NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	7/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1728

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$61,799,000	$64,173,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$61,799,000	$64,173,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$61,799,000	$64,173,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund for using methadone and/or levoalphacetylmethadol (LAAM) as narcotic replacement medications.

Authority:
Title 22, California Code of Regulations 51341.1 (14)
AB 106 (Chapter 32, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Narcotic Treatment Program services are provided to beneficiaries that are opiate addicted and have substance abuse diagnoses, and/or who are Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible. Methadone and/or LAAM are used as one component of a comprehensive treatment program for narcotic addiction, along with a medical evaluation, treatment planning, and counseling. These synthetic opiates used in replacement narcotic therapy, appear to normalize brain chemistry and permit resumption of a normal life.

Perinatal services were budgeted in the Department of Alcohol and Drug Program's perinatal appropriation 4200-102-001 and 4200-101-0890. The non-perinatal services were budgeted in the Drug Medi-Cal (DMC) services appropriation 4200-103-0001 and 4200-101-0890. Effective July 1, 2012, these services federal funds will be budgeted in the Department's appropriation 4260-101-0890.

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

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

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BASE POLICY CHANGE NUMBER: 53

2. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.

3. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an 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 implicit price (CIP) deflator, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

Narcotic Treatment	FY 2009-10 UOS Rate	CIP Deflator	FY 2012-13 Rates*	FY 2012-13 Developed Rates	FY 2012-13 Required Rates
Regular					
Dosing	$11.34	7.1%	$12.15	$11.97	$11.97
Individual	$13.30	7.1%	$14.24	$16.60	$14.24
Group	$3.14	7.1%	$3.36	$3.54	$3.36
Perinatal					
Dosing	$12.21	7.1%	$13.08	$13.05	$13.05
Individual	$19.04	7.1%	$20.39	$25.11	$20.39
Group	$6.36	7.1%	$6.81	$6.89	$6.81

*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

5. The cost estimate is developed by the following, Caseload x Units of Service (UOS) x Rates:

FY 2012-13 DMC Regular	Caseload	UOS	Rates	Total
Regular				
Dosing	86,685	74.2	$11.97	$76,991,363
Group	86,685	0.2	$3.36	$58,252
Individual	86,685	34.5	$14.24	$42,586,607
EPSDT				
Dosing	815	65.0	$11.97	$634,111
Group	815	0.2	$3.36	$548
Individual	815	31.6	$14.24	$366,737
Total				$120,637,618

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DMC Regular	Caseload	UOS	Rates	Total
Minor Consent				
Dosing	490	8.8	$11.97	$51,615
Group	490	0.0	$3.36	$0
Individual	490	4.9	$14.24	$34,190
Total				$85,805

DMC Perinatal	Caseload	UOS	Rates	Total
Perinatal				
Dosing	1,967	8.8	$13.05	$225,890
Group	1,967	0.1	$6.81	$1,340
Individual	1,967	3.5	$20.39	$140,375
Total				$367,605

FY 2013-14

DMC Regular	Caseload	UOS	Rates	Total
Regular				
Dosing	93,660	74.2	$11.97	$83,186,377
Group	93,660	0.2	$3.36	$62,940
Individual	93,660	34.5	$14.24	$46,013,285
EPSDT				
Dosing	924	65.0	$11.97	$718,918
Group	924	0.2	$3.36	$621
Individual	924	31.6	$14.24	$415,785
Total				$130,397,926
Minor Consent				
Dosing	559	8.8	$11.97	$58,883
Group	559	0.0	$3.36	$0
Individual	559	4.9	$14.24	$39,005
Total				$97,888

DMC Perinatal	Caseload	UOS	Rates	Total
Perinatal				
Dosing	2,115	8.8	$13.05	$242,887
Group	2,115	0.1	$6.81	$1,440
Individual	2,115	3.5	$20.39	$150,937
Total				$395,264

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 53

6. 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.

		(In Thousands)	
Fiscal Year	**Accrual**	**FY 2012-13**	**FY 2013-14**
DMC Regular	$130,890	$32,723	$0
Minor Consent	$42	$11	$0
DMC Perinatal	$485	$121	$0
FY 2011-12	$131,417	$32,855	$0
DMC Regular	$ 120,638	$90,478	$30,159
Minor Consent	$ 86	$64	$21
DMC Perinatal	$ 368	$276	$92
FY 2012-13	$121,092	$90,818	$30,272
DMC Regular	$ 130,398	$0	$97,798
Minor Consent	$ 98	$0	$73
DMC Perinatal	$ 395	$0	$296
FY 2013-14	130,891	$0	$98,167

7. Below the costs are on a cash basis.

		(In Thousands)	
	Regular	**Perinatal**	**Minor Consent**
FY 2011-12	$32,723	$121	$11
FY 2012-13	$90,478	$276	$64
Total FY 2012-13	$123,201	$397	$75
FY 2012-13	$30,159	$92	$21
FY 2013-14	$97,798	$296	$73
Total FY 2013-14	$127,957	$388	$94

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 53

8. Funding is 50% County Funds and 50% Federal Funds Participation (FFP). Costs related to minor consent are fully funded by the county.

(In Thousands)

	TF	FFP	County
DMC Regular	$123,277	$61,600	$61,677
DMC Perinatal	$397	$199	$198
Total FY 2012-13	$123,673	**$61,799**	$61,875

	TF	FFP	County
DMC Regular	$128,052	$63,979	$64,073
DMC Perinatal	$388	$194	$194
Total FY 2013-14	$128,440	**$64,173**	$64,267

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

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1727

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$25,759,000	$26,078,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$25,759,000	$26,078,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$25,759,000	$26,078,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for Outpatient Drug Free (ODF) Treatment services provided under the Drug Medi-Cal (DMC) program.

Authority:
Title 22, California Code 51341.1 (15)
AB 106 (Chapter 32, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
ODF Treatment services program are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance abuse 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 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 Department of Alcohol and Drug Programs administered the Drug Medi-Cal program before July 1, 2012, whereupon, the program transferred to the Department. Prior to the transfer, the Department of Alcohol and Drug Program's perinatal appropriation (4200-102-001 and 4200-101-0890) and DMC appropriation (4200-103-0001 and 4200-101-0890) funded these services. Effective July 1, 2012,

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

federal funds for these services are budgeted in the Department's appropriation 4260-101-0890.

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

Methodology:

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

2. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports are not finalized, the four quarters, July 2011 through June 2012, are not included in determining the caseload projections.

