drugs added to the Medi-Cal Statewide Contract Drug List pursuant to Welfare & Institutions Code section 14105.33. Examples of prescription drugs subject to MCO state supplemental rebates may include drugs to treat diseases such as, but not limited to, cancer, HIV/AIDS, hemophilia and hepatitis C. The Department is pursuing contracts for these rebates.

DRUG MEDI-CAL

1. Naltrexone Treatment Services

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and substance use disorder diagnoses. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.

2. SUD Services Modification for Narcotic Treatment Program

Effective January 1, 2014, SPA #13-038 modified SUD services by removing the 200 minute per month cap on individual counseling services for Narcotic Treatment Programs. This policy allows medical necessity to be the basis for the amount of counseling needed by the patient. Individuals are evaluated and assessed prior to receiving treatment, hence the clinician would make the assessment of how many minutes of therapy a client needs.

INFORMATION ONLY**3. SUD Services Modification for DMC Treatment Programs**

Effective January 1, 2015, SPA #15-012 modified SUD services by expanding the group counseling size limits for DMC. This policy allows flexibility to ensure patients have access to groups.

This change affects the following programs:

- Narcotic Treatment Program (NTP)
- Intensive Outpatient Treatment Services (IOT)
- Outpatient Drug Free Treatment Services (ODF)

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE**1. CCS Redesign**

To improve access to health care for the Children and Youth with Special Health Care Needs (CYSHCN) and to eliminate the fragmentation that exists in the current CSS health care delivery system, the department initiated a CCS Redesign project with stakeholder input.

To move incrementally toward a better integrated and coordinated system of care for CCS, the Department has developed a multi-year framework for a “Whole Child” model that builds on existing successful models and delivery systems. This balanced approach will assure maintenance of core CCS provider standards and network of pediatric specialty and subspecialty care providers, by implementing a gradual change in CCS service delivery with an extended phase-in and stringent readiness and monitoring requirements that will ensure continuity of care and continued access to high-quality specialty care. The “Whole Child” model provides an organized delivery system of care for comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children’s hospitals, specialty care providers, and counties.

Starting in January 2017, subject to successful readiness review by the department, the first phase will incorporate CCS into the integrated care systems of most County-Organized Health Systems (COHS). COHS are county developed and operated Medi-Cal managed care plans with strong community ties. CCS is already integrated into three COHS in six counties, through the CCS “carve-in,” so three of the COHS plans already have experience with key elements of this model. In addition the Health Plan of San Mateo has already implemented most elements of this model. With the Whole-Child model, the COHS health plans will provide and coordinate all primary and specialty care, similar to the Health Plan of San Mateo model. These plans will be required to demonstrate support from various stakeholders that may include the

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respective county CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families.

The “Whole Child” model may also be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The extension of the “Whole Child” model to these counties will begin no earlier than July 2017, and will be subject to a successful readiness review by the Department.

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

1. Hospital Inpatient Rate Freeze

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

2. Capital Project Debt Reimbursement

In February 2014, Los Angeles County requested reimbursement of a \$322 million bond project for the Construction, Renovation and Reimbursement Program (CRRP). The project was completed in April 2014. The Department is currently working with Los Angeles County to determine eligibility for this project under the CRRP program.

OTHER: AUDITS AND LAWSUITS

1. SB 1103 Litigation

- OAHA Administrative Appeals and Superior and Appellate Court Actions

In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103 (~~See *Mission Hospital Regional Medical Center v. Douglas*, above~~). During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA). ~~The 50 some hospitals include both *Mission* litigants and non-*Mission* litigants.~~ All challenge SB 1103's validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103's alleged invalidity.

OAHA has been holding these administrative appeals in abeyance during the *Mission Hospital Regional Medical Center v. Douglas* litigation, which finally terminated in early 2014. Currently, 23 cases remain in abeyance. Since 2013, OAHA has dismissed at least 17 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission*

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litigation's challenge to SB 1103. In one case, the hospital has ordered the administrative record but the petition for writ of mandate has not yet been filed. In 18 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petition and the hospitals have appealed. (*Dignity Health v. Douglas*; *Hi-Desert Med. Center v. Douglas & Modoc Med. Center v. Douglas*). In the four other cases, the superior court denied the writ petition and the Department has appealed one. (*George L. Mee Mem'l Hosp. v. Douglas*). The Department has not yet filed a notice of appeal in the other two cases. (*Desert Valley Hosp. v. Douglas & Ridgecrest Regional Hosp. v. Douglas*.)

To date, no court has ruled on SB 1103's substantive validity.

2. California Hospital Association v. Shewry

The California Hospital Association (Plaintiff) is a trade association representing nursing facilities that are a distinct part of a hospital (DP/NFs). Plaintiff contends the Department's policy of excluding the projected costs of facilities with less than 20% Medi-Cal days in determining the median rate results in rates that violate various laws, including 42 U.S.C. section 1396a(a)(30)(A). Plaintiff also contends that the freeze in rates during rate year 2004-05 violated section 1396a(a)(30)(A). Plaintiff seeks an injunction against the continued use of the 20% exclusion policy and a writ of mandate requiring the Department to recalculate rates for rate years 2001-02 to present and pay DP/NFs the additional amount owed based on the recalculations.