3. The Units of Service (UOS) data is applied to the four most recent complete quarters, July 2010 through June 2011, to calculate an 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 implicit price (CIP) deflator, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 required rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

DCR	FY 2009-10 UOS Rate	CIP Deflator	FY 2012-13 Rates*	FY 2012-13 Developed Rates	FY 2012-13 Required Rates
Regular					
Individual	$66.53	7.1%	$71.25	$82.98	$71.25
Group	$28.27	7.1%	$30.28	$31.84	$30.28
Perinatal					
Individual	$95.23	7.1%	$101.99	$125.57	$101.99
Group	$57.26	7.1%	$61.33	$62.05	$61.33

*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

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

FY 2012-13

DMC Regular	Caseload	UOS	Rates	Total
Regular				
Group	78,259	14.7	$30.28	$34,834,333
Individual	78,259	1.6	$71.25	$8,921,526
EPSDT				
Group	41,518	4.3	$30.28	$5,405,810
Individual	41,518	0.8	$71.25	$2,366,526
Total				$51,528,195
Minor Consent				
Group	26,255	16.6	$30.28	$13,197,023
Individual	26,255	1.9	$71.25	$3,554,271
Total				$16,751,294

DMC Perinatal	Caseload	UOS	Rates	Total
Perinatal				
Group	3,189	1.7	$61.33	$332,488
Individual	3,189	0.2	$101.99	$65,049
Total				$397,538

FY 2013-14

DMC Regular	Caseload	UOS	Rates	Total
Regular				
Group	78,205	14.7	$30.28	$34,810,297
Individual	78,205	1.6	$71.25	$8,915,370
EPSDT				
Group	43,399	4.3	$30.28	$5,650,723
Individual	43,399	0.8	$71.25	$2,473,743
Total				$51,850,133
Minor Consent				
Group	28,066	16.6	$30.28	$14,107,319
Individual	28,066	1.9	$71.25	$3,799,435
Total				$17,906,754

DMC Perinatal	Caseload	UOS	Rates	Total
Perinatal				
Group	3,060	1.7	$61.33	$319,039
Individual	3,060	0.2	$101.99	$62,418
Total				$381,457

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

6. 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. Below the costs are on an accrual basis.

(In Thousands)

Fiscal Year	Accrual	FY 2012-13	FY 2013-14
DMC Regular	$49,844	$12,461	$0
Minor Consent	$13,535	$3,384	$0
DMC Perinatal	$447	$112	$0
FY 2011-12	$63,826	$15,957	$0

Fiscal Year	Accrual	FY 2012-13	FY 2013-14
DMC Regular	$51,528	$38,646	$12,882
Minor Consent	$16,751	$12,563	$4,188
DMC Perinatal	$398	$299	$99
FY 2012-13	$68,677	$51,508	$17,169
DMC Regular	$ 51,850	$0	$38,888
Minor Consent	$ 17,907	$0	$13,430
DMC Perinatal	$ 381	$0	$286
FY 2013-14	$ 70,138	$0	$52,604

7. Below the costs are on a cash basis.

(In Thousands)

	Regular	Perinatal	Minor Consent
FY 2011-12	$12,461	$112	$3,384
FY 2012-13	$38,646	$298	$12,563
Total FY 2012-13	$51,107	$410	$15,947
FY 2012-13	$12,882	$99	$4,188
FY 2013-14	$38,888	$286	$13,430
Total FY 2013-14	$51,770	$385	$17,618

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

8. Funding is 50% County Funds and 50% federal funds. Costs related to minor consent are fully funded by the county.

(In Thousands)

	TF	FFP	County
DMC Regular (plus Minor Consent)	$67,054	$25,554	$41,500
DMC Perinatal	$410	$205	$205
Total FY 2012-13	$67,464	**$25,759**	$41,705

	TF	FFP	County
DMC Regular (plus Minor Consent)	$69,388	$25,885	$43,503
DMC Perinatal	$385	$193	$192
Total FY 2013-14	$69,773	**$26,078**	$43,695

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

DAY CARE REHABILITATIVE SERVICES

BASE POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1726

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$11,441,000	$9,495,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,441,000	$9,495,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$11,441,000	$9,495,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Day Care Rehabilitative (DCR) services.

Authority:
Title 22, California Code of Regulations 51341.1 (6)
AB 106 (Chapter 32, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
DCR services are provided to beneficiaries with substance abuse diagnoses, who are pregnant or in the postpartum period, and/or are Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible. 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.

Perinatal services were budgeted in the Department of Alcohol and Drug Program's perinatal appropriation 4200-102-001 and 4200-101-0890. The non-perinatal services were budgeted in the Drug Medi-Cal (DMC) services appropriation 4200-103-0001 and 4200-101-0890. Effective July 1, 2012, these services federal funds will be budgeted in the Department's appropriation 4260-101-0890.

DAY CARE REHABILITATIVE SERVICES

BASE POLICY CHANGE NUMBER: 55

Reason for Change from Prior Estimate:
Previous cost settlements showed that providers were billing for services incorrectly.

Methodology:

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

2. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.

3. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an 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 implicit price (CIP) deflator, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

DCR	FY 2009-10 UOS Rate	CIP Deflator	FY 2012-13 Rates *	FY 2012-13 Developed Rates	FY 2012-13 Required Rates
Regular	$61.05	7.1%	$65.38	$67.79	$65.38
Perinatal	$73.04	7.1%	$78.23	$80.64	$78.23

*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

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

FY 2012-13

DCR	Caseload	UOS	Rates	Total
Regular EPSDT	7,393	41.8	$65.38	$20,204,211
Perinatal	560	16.6	$78.23	$727,226

FY 2013-14

DCR	Caseload	UOS	Rates	Total
Regular EPSDT	6,499	41.8	$65.38	$17,761,013
Perinatal	447	16.6	$78.23	$580,482

DAY CARE REHABILITATIVE SERVICES

BASE POLICY CHANGE NUMBER: 55

6. 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.

		(In Thousands)	
Fiscal Year	**Accrual**	**FY 2012-13**	**FY 2013-14**
DMC Regular	$27,872	$6,968	$0
DMC Perinatal	$859	$215	$0
FY 2011-12	$28,731	$7,183	$0
DMC Regular	$20,204	$15,153	$5,051
DMC Perinatal	$727	$545	$182
FY 2012-13	$20,931	$15,698	$5,233
DMC Regular	$17,761	$0	$13,321
DMC Perinatal	$580	$0	$435
FY 2013-14	$18,341	$0	$13,756

7. Below the costs are on a cash basis.

	(In Thousands)	
	Regular	**Perinatal**
FY 2011-12	$6,968	$215
FY 2012-13	$15,153	$545
Total FY 2012-13	$22,121	$760
FY 2012-13	$5,051	$182
FY 2013-14	$13,321	$435
Total FY 2013-14	$18,372	$617

8. Funding is 50% County Funds and 50% Federal Funds Participation (FFP). Costs related to minor consent are fully funded by the county.