On August 20, 2010, the Court of Appeal issued a decision reversing the trial court's judgment in favor of the Department. The Court of Appeal held that the Department violated section 1396a(a)(30)(A) by failing to evaluate whether rates were reasonable relative to provider costs. On October 12, 2011, the United States Supreme Court denied the Department's petition for certiorari (i.e., review) of the Court of Appeal decision. The case was then remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 to present. ~~So far, there has been some additional discovery, but no other activity has occurred since the remand.~~ Additional discovery was conducted during February and March of 2012, but no other activity has occurred since the remand and it is the plaintiffs' obligation to pursue further action at the trial court level.

INFORMATION ONLY**3. Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services**

Plaintiffs are 17 hospitals that contend that the 10% Medi-Cal payment reductions the Department implemented for non-contract hospital inpatient services, pursuant to ABX45 (Chapter 3, Statutes of 2008), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30). The status of the case is as follows:

- On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% payment reduction for non-contract hospital inpatient services rendered on or after that date with respect to only the 17 plaintiff hospitals,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On February 22, 2012, the United States Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction, and
- On January 9, 2014, the Ninth Circuit issued a decision reversing and vacating the November 2009 injunction and remanded to the district court for further proceedings.
- On October 10, 2014, the district court stayed further proceedings, pending a decision by the United States Supreme Court in the case of *Armstrong, et al. v. Exceptional Child Center, et al.* The Court in *Armstrong* will be deciding whether the Supremacy Clause of the United States Constitution confers a right of action upon providers to sue states for violation of 42 U.S.C. section 1396a(a)(30)(A), which is one of the federal Medicaid provisions at issue.
- **On March 31, 2015, the Supreme Court held in the *Armstrong* case that the Supremacy Clause of the United States Constitution did not confer a right of action for providers to sue states for violation of section 1396a(a)(30)(A). In June 2015 the parties in the *Santa Rosa* case completed supplemental briefing on the impact of that case and are waiting on the federal district court to issue a decision on the parties pending cross-motions for summary judgment.**

4. Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly

This lawsuit challenges the 10% reduction required by AB 5 (Chapter 3, Statutes of 2008) in Medi-Cal payments that took effect on July 1, 2008. These reductions are mandated by W&I Code sections 14105.19 and 14166.245. Plaintiffs contend that these reductions violate 42 U.S.C. section 1396a(a)(30)(A) and the Americans with Disabilities Act. The status of this case is as follows:

- On August 18, 2008, the district court issued a preliminary injunction against the 10% reduction for physicians, dentists, optometrists, adult day health care centers, clinics, and for prescription drugs for services on or after August 18, 2008,
- On November 17, 2008, the district court issued a preliminary injunction against the 10% reduction for home health and non-emergency medical transportation (NEMT) services for services on or after November 17, 2008,
- On July 9, 2009, the Ninth Circuit issued a decision affirming the district court's August 18, 2008, preliminary injunction. The Ninth Circuit further granted plaintiffs'

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- appeal with respect to their claim that the district court's August 18, 2008, injunction should have applied to service back to July 1, 2008,
- On August 7, 2009, the Ninth Circuit issued a decision affirming the district court's preliminary injunction with respect to NEMT and home health services,
 - On January 22, 2010, the district court issued an order requiring the Department to pay additional money due for July 1, 2008 through August 17, 2008 to providers in the 6 categories covered by the August 18, 2008 injunction,
 - On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case to the Ninth Circuit to reconsider the Department's appeals of the two injunctions. ~~Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.~~

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, Statutes of 2008), AB 1183 (Chapter 758, Statutes of 2008), and AB 5 (Chapter 5, Statutes of 2009). Under the terms of the global settlement, the Department agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money the Department will not be recouping. ~~The terms of the settlement are subject to approval by the~~ **The federal government approved the settlement on March 24, 2015. In accordance with the settlement, the plaintiffs have dismissed their lawsuit with prejudice. This litigation is now closed and will no longer be reported.** ~~On October 22, 2014, the Department submitted a request to the federal government for approval.~~

5. AB 1183 Litigation

Two lawsuits challenged provider payment reductions that were mandated by AB 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs, adult day health care center (ADHC) services, and other hospital services. The plaintiffs in these cases contend that the reductions violate 42 US Code Section 1396(a)(30)(A).

- In the *Independent Living Center of Southern California (formerly Managed Care Pharmacy) v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs.
- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHC services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the

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hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Ninth Circuit issued three decisions that affirmed preliminary injunctions against the AB 1183 payment reductions for prescription drugs, ADHC and hospital services. On February 22, 2012, the Supreme Court issued a ruling that vacated the Ninth Circuit decisions and remanded both cases back to the Ninth Circuit to reconsider the Department's appeals of the three injunctions in the above cases. ~~Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.~~

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, Statutes of 2008), AB 1183 (Chapter 758, Statutes of 2008), and AB 5 (Chapter 5, Statutes of 2009). Under the terms of the global settlement, the Department agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money the Department will not be recouping. ~~The terms of the settlement are subject to approval by the~~ **The federal government approved the settlement on March 24, 2015. In accordance with the settlement, the plaintiffs have dismissed their lawsuit with prejudice. This litigation is now closed and will no longer be reported.** ~~On October 22, 2014, the Department submitted a request to the federal government for approval.~~

6. AB 97 Litigation

Four lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

- *California Hospital Association v. Douglas, et al.*

Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011, shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government (~~Secretary of the Department of Health and Human Services, Kathleen Sebelius~~), which approved a State Plan Amendment (SPA) concerning these reductions, ~~was~~ **has** been named as a co-defendant.

On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011, that were not reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On

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May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. The lawsuit has been remanded to the federal district court where plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs.

- *California Medical Transportation Association v. Douglas, et al.*

Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services.

- *California Medical Association et al. v. Douglas,*

Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government (~~Kathleen Sebelius, Secretary of Health and Human Services~~), which recently approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

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On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments.

- *Eastern Plumas Healthcare District, et al. v. Dept. of Health Care Services, et al.*

Plaintiffs are nine hospitals that operate nursing facilities that are a distinct part of a hospital (DP/NFs). This lawsuit was filed May 2014 in San Francisco Superior Court to challenge the validity of the AB 97 reduced rates for DP/NFs that are to be implemented for the period June 1, 2011, through September 30, 2013, pursuant to the federally approved State Plan.

7. *California Hospital Association v. David Maxwell-Jolly*

This lawsuit seeks to enjoin a "freeze" in rates for the 2009-10 rate year (i.e. freeze rates at the 2008-09 rate levels) for hospital based nursing facility and sub-acute care services and the extension to some small and rural hospitals of the 10% reduction for non-contract hospital inpatient services. Plaintiff alleges violations of various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30), and that implementation of these statutory changes is preempted by the Supremacy clause of the United States Constitution.

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department's motion for a stay of appellate proceedings pending petitions for certiorari in *Maxwell-Jolly v. Independent Living Centers* and *Maxwell-Jolly v. California Pharmacists Association*. On March 30, 2012, the Ninth Circuit ordered an end to the stay. ~~This case has been referred to non-binding mediation in the Ninth Circuit, so there will be no further briefs submitted by the parties until the mediation is complete.~~

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and

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several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, Statutes of 2008), AB 1183 (Chapter 758, Statutes of 2008), and AB 5 (Chapter 5, Statutes of 2009). Under the terms of the global settlement, the Department agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money the Department will not be recouping. The terms of the settlement are subject to approval by the ~~The~~ federal government **approved the settlement on March 24, 2015. In accordance with the settlement, the plaintiffs have dismissed their lawsuit with prejudice. This litigation is now closed and will no longer be reported.**

8. ABX3 5 Litigation

- California Association of Rural Health Clinics, et al. v. Maxwell Jolly

Plaintiffs, an individual Federally Qualified Health Center (FQHC) and an association representing multiple Rural Health Clinics (RHCs), allege that the Department illegally applied the 2009 elimination of certain optional Medi-Cal benefits required by ABX3 5 (Chapter 20, Statutes of 2009) to FQHCs and RHCs. Plaintiffs contend that certain benefits are mandatory when provided by an FQHC and seek to compel the Department to continue to reimburse FQHCs for these services. Plaintiffs contend that W&I Code section 14131.10 is preempted via the Supremacy Clause of the US Constitution as to Departmental payment to FQHCs and RHCs for the provision of these eliminated benefits.

On October 20, 2010, the district court issued an order enjoining the Department from disallowing certain optional benefits to RHCs and FQHCs until the applicable SPA was approved by CMS. Both the Department and Plaintiffs appealed. On May 23, 2011, CMS approved the SPA eliminating the Medi-Cal optional benefits for all providers, including FQHCs and RHCs.

On July 5, 2013, the Ninth Circuit Court of Appeals found that the statutory definition of physician services for FQHCs and RHCs includes the eliminated services. Although these services are optional under Medi-Cal, in FQHCs and RHCs, they are mandatory and Medi-Cal must reimburse for them. The Ninth Circuit further found that the Department was obligated to obtain SPA approval before implementing it. This ruling became effective on September 26, 2013. Accordingly, beginning September 26, 2013, the Department began reimbursing FQHCs and RHCs for podiatry, optometry and chiropractic services. The parties are currently litigating the form of the judgment.

- American Indian Health Services, Inc., et al. v. Toby Douglas, et al.

Petitioners and plaintiffs, which are Federally Qualified Health Centers (FQHC), filed a Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief. Petitioners and plaintiffs seek an order requiring the Department to process and pay claims for adult dental, podiatry, and chiropractic services that petitioners provided to

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eligible Medi-Cal beneficiaries during the period July 1, 2009, to September 26, 2013, pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (2), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007. **The parties are currently in the discovery process with hearing set for November 13, 2015.**

9. Managed Care Potential Legal Damages

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

- *Santa Clara County Health Authority dba Santa Clara Family Health Plan v. DHCS*
- *Health Net of California, Inc. v. DHCS*
- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

On April 20, 2011, the trial court issued a judgment in favor of plaintiff Santa Clara County Health Authority and on June 13, 2011, judgment was issued in favor of plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The Department and Santa Clara have also entered into a settlement agreement. In November 2014, the Department fully paid Santa Clara in accordance with the terms of the settlement.