	(In Thousands)		
	TF	**FFP**	**County**
DMC Regular	$22,121	$11,061	$11,060
DMC Perinatal	$760	$380	$380
Total FY 2012-13	$22,881	**$11,441**	$11,440
	TF	**FFP**	**County**
DMC Regular	$18,372	$9,186	$9,186
DMC Perinatal	$617	$309	$308
Total FY 2013-14	$18,989	**$9,495**	$9,494

DAY CARE REHABILITATIVE SERVICES

BASE POLICY CHANGE NUMBER: 55

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

PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

BASE POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	7/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1725

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$827,000	$673,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$827,000	$673,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$827,000	$673,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Perinatal Residential Substance Abuse Services program.

Authority:
Title 22, California Code of Regulations 51341.1 (17)
AB 106 (Chapter 32, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Perinatal Residential Substance Abuse program provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in her efforts to:

- Restore,
- Maintain,
- 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 program provides a range of activities and services for pregnant and postpartum women such as:

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

PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

BASE POLICY CHANGE NUMBER: 56

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

Perinatal services were budgeted in the Department of Alcohol and Drug Program's perinatal appropriation 4200-102-001 and 4200-101-0890. The non-perinatal services were budgeted in the Drug Medi-Cal (DMC) services appropriation 4200-103-0001 and 4200-101-0890. Effective July 1, 2012, these services federal funds will be budgeted in the Department's appropriation 4260-101-0890.

Reason for Change from Prior Estimate:
Updated data reflects a decrease in caseload.

Methodology:

1. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.

2. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an 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 implicit price (CIP) deflator, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

Description	FY 2009-10 UOS Rate	CIP Deflator	FY 2012-13 Rates*	FY 2012-13 Developed Rates	FY 2012-13 Required Rates
Perinatal	$89.90	7.1%	$96.28	$110.90	$96.28

* Rates calculation: FY 2009-10 rates adjusted by the CIP deflator.

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

FY 2012-13	Caseload	UOS	Rates	Total
DMC Perinatal	856	18.1	$96.28	$1,491,724

FY 2013-14	Caseload	UOS	Rates	Total
DMC Perinatal	744	18.1	$96.28	$1,296,545

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.

		(In Thousands)	
Fiscal Year	Accrual	FY 2012-13	FY 2013-14
FY 2011-12	$2,138	$535	$0
FY 2012-13	$1,492	$1,119	$373
FY 2013-14	$1,297	$0	$973

PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

BASE POLICY CHANGE NUMBER: 56

6. Below the costs are on a cash basis.

	(In Thousands) Perinatal
FY 2011-12	$535
FY 2012-13	$1,119
Total FY 2012-13	$1,654

	Perinatal
FY 2012-13	$373
FY 2013-14	$973
Total FY 2012-13	$1,346

7. Funding is 50% County Funds and 50% Federal Funds Participation (FFP). Minor consents costs are fully funded by the county.

(In Thousands)

FY 2012-13	**TF**	**FFP**	**County**
DMC Perinatal	$1,654	**$827**	$827

FY 2013-14	**TF**	**FFP**	**County**
DMC Perinatal	$1,346	**$673**	$673

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

NALTREXONE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	7/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1743

	FY 2012-13	FY 2013-14
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 federal fund costs of the drug, Naltrexone, for detoxified opioid-dependent patients who have a substance use disorder.

Authority:
Title 22, California Code of Regulations 51341.1 (13)
AB 106 (Chapter 32, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
Naltrexone is an outpatient treatment service provided to beneficiaries who have a confirmed, documented history of opioid dependence, are at least 18 years of age, are opioid-free, and are not pregnant. The Naltrexone medication is used to block the euphoric effects of opioids and helps prevent relapse to opioid addiction. Naltrexone treatment services include:

- Intake,
- Admission physical examinations,
- Treatment planning,
- Provision of medication services,
- Individual and group counseling,
- Collateral services, and
- Crisis intervention.

Perinatal services were budgeted in the Department of Alcohol and Drug Program's perinatal appropriation 4200-102-0001 and 4200-101-0890. The non-perinatal services were budgeted in the Drug Medi-Cal services appropriation 4200-103-0001 and 4200-101-0890. Effective July 1, 2012, these services federal funds will be budgeted in the Department's appropriation 4260-101-0890.

NALTREXONE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 57

The program is funded by both Federal Financial Participation (FFP) and County Funds.

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

Methodology:

1. For FY 2012-13 and FY 2013-14, funding is 50% County Funds and 50% FFP.
2. Costs related to minor consent are fully funded by the county.
3. While these benefits are available and the drug is still being manufactured, beneficiaries are currently not utilizing this service.

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

CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT

BASE POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	7/2012
ANALYST:	Betty Lai
FISCAL REFERENCE NUMBER:	1709

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,215,939,000	$1,190,661,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,215,939,000	$1,190,661,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,215,939,000	$1,190,661,000

DESCRIPTION

Purpose:
This policy change estimates the base cost for children's, adults, and psychiatric inpatient hospital Medi-Cal specialty mental health services.

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

Interdependent Policy Changes:
Not Applicable

Background:
The Medi-Cal Specialty Mental Health Services Program is "carved-out" of the broader Medi-Cal program and is also 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 specialty mental health services. All MHPs are county mental health departments.

Specialty mental health services 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 specialty mental health services.

Mental health services for Medi-Cal beneficiaries who do not meet the criteria for specialty mental health services are provided under the broader Medi-Cal program either through managed care plans (by primary care providers within their scope of practice) or fee-for-service.

CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT

BASE POLICY CHANGE NUMBER: 60

The following Medi-Cal specialty mental health services are provided for children and adults:

Services	Children	Adult
Rehabilitative Services include:		
Mental Health Services	X	X
Medication Support Services	X	X
Day Treatment Intensive	X	X
Day Rehabilitation	X	X
Crisis Intervention	X	X
Crisis Stabilization	X	X
Adult Residential Treatment Services*	X	X
Crisis Residential Treatment Services*	X	X
Psychiatric Health Facility Services	X	X
Psychiatric Inpatient Hospital Service	X	X
Targeted Case Management	X	X
Therapeutic Behavioral Services	X	

*Children - Age 18 through 20

Medi-Cal's child component, known as Early Periodic Screening Diagnosis and Treatment (EPSDT), is designed to meet the special physical, emotional, and developmental needs of low income children under age 21. Medi-Cal specialty mental health services are provided to children under the EPSDT benefit.