~~The Department is also currently in the process of settling a similar rates dispute with Medi-Cal Managed Care Plan Inland Empire Health Plan (IEHP). This case is currently pending before the Office of Administrative Hearings and Appeals and settlement discussions are on-going.~~

10. AIDS Healthcare dba Positive Healthcare

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As a result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff appealed. On November 3, 2011, the Ninth Circuit Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA proceeded. In October 2012, the U.S. District Court stayed this case pending a ruling in the AB 97 consolidated appeal. On December 13, 2012, the Ninth Circuit Court of

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Appeal issued a decision in the AB 97 consolidated cases. The Department filed a motion to continue the stay, but on February 25, 2013, the court lifted the stay.

After the stay was lifted, the parties filed cross-motions for summary judgment. On March 18, 2013, the court found in favor of the Department on the Equal Protection claims, but ruled in favor of Plaintiff on their cross-motion for summary judgment on the (a)(30)(A) and SPA approval causes of action. The court held that:

- The Department was required to obtain SPA approval prior to implementation and did not do so, and
- Neither the legislature nor the Department considered the relevant factors under (a)(30)(A). The court enjoined the Department from implementing the 340B drug program, effective May 3, 2013.

The Department submitted the SPA on November 1, 2013. CMS approved the SPA on January 30, 2014. Following the Department's motion the Ninth Circuit vacated the judgment and remanded to the district court to consider the impact of CMS' approval. At the June 18, 2014, hearing on the order of the Ninth Circuit Vacating and Remanding, the district court changed the findings of fact to reflect the SPA approval, but re-issued the permanent injunction. ~~The Department plans to appeal to the Ninth Circuit.~~

~~On November 14, 2014, the Ninth Circuit granted the Director's motion to stay the district court order pending our appeal.~~ **The Ninth Circuit granted the Director's motion for a stay until June 22, 2015, at which time the Department filed in the Ninth Circuit a Motion for Summary Reversal and Remand with Direction to Dismiss, and for a Stay of the Briefing Schedule. AHF's opposition was filed on July 16, 2015.**

11. California Pharmacists Association v. David Maxwell-Jolly

This lawsuit challenges the legality of a new upper billing limit provision concerning maximum allowable ingredient costs (MAICs) and the use of recently reduced average wholesale prices (AWPs) in reimbursing drugs. Plaintiffs claim that the State has not complied with 42 U.S.C. section 1396a(a)(30)(A) in enacting and implementing these changes.

On May 5, 2010, the district court issued an order granting preliminary injunction concerning the new upper billing limit and new MAICs, but denied the preliminary injunction concerning the AWP reductions. The Department and plaintiff both appealed. On April 2, 2012, the Ninth Circuit lifted a stay of the appellate injunction that had been in effect, however the preliminary injunction remains in effect. The Ninth Circuit has postponed the appellate court briefing to allow the parties time to explore a possible settlement. Mediation activities are ongoing.

12. Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly

This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the

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Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The Court granted Petitioners' writ on the third cause of action (duty to review rates annually) and ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. On October 24, 2014, the Court found the Department's 2011 rate review report and the analyses of the five third-party payor rates data satisfactory, and discharged the Department's ministerial duty under Welfare and Institutions Code section 14079. The Court also found that the Department satisfactorily demonstrated its intention of conducting this rate review on an annual basis. **On May 22, 2015, Petitioners filed a motion for attorneys' fees in the amount of \$2.5 million in attorneys' fees and costs. On July 10, 2015, the Court ordered both Petitioners and the Department to file a supplemental brief as to the timeliness of the motion. The hearing on the motion was on September 11, 2015.**

13. **Family Planning Services – Los Angeles County Claims Reviewed by the OIG**

~~The Office of the Inspector General (OIG) plans to conduct an audit of family planning services claimed under the Family PACT program in Los Angeles County. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning services provided under the Family PACT program. The audit period covers payments made during the period October 1, 2010 through September 30, 2011.~~

Family Planning Drugs and Supplies – Office of Inspector General (OIG) Audits (Los Angeles and Orange Counties)

The OIG is conducting an audit of family planning drugs and supplies claimed under the Family PACT program in Los Angeles and Orange counties. This audit is a result of duplicate payments identified in the review of Family PACT drugs and supplies in Orange County. The audit covers payments made during the period October 1, 2011, through December 31, 2013.

14. **Family Planning Drugs and Supplies – Office of Inspector General (OIG) Audits (Los Angeles County)**

The OIG is conducting an audit of family planning drugs and supplies claimed under the Family PACT program in Los Angeles county. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning drugs and supplies provided under the Family PACT program. The audit period covers payments made during the period October 1, 2011, through September 30, 2012.

INFORMATION ONLY15. Marquez v. California Department of Health Care Services, David Maxwell-Jolly Lawsuit

Petitioners sought a writ of mandate that would have required the Department to provide a Medi-Cal beneficiary with a due process notice (Notice of Action) and the right to appeal (Fair Hearing) when other health coverage (OHC) is added to a Medi-Cal beneficiary's record. Alternatively, petitioners contended that the Medi-Cal program should change from a cost-avoidance system to a "pay and chase" recovery process. The petition was denied and petitioners have appealed. **Oral argument was heard on July 14, 2015.**

16. Saavedra, et al. v. Toby Douglas, California Department of Health Services Lawsuit

In this writ litigation, petitioners allege that the Department improperly transitioned Seniors and Persons with Disabilities from the fee-for-service Medi-Cal delivery system into the managed care Medi-Cal delivery system by failing to appropriately respond to and process beneficiary requests to be exempted from the transition to managed care ("medical exemption requests"). Petitioners assert that the Department is applying improper standards in deciding medical exemption requests. The Department has revised the denial letter, denial codes and the regulation governing medical exemption requests and is resuming settlement discussions with Petitioners' counsel. **The hearing in this matter was taken off calendar after the parties agreed to settle the Petition for Writ of Mandate with the Department making a payment of \$475,000 for Petitioners attorneys' fees and costs. The Court approved the settlement on May 28, 2015.**

17. Farrow v. Toby Douglas, Director of DHCS, et al.

Petitioner is a disabled Medi-Cal beneficiary whose services were reduced when he reached the age of twenty-one (21). Petitioner alleges that the Department failed to provide petitioner with medically necessary in-home nursing services to which he was entitled under the Medi-Cal program, thereby placing him at risk of institutionalization in violation of state and federal anti-discrimination laws. Petitioner also alleges that the Department failed to comply with statutory and Constitutional due process requirements, including timely notice of termination of benefits, a pre-termination hearing, and aid pending a hearing decision. In addition, petitioner contends that the Department denied him a fair administrative hearing. No hearing has been scheduled. It is petitioner's obligation to set this matter for hearing and they have not done so. If petitioner does not set a hearing date, the Department may move to dismiss in 2016.

18. T. Michael, LLC v. Toby Douglas, Director of DHCS

Plaintiff, on its own behalf and as a class action representative for Residential Care Facilities for the Elderly (RCFEs), challenges the Department's implementation of the 10% payment reductions enacted pursuant to Assembly Bill (AB) 97 (Statutes of 2011) on services provided under the Assisted Living Waiver (ALW).

In April 2013, the Department, pending waiver amendments, reversed its decision to implement the AB 97 reductions on RCFEs and services provided under the ALW. In May 2013 the Department instructed its contractor-agent to process the Erroneous Payment

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Corrections (EPCs) retroactive to June 2011. The Department's contractor-agent failed to process the EPCs within the required contractual deadline of 120 days.

In April 2014 plaintiff filed a state class action lawsuit and seeks to: (1) have the EPCs processed within 10 days; (2) receive interest; (3) attorneys' fees.

As of May 2014, the Department processed and paid the EPC for the entire RCFEs class. ~~Parties are disputing interest and attorneys' fees.~~ **Plaintiff withdrew their original petition in December 2014, and refiled in April 2015 seeking interest, penalties, and attorneys' fees on behalf of the class.**

19. *Asante, et al. v. Department of Health Care Services, et al.*

Plaintiffs are 18 out-of-state hospitals that challenge the validity of Medi-Cal reimbursement paid to out-of-state hospitals for hospital inpatient services. They filed this lawsuit in June 2014 in San Francisco Superior Court. Plaintiffs contend that aspects of the new diagnosis-related group (DRG) reimbursement policy discriminate against out-of-state hospitals in violation of the Interstate Commerce clause and Equal Protection clause of the United States Constitution. They further contend that the Department is violating federal Medicaid law by not making disproportionate share hospital (DSH) payments to qualifying out-of-state hospitals.

20. *Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.*

On July 30, 2014, Plaintiff Riverside Recovery Resources served the Department an amended complaint filed July 22, 2014, in Riverside County Superior Court against the Department and Riverside County Department of Mental Health contesting disallowances of monies for Drug Medi-Cal services provided to minors in Riverside County schools. ~~Post Services Post Payment audit that found services were claimed for duration of time in which Riverside Recovery Resources satellite sites were not lawfully certified for reimbursement.~~ **A Post Services Post Payment audit found that plaintiff submitted claims for services provided at uncertified satellite sites, which were not eligible for reimbursement.** As a result, Riverside County has withheld reimbursement for services during the period of time Riverside Recovery Resources was found to be in non-compliance. Plaintiff disputes the facts upon which the non-compliance findings were based, and **alleges** denial of due process in the administrative appeal process. ~~A trial setting conference is set for February 17, 2015.~~ **Plaintiff filed their opening brief in support of the writ of administrative mandamus on May 1, 2015. Plaintiff argues the Department should be equitably estopped from disallowing the claims because of a lack of clarity in the certification standards. The Department filed its opposition on June 30, 2015. Plaintiff's reply brief was on July 31, 2015, and oral argument was set for August 15, 2015.**