Effective July 1, 2012, the administration of Medi-Cal specialty mental health services transferred to the Department from the former Department of Mental Health. The transfer did not impact the service delivery model or services.

Reason for Change from Prior Estimate:
Changes are due to additional approved claims data.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) approved claims data from August 2006 through May 2012, excluding disallowed claims. Additional exclusions apply for each category, as listed below:

    - Children's cost excludes adult claims.
    - Adults cost excludes children claims.
    - Psychiatric inpatient hospital costs includes both children and adults.

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

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

CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT

BASE POLICY CHANGE NUMBER: 60

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

Accrual Estimate TF	Children	Adults	Inpatient	Total
	(In Thousands)			
FY 2010-11	$1,212,768	$775,047	$174,829	$2,162,644
FY 2011-12	$1,259,085	$787,241	$179,697	$2,226,023
FY 2012-13	$1,319,942	$791,589	$184,908	$2,296,439
FY 2013-14	$1,380,800	$795,937	$190,271	$2,367,008

5. For children's Medi-Cal specialty mental health services, the counties' shares of cost is a combination of county funds. The county fund requirement amount is determined by taking the difference between the total fund amount and the federal financial participation (FFP) amount then multiplying it by the county funding requirement ratio of 15.58%. Below are the accrual budgets:

Accrual Estimate	TF	FFP	LRF	County Fund
	(In Thousands)			
FY 2012-13	$1,319,942	$663,723	$553,985	$102,234
FY 2013-14	$1,380,800	$694,552	$579,336	$106,912

6. On a cash basis for FY 2012-13, the Department will be paying 1% of FY 2010-11 claims, 33% of FY 2011-12 claims, and 73% of FY 2012-13 claims.

Cash Estimate TF	Children	Adults	Inpatient	Total
	(In Thousands)			
FY 2010-11	$12,128	$7,750	$1,748	$21,626
FY 2011-12	$410,655	$256,762	$48,242	$715,659
FY 2012-13	$965,589	$579,078	$135,268	$1,679,935
Total FY 2012-13	$1,388,372	$843,590	$185,258	$2,417,220

7. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 27% of FY 2012-13 claims, and 73% of FY 2013-14 claims.

Cash Estimate TF	Children	Adults	Inpatient	Total
	(In Thousands)			
FY 2011-12	$12,591	$7,872	$1,797	$22,260
FY 2012-13	$354,354	$212,511	$49,641	$616,506
FY 2013-14	$1,010,108	$582,259	$139,190	$1,731,557
Total FY 2013-14	$1,377,053	$802,642	$190,628	$2,370,323

CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT

BASE POLICY CHANGE NUMBER: 60

8. Medi-Cal Specialty Mental Health programs costs are shared between federal funds and county funds (County). Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement of 65%. Medi-Cal (MC) claims are eligible for 50% federal reimbursement.

(In Thousands)

Cash Estimate	TF	FFP	ARRA	M-CHIP*	County
Children	$1,388,372	$681,295	$1,159	$16,758	$689,160
Adults	$843,590	$421,882	$752	$0	$420,956
Inpatient	$185,257	$88,315	$170	$5,608	$91,164
Total FY 2012-13	$2,417,219	**$1,191,492**	**$2,081**	**$22,366**	$1,201,280

(In Thousands)

Cash Estimate	TF	FFP	M-CHIP*	County
Children	$1,377,053	$674,933	$17,672	$684,448
Adults	$802,642	$401,411	$0	$401,231
Inpatient	$190,628	$90,875	$5,770	$93,983
Total FY 2013-14	$2,370,323	**$1,167,219**	**$23,442**	$1,179,662

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

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	108
IMPLEMENTATION DATE:	7/2000
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	56

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$6,796,111,000	$6,871,122,000
- STATE FUNDS	$3,384,243,300	$3,420,899,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,796,111,000	$6,871,122,000
STATE FUNDS	$3,384,243,300	$3,420,899,300
FEDERAL FUNDS	$3,411,867,700	$3,450,222,700

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 209 Extend Gross Premium Tax
PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
PC 208 Extend Gross Premium Tax – Funding Adjustment
PC 123 Capitated Rate Adjustment for FY 2013-14

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. Beginning January 1, 2013, Health Plan of San Joaquin will replace Anthem in Stanislaus County, and Health Net will replace Anthem in San Joaquin County.

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

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: 108

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.

3. The FY 2012-13 and FY 2013-14 rates include:
   - Annual rate redeterminations for FY 2012-13.
   - An adjustment for pharmacy avoidable costs.

4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through June 30, 2012. The Department has proposed legislation that would extend the tax through June 30, 2014.

5. 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 Funding Adjustment of Gross Premium Tax to General Fund and the Extend Gross Premium Tax – Funding Adjustment policy changes.

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

7. A 2.97% rate increase for FY 2013-14 is assumed and budgeted for in the Capitation Rate Adjustment for 2013-14 policy change.

8. An adjustment has been made to show the actuarial value of the cost of services to Seniors and Persons with Disabilities (SPDs). The adjustment for FY 2012-13 includes dollars from FY 2011-12 and FY 2012-13.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 108

(Dollars in Thousands)

FY 2012-13	Eligible Months	Total
Alameda	1,968,665	$411,581
Contra Costa	1,100,202	$228,329
Kern	1,939,527	$290,688
Los Angeles	18,011,068	$2,727,960
Riverside	3,302,724	$517,545
San Bernardino	3,932,829	$608,870
San Francisco	869,709	$225,992
San Joaquin	1,550,989	$260,699
Santa Clara	1,866,668	$328,751
Stanislaus	1,026,732	$197,449
Tulare	1,448,862	$218,296
Fresno	2,809,925	$472,390
Kings	299,912	$47,852
Madera	370,521	$53,020
Total FY 2012-13	40,498,333	$6,589,422
SPD Adjustment 2011-12		$76,868
SPD Adjustment 2012-13		$129,821
Total with Adjustments		**$6,796,111**

FY 2013-14	Eligible Months	Total
Alameda	2,026,523	$422,633
Contra Costa	1,124,197	$232,768
Kern	1,979,610	$295,204
Los Angeles	18,227,801	$2,807,341
Riverside	3,375,522	$530,793
San Bernardino	4,047,378	$632,964
San Francisco	887,190	$237,530
San Joaquin	1,587,781	$269,747
Santa Clara	1,908,794	$340,750
Stanislaus	1,045,357	$205,194
Tulare	1,469,513	$223,807
Fresno	2,858,413	$476,262
Kings	300,138	$48,259
Madera	377,285	$53,948
Total FY 2013-14	41,215,502	$6,777,200
SPD Adjustment		$93,922
Total with Adjustment		**$6,871,122**