21. *Westside Center for Independent Living, et al v. DHCS*

On July 2, 2014, seven petitioners filed a lawsuit in state court against the Department and its director asking the court to enjoin the implementation of the Coordinated Care Initiative (CCI) and to dis-enroll beneficiaries currently enrolled in CCI. CCI is a joint CMS/Department project seeking to coordinate care for dual eligible

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beneficiaries. Petitioners allege that the Department was without authority to implement CCI and violated certain statutory provisions and due process by failing to comply with necessary notice requirements. On July 11, 2014, the court denied petitioners' ex parte application for a temporary restraining order. The court continued the matter for hearing until August 1, 2014, to decide whether the court should enjoin CCI pending a hearing on the merits. On August 1, 2014, the court denied petitioners' motion for preliminary injunction. Petitioners did not appeal the order denying the motion for preliminary injunction. The Department filed a demurrer seeking to dismiss the petition, which was heard on January 9, 2015. The demurrer was overruled. ~~There is no hearing date currently set for a decision on the merits of the case.~~ **Subsequently, the Department filed a motion for judgement on the pleadings (MJOP), which the court granted in part and denied in part. In its ruling on the MJOP on April 25, 2015, the court found that the Department has authority to implement CCI. Petitioners have not yet set a hearing date on the issue of whether the CCI notices are legally sufficient and comport with due process.**

22. Placentia-Linda Hospital, et al. v. California Department of Health Care Services

The lawsuit was filed in San Francisco County Superior Court on April 9, 2014. Plaintiffs are five hospitals that contend that the Department implemented Medi-Cal payment reductions for non-contract hospital inpatient services from July 1, 2008, through April 12, 2011, as required by Assembly Bill 5 (statutes 2008) and Assembly Bill 1183 (statutes 2008), in violation of 42 United States Code sections 1396a(a)(13) and 1396a(a)(30)(A). Plaintiffs seek a court order requiring the Department to retroactively pay them the additional money they would have received if the Department had not implemented the reductions.

23. Korean Community Center of the East Bay, et al. v. Toby Douglas, et al.

Petitioners seek a preliminary injunction and writ of mandate preventing DHCS from terminating Medi-Cal benefits for those beneficiaries who failed to return any renewal information during the 2014 renewals, until the renewal form (the Request for Tax Household Information or RFTHI) is translated into all threshold languages and the 90 day cure period is included in all notices of action issued by the counties. Petitioners also claim that the ex parte process required by state and federal law is not being utilized and fails to comply with the law.

Petitioners sought a temporary restraining order to prevent counties from terminating beneficiaries. At the hearing on November 18, 2014, the TRO was denied for lack of evidence of exigency and irreparable harm. A hearing on Petitioners request for Preliminary Injunction (Petitioners asked the court to make their request for TRO and Writ petition into a request for Preliminary Injunction) was held on December 9, 2014. Because Petitioner's submitted over 200 pages of new evidence in reply to the Department's opposition brief, the court ordered the Department to further brief the issue and held a further hearing on December 23, 2014. ~~The parties await the court's opinion and order.~~

~~The parties have stipulated to continue the February 2, 2015, case management conference. The court has not issued a ruling regarding the petition for preliminary~~

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injunction. Rather, the court requested, and the parties submitted, supplemental briefing on February 2, 2015. The issues raised by the court in the request for supplemental briefing go to the core of the issues raised regarding translations of Department forms into all threshold languages. As such, it is difficult to predict what the court will do. At the last hearing, the court indicated it was inclined to give greater weight to the Department's arguments; however, with this request for additional briefing, the Department can no longer be confident of the court's leanings.

The court denied in part and granted in part Petitioner's request for Preliminary Injunction. In response, the Department filed a motion for reconsideration. The court denied the motion and issued the preliminary injunction on June 23, 2015, enjoining the termination of beneficiaries for failure to respond or provide requested information who do not have compliant 90 day cure period language in the notices of action and do not have requisite specificity regarding the information required for redetermination but not provided. The Department has directed the SAWS and the counties to cease terminations effective June 23, 2015, for these reasons. The Department is working with CalHEERS and the SAWS to program compliant language provided by the Department.

24. **Thomas, et al. v. Jennifer Kent, Director of DHCS, et al.**

Plaintiffs are disabled Medi-Cal beneficiaries receiving nursing care and other services in their homes under the Medi-Cal Home and Community Based Services Nursing Facility/Acute Hospital Waiver. Plaintiffs allege that they are unable to obtain needed services to continue living safely in their homes because of the Waiver's individual cost limitations for each level of care, which are below the cost for the individual to live in an equivalent institution. Plaintiffs allege that the individual cost cap places the plaintiffs and other similarly situated Medi-Cal beneficiaries at risk of institutionalization, and therefore violates the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and California Government Code section 11135. Plaintiffs ask the US District Court to:

- **Declare the Waiver's individual cost limitations unlawful;**
- **Enjoin the Department from reducing services, discriminating against plaintiffs, and putting them at risk of institutionalization through the cost and eligibility limitations;**
- **Order the Department to provide plaintiffs needed services, and amend policies and procedures to meet plaintiffs' needs and federal cost neutrality requirements. (By, among other things, amending the waiver to an aggregate cap, increasing the total cost of the waiver, and adding additional participant slots to the waiver.)**

25. **A.D. v. Jennifer Kent, et al.**

Plaintiff is a medically fragile child living at home with the help of nursing services provided through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Plaintiff alleges that the Department assessment process for determining covered nursing services violates Medicaid's EPSDT requirements.the

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Americans with Disabilities Act, and the Rehabilitation Act because it fails to consider individual medical necessity and instead imposes service limitations. Plaintiff seeks a declaration of those violations, an injunction against the Department reducing services to plaintiff and others, and an order requiring the Department to amend its policies and procedures to comply with legal authorities.

26. Nooraldeen Kathem and Llal Tluang v. CDSS and DHCS

Petitioners are unaccompanied refugee minors, and as such are beneficiaries of the United States Office of Refugee Resettlement's (ORR) Unaccompanied Refugee Minor (URM) program. The URM program ensures that eligible unaccompanied refugee minors receive foster care and other services, such as health care, upon arrival in the U.S. The California Department of Social Services (CDSS) is responsible for overseeing California's URM program. URM's are not part of California's dependency program and the state does not take legal responsibility for these children. Rather, URM's in California are the legal responsibility of either Catholic Charities or Crittenton, two non-profit agencies selected by ORR that contract with the state. Under current law, URM's may be eligible to receive full, limited, or restricted scope Medi-Cal administered by the Department of Health Care Services (Department). URM's assert that they must be given the option to select fee for service Medi-Cal rather than a managed care plan. Foster youth are also eligible for "former foster youth" Medi-Cal if they are (1) in foster care under the responsibility of the state and (2) are Medi-Cal beneficiaries at age 18 or when they age out of foster care, with no income eligibility or annual renewal, until age 26.

CDSS and the Department have been engaged in discussions with our federal partners for two years concerning this population, and are now preparing a joint All County Welfare Directors Letter (ACWDL) /All County Letter (ACL) that should solve the substance of the issues in the writ. A case management conference is set for October 1, 2015 to allow the parties time to discuss settlement. CDSS and the Department have filed a demurrer in this matter and a hearing is currently set for November 24, 2015 if the parties do not settle all of the issues before that time.

27. Rivera v. Douglas, Director of DHCS

There were a significant number of Medi-Cal applicants whose applications had not been processed within 45 days of the application date ("backlog") and that were still pending. Petitioners filed a writ seeking an order that this backlog is in violation of state law and that state law requires that all Medi-Cal applicants that appear to be eligible should be granted eligibility for Medi-Cal benefits while any necessary verifications are being completed; and specifically that the Department (1) give notice to all applicants in the backlog that they have a right to hearing on the delay, and (2) grant all pending applicants that appear eligible immediate eligibility for Medi-Cal benefits.

Petitioners' Motion for Preliminary Injunction (PI) Motion was granted on January 20, 2015. The Preliminary Injunction prohibits the Department from failing to comply with its duty to make eligibility determinations within 45 days unless certain

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specified legal exceptions apply. It further orders that when an application has not been determined within 45 days, the Department may comply with the injunction by (1) for applicants who appear likely eligible for Medi-Cal, granting Medi-Cal benefits, including a notice of action, pending completion of the final eligibility determination, and (2) for each applicant who has not been granted these benefits and to whom none of the exceptions apply, provide with a notice of hearing rights. Petitioners' claim that all applicants that appear to be eligible should be granted immediate eligibility while verification is completed was not determined in the PI ruling. The Writ has heard on May 18, 2015. The Court has not ruled on the Writ.

Unknown at this time, but it is likely that the costs attributable to the Writ will be (1) for sending out notices to applicants that do not have their eligibility determined within 45 days, (2) granting provisional eligibility to applicants whose applications have not been determined within 45 days until there is no longer a backlog being created, and (3) for Petitioners' attorneys' fees. It is possible, but not likely, that if Petitioners' additional claim that immediate eligibility should be granted while verification is completed is successful the fiscal impact could be in the millions.

OTHER: REIMBURSEMENTS**1. Federal Upper Payment Limit**

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

2. Accrual Costs Under Generally Accepted Accounting Principles

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis. For the most recently completed fiscal year (FY 2012-13), the June 30, 2013, Medi-Cal accrual amounts were estimated to be \$2.23 billion state General Fund, \$5.09 billion federal funds, and \$1.47 billion special fund, for a total of \$8.79 billion.

3. Freestanding Clinic – Former Agnews State Hospital

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by

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July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

4. Refund of Recovery

CMS requested the Department prepare reconciliations of grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of \$240 million FFP for federal FY 2007 through 2011 and \$34 million FFP ongoing each month.