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 108

Funding:
(in Thousands)
FY 2012-13:

		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	$3,357,456	$3,357,456	$6,714,911
State GF	4260-101-0001	$20,742		$20,742
Family Planning 90/10 GF	4260-101-0001/0890	$6,046	$54,412	$60,458
Total		**$3,384,244**	**$3,411,868**	**$6,796,111**

FY 2013-14:

		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	$3,394,195	$3,394,195	$6,788,390
State GF	4260-101-0001	$20,479		$20,479
Family Planning 90/10 GF	4260-101-0001/0890	$6,225	$56,028	$62,253
Total		**$3,420,899**	**$3,450,223**	**$6,871,122**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	12/1987
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	57

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$3,603,868,000	$3,657,882,000
- STATE FUNDS	$1,795,171,900	$1,821,952,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,603,868,000	$3,657,882,000
STATE FUNDS	$1,795,171,900	$1,821,952,800
FEDERAL FUNDS	$1,808,696,100	$1,835,929,200

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 209 Extend Gross Premium Tax
PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
PC 208 Extend Gross Premium Tax – Funding Adjustment
PC 123 Capitated Rate Adjustment for 2013-14
PC 130 Discontinue Undocumented Beneficiaries from PHC

Background:
A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS Model: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo.

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

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: 109

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.

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

4. The FY 2012-13 and FY 2013-14 rates include:
   - Annual rate redeterminations for FY 2012-13.
   - An adjustment for pharmacy avoidable costs.

5. AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. The Department has proposed trailer bill language that will eliminate the sunset date for the gross premium tax on the total operating revenue for the Medi-Cal managed care plans. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the gross premium tax extension, see the Extend Gross Premium Tax – Incr. Capitation Rates and the Extend Gross Premium Tax-Funding Adjustment policy changes.

6. 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 Funding Adjustment of MCO Tax to General Fund policy change.

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

8. A 2.97% rate increase for FY 2013-14 is assumed and budgeted for in the Capitation Rate Adjustment for 2013-14 policy change.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 109

(Dollars in Thousands) **FY 2012-13**	**Eligible Months**	**Total**
San Luis Obispo	343,553	$101,391
CalOPTIMA(Orange)	4,635,663	$1,238,011
Monterey	913,802	$234,314
Napa	177,269	$58,411
San Mateo	757,654	$360,414
Santa Barbara	779,022	$220,513
Santa Cruz	426,938	$125,200
Solano	742,200	$241,194
Yolo	331,284	$102,974
Sonoma	657,009	$218,682
Merced	901,173	$227,447
Marin	207,605	$90,042
Mendocino	245,427	$81,482
Ventura	1,233,120	$303,793
Total FY 2012-13	**12,351,719**	**$3,603,868**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 109

(Dollars in Thousands) **FY 2013-14**	**Eligible Months**	**Total**
San Luis Obispo	347,798	$102,112
CalOPTIMA(Orange)	4,730,627	$1,260,384
Monterey	930,746	$238,560
Napa	182,484	$60,042
San Mateo	774,295	$365,910
Santa Barbara	789,042	$222,883
Santa Cruz	431,592	$126,712
Solano	757,422	$246,637
Yolo	338,323	$104,930
Sonoma	669,346	$221,860
Merced	918,422	$231,378
Marin	207,910	$90,178
Mendocino	246,044	$81,710
Ventura	1,238,153	$304,586
Total FY 2013-14	**12,562,204**	**$3,657,882**

Funding: (In Thousands)

FY 2012-13:

		GF	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	$1,789,932	$1,789,932	$3,579,864
State GF	4260-101-0001	$3,155		$3,155
Family Planning 90/10 GF	4260-101-0001/0890	$2,085	$18,764	$20,849
Total		**$1,795,172**	**$1,808,696**	**$3,603,868**

FY 2013-14:

		GF	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	$1,816,608	$1,816,608	$3,633,216
State GF	4260-101-0001	$3,198		$3,198
Family Planning 90/10 GF	4260-101-0001/0890	$2,147	$19,321	$21,468
Total		**$1,821,953**	**$1,835,929**	**$3,657,882**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	4/1994
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	58

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,161,040,000	$1,176,207,000
- STATE FUNDS	$578,013,100	$585,440,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,161,040,000	$1,176,207,000
STATE FUNDS	$578,013,100	$585,440,700
FEDERAL FUNDS	$583,026,900	$590,766,300

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 209 Extend Gross Premium Tax
PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
PC 208 Extend Gross Premium Tax – Funding Adjustment
PC 123 Capitated Rate Adjustment for FY 2013-14

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:
There is no material change.

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

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

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 110

3. The FY 2012-13 and FY 2013-14 rates include:
   - Annual rate redeterminations for FY 2012-13
   - Pharmacy rate adjustment to exclude avoidable costs

4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. The Administration is proposing legislation to eliminate the sunset date on the Gross Premium Tax on the total operating revenue for the Medi-Cal Managed Care plans. The FY 2012-13 impact of the increase in capitation payments related to the Gross Premium Tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the gross premium tax extension see policy changes Extend Gross Premium Tax – Incr. Capitation Rates and Extend Gross Premium Tax – Funding Adjustment.

5. 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 Funding Adjustment of MCO Tax to General Fund policy change.

6. The FY 2012-13 and FY 2013-14 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

7. An adjustment has been made to show the actuarial value of the cost of services to Seniors and Persons with Disabilities (SPDs). The adjustment for FY 2012-13 includes dollars from FY 2011-12 and FY 2012-13.

(Dollars in Thousands)

FY 2012-13	**Eligible Months**	**Total**
Sacramento GMC	2,800,085	$ 501,640
San Diego GMC	3,326,273	$ 624,089
Total FY 2012-13	6,126,358	$1,125,729
SPD Adjustment 2011-12		$ 13,132
SPD Adjustment 2012-13		$ 22,179
Total with Adjustments		**$1,161,040**

FY 2013-14	**Eligible Months**	**Total**
Sacramento GMC	2,844,467	$ 515,542
San Diego GMC	3,395,942	$ 644,587
Total FY 2013-14	6,240,409	$1,160,129
SPD Adjustment		$ 16,078
Total with Adjustments		**$1,176,207**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 110

Funding:

(Rounded in Thousands)

FY 2012-13:

		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	$573,927	$573,927	$1,147,854
State GF	4260-101-0001	$ 3,075	$ 0	$ 3,075
Family Planning 90/10 FFP	4260-101-0001/0890	$ 1,011	$ 9,100	$ 10,111
Total		**$578,013**	**$583,027**	**$1,161,040**

FY 2013-14:

		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	$ 581,396	$581,396	$1,162,791
State GF	4260-101-0001	$ 3,004	$ 0	$ 3,004
Family Planning 90/10 FFP	4260-101-0001/0890	$ 1,041	$ 9,371	$ 10,412
Total		**$ 585,441**	**$590,767**	**$1,176,207**

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	115
IMPLEMENTATION DATE:	7/1992
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	62

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$170,011,000	$253,075,000
- STATE FUNDS	$85,005,500	$126,537,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$170,011,000	$253,075,000
STATE FUNDS	$85,005,500	$126,537,500
FEDERAL FUNDS	$85,005,500	$126,537,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14591-14593
Balanced Budget Act of 1997 (BBA)

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 five contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. Four new PACE organizations will begin operation in FY 2012-13 and one in FY 2013-14. 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. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

Reason for Change from Prior Estimate:
Implementation dates for the new PACE organizations have been delayed due to delays within each PACE organization.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 115

Below is a list of PACE organizations:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco Alameda Santa Clara	November 1, 1983 July 1, 2002 January 1, 2009
Centers for Elders Independence	Alameda	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
Alta Med Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE-(Community Elder Care of San Diego)	San Diego	February 1, 2008
Cal Optima	Orange	April 1, 2013
Brandman (LA Jewish Home)	Los Angeles	December 1, 2012
InnovAge	San Bernardino	June 1, 2013
SCAN	Los Angeles	April 1, 2013
Central Valley Medical Svs.	Fresno	April 1, 2014

Methodology:

1. Assume the 2012 rates are calculated using the Upper Payment Limit (UPL) for each year. The 2012 and 2013 rate setting methodology will be calculated using the UPL methodology.

2. FY 2012-13 and FY 2013-14 estimated funding is based on calendar year 2012 proposed rates effective January 1, 2012.

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

4. The Department anticipates recoupment a $8,844,000 of PACE rates due to the change in rates paid at the previous reimbursement rates.

5. The Department anticipates restructuring the methodology to determine the rates beginning in January 2014. The Department expects to achieve savings in FY 2013-14.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 115

FY 2012-13	Costs	Eligible Months	Average Monthly Enrollment
Center for Elders Independence	$30,145,000	7,077	590
Sutter Senior Care	$10,369,000	2,836	236
Alta Med Senior BuenaCare	$59,678,000	16,098	1,341
On Lok Lifeways	$61,620,000	14,534	1,211
St. Paul's PACE (CESD)	$15,910,000	4,228	352
Brandman (LAJH)	$622,000	189	16
Cal Optima	$224,000	54	5
InnovAge	$50,000	15	1
SCAN	$237,000	72	6
Total Capitation Payments	$178,855,000		
Recoupment	($8,844,000)		
Total	**$170,011,000**	45,103	3,758

FY 2013-14			
Center for Elders Independence	$36,454,000	8,574	715
Sutter Senior Care	$12,835,000	3,417	285
Alta Med Senior BuenaCare	$79,922,000	21,501	1,792
On Lok Lifeways	$72,687,000	17,075	1,423
St. Paul's PACE (CESD)	$33,412,000	8,828	736
Brandman (LAJH)	$3,642,000	894	75
Cal Optima	$3,153,000	756	63
InnovAge	$8,688,000	2,130	178
SCAN	$8,176,000	2,005	167
Central Valley Medical Svs.	$159,000	48	4
Savings-Rate Adjustment	($6,053,000)		
Total Capitation Payments	**$253,075,000**	65,228	5,438

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	7/2004
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1029

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$52,576,000	$53,418,000
- STATE FUNDS	$26,288,000	$26,709,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$52,576,000	$53,418,000
STATE FUNDS	$26,288,000	$26,709,000
FEDERAL FUNDS	$26,288,000	$26,709,000

DESCRIPTION

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

Authority:
Social Security Act, Title XIX

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 four Geographic Managed Care (GMC) plans and six Prepaid Health Plans (PHP) for providing dental services to Medi-Cal beneficiaries in Sacramento, Los Angeles, Riverside, and San Bernardino 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.

Reason for Change from Prior Estimate:
Rates have been updated from January 1, 2012 through December 31, 2012.

Methodology:

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

2. The retroactive adjustments of the rates from January 2012 to June 2012 are shown in the Dental Retroactive Rate Changes policy change.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 117

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

4. No rate adjustments have been included for FY 2013-14. The prior period rates have been used.

FY 2012-13		**Capitation Rate**	**Average Monthly Eligibles**	**Total Funds**
GMC				
	<21	$11.46	140,269	$19,290,000
	21+	$1.45	77,952	$1,356,000
PHP				
	<21	$11.46	221,037	$30,397,000
	21+	$1.45	88,091	$1,533,000
Total				**$52,576,000**
FY 2013-14				
GMC				
	<21	$11.46	142,285	$19,567,000
	21+	$1.45	79,073	$1,376,000
PHP				
	<21	$11.46	224,808	$30,916,000
	21+	$1.45	89,594	$1,559,000
Total				**$53,418,000**

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

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	2/1985
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	61

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$18,283,000	$40,100,000
- STATE FUNDS	$9,141,500	$20,050,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,283,000	$40,100,000
STATE FUNDS	$9,141,500	$20,050,000
FEDERAL FUNDS	$9,141,500	$20,050,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
PC 129 SCAN Transition to Managed Care

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. SCAN operates as a social health maintenance organization under special waivers and has held a contract with the Centers for Medicare and Medicaid Services (CMS) since 1985. 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.

The Department does not plan to renew the SCAN contract. A one-year contract extension for the period of January 1, 2013 through December 31, 2013 has been executed to facilitate transition of SCAN Medi-Cal population to existing Medi-Cal programs. A separate policy change budgets the costs associated with the transition of SCAN population into managed care plans.

Reason for Change from Prior Estimate:
The estimated costs for FY 2012-13 have changed due to amendments of the SCAN rates.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 118

Methodology:

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

2. Total enrollment is projected to be 7,429 in June 2013 and 7,432 by December 2013 based on Medi-Cal eligibles data submitted by SCAN.

3. The 2010, 2011, and 2012 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for 2012 have not been finalized. Therefore, FY 2012-13 and FY 2013-14 rates are based on preliminary rates. Rates in development will be based on SCAN plans' actual experience.

4. AB 1422 (Chapter 157, Statues of 2009) imposes a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. AB 1422 was extended through June 30, 2012.

5. Through a departmental medical audit, individuals who were ineligible for SCAN benefits were enrolled during the periods of May 1, 2008 through December 31, 2008 and January 1, 2009 through December 31, 2009. SCAN will repay the Department for those costs. The Department expects recoupment in FY 2012-13.

6. Assume SCAN participants will transition out of SCAN into managed care plans beginning January 1, 2014. This transition is budgeted in a separate policy change.

FY 2012-13	**Costs**	**Eligible Months**	**Average Monthly Enrollment**
Los Angeles	$25,898,000	56,948	4,746
Riverside	$8,001,000	19,165	1,597
San Bernardino	$5,285,000	12,069	1,006
Total Capitation Payments	$39,184,000	88,182	7,349
Recoupment	($20,901,000)		
Total	**$18,283,000**		
FY 2013-14			
Los Angeles	$26,520,000	58,314	4,860
Riverside	$8,178,000	19,590	1,633
San Bernardino	$5,402,000	12,336	1,028
Total Capitation Payments	**$40,100,000**	90,240	7,521

Funding:

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	5/1985
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	63

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$13,359,000	$14,579,000
- STATE FUNDS	$6,679,500	$7,289,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,359,000	$14,579,000
STATE FUNDS	$6,679,500	$7,289,500
FEDERAL FUNDS	$6,679,500	$7,289,500

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 209 Extend Gross Premium Tax
PX 207 Extend Gross Premium Tax – Incr. Capitation Rates
PC 208 Extend Gross Premium Tax – Funding Adjustment

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 the PCCM plan to participate in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department has determined that there are no shared savings for calendar year (CY) 2009 and CY 2010. The shared savings for CY 2011 and beyond have not yet been determined. On January 1, 2012, the Department entered into a new five year contract with AIDS Healthcare Foundation.

AB 1422 (Chapter 157, Statues of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 has extended the gross premium tax through June 30, 2012, and legislation has been proposed to extend it through June 30, 2014.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 119

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 Funding Adjustment of MCO Tax to General Fund policy change.

Reason for Change from Prior Estimate:
Revised based on updated eligibles.

Methodology:

1. Assume in FY 2012-13 dual eligible months will be 4,933 and 5,381 in FY 2013-14.

2. Assume in FY 2012-13 Medi-Cal only eligible months will be 6,532 and 7,129 in FY 2013-14.

3. Dual capitation rates are assumed to be $272.23 for FY 2012-13 and FY 2013-14.

4. Medi-Cal only capitation rates are assumed to be $1,839.50 for FY 2012-13 and FY 2013-14.

Duals:
FY 12/13: 4,933 x $272.23 = $1,343,000
FY 13/14: 5,381 x $272.23 = $1,465,000

Medi-Cal Only:
FY 11/12: 6,532 x $1,839.50 = $12,016,000
FY 12/13: 7,129 x $1,839.50 = $13,114,000

	FY 12/13	FY 13/14
Dual	$ 1,343,000	$ 1,465,000
Medi-Cal Only	$12,016,000	$13,114,000
Total (Rounded)	**$13,359,000**	**$14,579,000**

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

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

BASE POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	3/1993
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	66

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,464,000	$0
- STATE FUNDS	$732,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,464,000	$0
STATE FUNDS	$732,000	$0
FEDERAL FUNDS	$732,000	$0

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:
Not Applicable

Background:
The Department's contract with the Family Mosaic Project is effective January 1, 2008 through December 31, 2012. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out of home placement.

Reason for Change from Previous Estimate:
The contract with the Family Mosaic Project expires in December 2012.

Methodology:

1. It is assumed the member months will be 792 for FY 2012-13.
2. The FY 2012-13 Family Mosaic capitation rates are assumed to be $1,848.75.
3. The FY 2012-13 costs for the Family Mosaic Project are expected to be:

   FY 2012-13: 792 x $1,848.75 = **$1,464,000 TF ($732,000 GF)**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	4/1993
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	22

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$2,899,710,000	$2,403,748,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,899,710,000	$2,403,748,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,899,710,000	$2,403,748,000

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) Personal Care Services Program (PCSP) and the Independence Plus Option (IPO) administered by CDSS.

Authority:
Interagency Agreements:
IHSS PCSP 03-75676
IPO 09-86307

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.

Legislation was proposed to mandatorily enroll dual eligible into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change Transition of Dual Eligibles-LTC for more information. IHSS costs are currently budgeted in this policy change, but due to the transition of IHSS recipients to managed care, some IHSS costs will be paid through managed care capitation beginning March 1, 2013. IHSS cost related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligbles-LTC policy change.

The estimates below were provided by CDSS. FFP for the county cost of administering the PCSP is in the Other Administration section of the Estimate.

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 166

Methodology:

CASH BASIS

	TF	FFP	CDSS GF/ County Share
FY 2012-13	$5,799,420	**$2,899,710**	$2,899,710
FY 2013-14	$4,807,496	**$2,403,748**	$2,403,748

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

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

BASE POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	7/1988
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	76

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$2,495,745,000	$2,651,874,000
- STATE FUNDS	$1,324,485,500	$1,409,069,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,495,745,000	$2,651,874,000
STATE FUNDS	$1,324,485,500	$1,409,069,000
FEDERAL FUNDS	$1,171,259,500	$1,242,805,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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 2012 Medicare Part A premium at $451 and the Medicare Part B premium at $99.90.

3. The 2013 premiums are estimated to increase by $1.00 to $452 for Medicare Part A, the same growth rate as 2012. Medicare Part B premium is estimated to increase by $9.20 to $109.10, a 9.21% increase projected by the Boards of Trustees of the Federal Hospital Insurance & Federal Supplementary Medical Insurance Trust Funds.

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

BASE POLICY CHANGE NUMBER: 167

4. The 2014 premiums are estimated to increase by $1.00 to $453 for Medicare Part A, the same growth rate as 2013. Medicare Part B premium is estimated to increase by $3.00 to $112.10, a 2.75% increase projected by the Boards of Trustees of the Federal Hospital Insurance & Federal Supplementary Medical Insurance Trust Funds.

FY 2012-13	**Part A**	**Part B**
Average Monthly Eligibles	172,014	1,175,751
Rate 07/2012-12/2012	$451.00	$99.90
Rate 01/2013-06/2013	$452.00	$109.10
FY 2013-14		
Average Monthly Eligibles	176,108	1,205,093
Rate 07/2013-12/2013	$452.00	$109.10
Rate 01/2014-06/2014	$453.00	$112.10

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

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	1/2006
ANALYST:	Jade Li
FISCAL REFERENCE NUMBER:	1019

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,456,141,000	$1,509,021,000
- STATE FUNDS	$1,456,141,000	$1,509,021,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,456,141,000	$1,509,021,000
STATE FUNDS	$1,456,141,000	$1,509,021,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 ⅔% each year until it reaches 75% (CY 2007 = 88 ⅓%, CY 2008 = 86 ⅔%, etc). 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:

Calendar Year	PMPM rate	
2010	$102.54	
2011	$100.77	
2012	$102.76	
2013	$103.70	
2014	$104.84	(estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 168

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 2009-10	$864,850,294	1,085,366
FY 2010-11	$1,049,777,643	1,113,792
FY 2011-12	$1,367,279,250	1,150,028

Reason for Change from Prior Estimate:
Updated data on the 2013 estimated growth in the PMPM and monthly dual eligible Part D enrollment.

Methodology:

1. The growth increase in the Medicare Part D PMPM for calendar year 2012 is 4.10% and Medi-Cal's PMPM increased to $102.76.

2. The 2013 growth increase is 3.09%, and Medi-Cal's PMPM increased to $103.70.

3. The 2014 growth increase is assumed to be 3.31%, the unadjusted 2013 estimated growth increase, and Medi-Cal's estimated PMPM is expected to increase to $104.84.

4. Phase-down payments have a two-month lag. For example, the invoice for the Medi-Cal beneficiaries eligible for Medicare Part D in May 2012 is received in June 2012 and payment is due in July 2012.

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly dual eligible Part D enrollment data for July 2008–July 2012.

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

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2012-13	12	1,177,250	$121,345,113	**$1,456,141,000**
FY 2013-14	12	1,208,186	$125,751,775	**$1,509,021,000**

Funding:
State Only General Fund (4260-101-0001)

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

BASE POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	7/1990
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	23

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,245,431,000	$1,165,802,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,245,431,000	$1,165,802,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,245,431,000	$1,165,802,000

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:
Increase is due to updated data.

Methodology:
1. The following estimates have been provided by CDDS:

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

BASE POLICY CHANGE NUMBER: 169

(In Thousands)

	Total Funds	CDDS GF	DHCS FFP
FY 2012-13	$2,490,861	$1,245,430	**$1,245,431**
FY 2013-14	$2,331,604	$1,165,802	**$1,165,802**

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	7/1988
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	135

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$441,893,000	$508,779,000
- STATE FUNDS	$217,237,150	$250,680,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$441,893,000	$508,779,000
STATE FUNDS	$217,237,150	$250,680,150
FEDERAL FUNDS	$224,655,850	$258,098,850

DESCRIPTION

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

Authority:
Social Security Act, Title XIX

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Revised based on additional months of actual data and new rates beginning July 2012.

Methodology:

1. The capitation rates for FY 2012-13 and FY 2013-14 are $5.74 for regular eligibles and $3.22 for refugees.

2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ended June 30, 2011 resulted in an estimated underwriting gain of $64.3 million. According to contract distribution provisions, the state will receive approximately $59.7 million and Delta Dental will retain approximately $4.6 million in FY 2012-13.

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 172

FY 2012-13	Rate	Average Monthly Eligibles	Total Funds
Regular 7/12 – 6/13	$5.74	6,649,017	$457,984,000
Refugee 7/12 – 6/13	$3.22	2,602	$101,000
Other FFS	Non-Capitated		$43,508,000
		Subtotal	$501,593,000
Underwriting Gain			($59,700,000)
FY 2012-13 Dental Total			**$441,893,000**

FY 2013-14	Rate	Average Monthly Eligibles	Total Funds
Regular 7/13 – 6/14	$5.74	6,665,769	$459,138,000
Refugee 7/13 – 6/14	$3.22	2,609	$101,000
Other FFS	Non-Capitated		$49,540,000
FY 2013-14 Dental Total			**$508,779,000**

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	175
IMPLEMENTATION DATE:	7/1997
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	77

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$251,686,000	$243,463,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$251,686,000	$243,463,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$251,686,000	$243,463,000

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 Small Facilities (SOSFs).

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOSFs. There are five DCs and two SOSFs 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 SOSFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

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. This policy change includes the additional FFP for FY 2011-12 and FY 2012-13. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

The General Fund (GF) is included 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:
No material change.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 175

Methodology:

1. The following estimates have been provided by CDDS.

CASH BASIS (In Thousands)	**Total Funds**	**CDDS GF**	**FFP Regular**	**IA #**
FY 2012-13	$503,372	$251,686	$251,686	01-15834
FY 2013-14	$486,926	$243,463	$243,463	01-15834

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

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	176
IMPLEMENTATION DATE:	7/1991
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	26

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$166,021,000	$142,042,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$166,021,000	$142,042,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$166,021,000	$142,042,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

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

Reason for Change from Prior Estimate:
Updated caseload.

Methodology:
1. The following estimates have been provided by CDDS:

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176

CASH BASIS (In Thousands)	**Total Funds**	**CDDS GF**	**DHCS FFP**	**IA #**
FY 2012-13	$332,043	$166,022	**$166,021**	03-75284
FY 2013-14	$284,085	$142,043	**$142,042**	03-75284

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

EPSDT SCREENS

BASE POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	7/2001
ANALYST:	Yumie Park
FISCAL REFERENCE NUMBER:	136

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$45,821,000	$46,234,000
- STATE FUNDS	$22,910,500	$23,117,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,821,000	$46,234,000
STATE FUNDS	$22,910,500	$23,117,000
FEDERAL FUNDS	$22,910,500	$23,117,000

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 (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.

Reason for Change from Prior Estimate:
Updated data reflected a decrease in the number of screens.

Methodology:
Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2012-13 and FY 2013-14, based on a historical trend dating back to September 2007.

FY 2012-13
Screens 766,026 x $59.82 (weighted average) = **$45,821,000** (rounded)

FY 2013-14
Screens 773,030 x $59.81 (weighted average) = **$46,234,000** (rounded)

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

MEDI-CAL TCM PROGRAM (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	6/1995
ANALYST:	Yao-Hui Yu
FISCAL REFERENCE NUMBER:	27

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$42,640,000	$44,345,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$42,640,000	$44,345,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$42,640,000	$44,345,000

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 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:
Updated data became available concerning the TCM expenditures.

Methodology:
1. The projected payment amount for FY 2012-13 was based on average expenditures from FY 2007-08 through FY 2011-12 plus an increase of 2% for a rate increase and 2% for cost reconciliation.

2. The projected payment amount for FY 2013-14 was based on the FY 2012-13 estimated amount plus an increase of 2% for a rate increase and 2% for cost reconciliation.

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

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	4/2000
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	32

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$37,995,000	$42,146,000
- STATE FUNDS	$18,997,500	$21,073,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$37,995,000	$42,146,000
STATE FUNDS	$18