5. Payment Deferrals

The Department issues weekly payments for Fee-For-Service providers. This process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the payments of the Fee-For-Service checkwrite by one week, and (2) the last checkwrite in June of each fiscal year has been delayed until the start of the next fiscal year. Beginning in FY 2012-13, an additional checkwrite and the last month of managed care capitation payments are delayed at the end of each fiscal year until the start of the next fiscal year.

OTHER: RECOVERIES

1. Additional Personal Injury Recoveries

In *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the United States Supreme Court held that a Medicaid agency's lien recovery from a Medicaid beneficiary's tort settlement is limited to the portion of the settlement that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Then, in *Wos v. E.M.A.* (2013) 133 S.Ct. 1391, the U.S. Supreme Court held that states may not adopt a one-size-fits-all mechanism for allocating medical expenses, such as deeming a specific percentage of a tort settlement or award to be the medical expenses portion.

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Instead, states must have processes for determining and recovering only that portion that is attributable to medical expenses.

In response to the *Ahlborn* ruling, California amended Welfare & Institutions (W&I) Code Section 14124.76 and enacted W&I Code Section 14124.785.

On December 26, 2013, H.J. Res. 59 (federal Budget Act) was signed into law. Section 202 of the Act addresses Medicaid third party liability. Section 202, effective October 1, 2014, essentially supersedes *Ahlborn* and *Wos* by allowing states to recover from the full amount of a beneficiary's tort settlement, instead of only the portion designated for medical expenses. The implementation date has been delayed to October 1, 2016. The nullification of the *Ahlborn* ruling is expected to increase savings for the Department.

FISCAL INTERMEDIARY: MEDICAL**1. Advance Payment Authority**

The Department proposes to seek legislative authority which authorizes the State Controller's Office to make advance payments pursuant to the California Medicaid Management Information Systems Fiscal Intermediary (FI) contract contingency payment process. This would allow advanced interim payments to providers in the event there are issues with checkwrite production during any of the System Replacement Releases. If approved, this legislation would reduce the State's potential risk of losing Federal Financial Participation due to non-compliance with federal and the California's Prompt Payment Act requirements, and allows up to twenty thousand providers to receive payment for services rendered to ensure California's 12 million Medi-Cal beneficiaries continue to receive health care services.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**FISCAL INTERMEDIARY: DENTAL****1. Dental Program Utilization Controls Assessment**

In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and other administrative requirements to make the program more provider friendly while maintaining program integrity. The results of this effort are anticipated to be increased provider participation and potentially increased beneficiary utilization.

2. Teledentistry

The Department considers Teledentistry a cost-effective alternative to dental services provided in-person, predominantly in underserved areas. Teledentistry is a way for dentists to deliver services to their patients that is similar to in-person care. The standard of care is the same whether the patient is seen in person or through the Teledentistry environment.

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This method of providing services would allow for improved access to care options for beneficiaries who typically experience access to care issues.

3. Dental Managed Care Experience Based Rates

The rates for the Dental Managed Care plans are currently based on Fee-for-Service program experience. The Dental Managed Care plans believe that the capitation rates they receive do not adequately compensate them for all the duties and benefits they provide. The Department is considering developing a rate setting methodology based on actual plan experience.

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY

AFFORDABLE CARE ACT

PC 20 Express Lane Enrollment
PC 24 ACA Delay of Redeterminations
PC 200 Accelerated Enrollment
PC 216 ACA Expansion-Additional CHIP Funding

BENEFITS

PC 42 Voluntary Inpatient Detoxification

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

PC 52 Restoration of Enteral Nutrition Benefit

DRUG MEDI-CAL

PC 68 Provider Fraud Impact to DMC Program

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PC 119 Change in PACE Methodology
PC 124 Managed Care Expansion to Rural Counties
PC 133 FFS Costs for Managed Care Enrollees
PC 128 Blood Factor Carve Out

PROVIDER RATES

PC 145 Genetic Disease Screening Program Fee Increase

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

OA 66 HCO PPDs – Cost Savings

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS

OA 56 Pediatric Palliative Care Waiver Evaluation
OA 51 MIS/DSS Contract Reprocurement Services

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

OA 43 Third Party Validation of Certified Providers

MENTAL HEALTH

OA 55 Katie A. V. Diana Bonta Special Master

1115 WAIVER—MH/UCD & BTR

PC 96 BTR—Increase Safety Net Care Pool
PC 98 BTR— LIHP Inpatient Hospital Costs for CDCR Inmates
PC 106 BTR—Increase Designated State Health Programs
PC 108 BTR—Health Care Coverage Initiative Rollover Funds

MANAGED CARE

PROVIDER RATES

PC 152 DRG—Inpatient Hospital Payment Methodology

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OA 46 DMHC Interagency Agreement - Administration

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

OA 61 HCO ACA Express Lane Enrollment Contractor Costs

OA 65 HCO LIHP Enrollment

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

PC 11 Federal Immigration Reform

AFFORDABLE CARE ACT

BENEFITS

OA 27 Family PACT Evaluation

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

PC 141 AB 1629 Add-Ons

PC 217 Elimination of Dental Provider Payment Reductions

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL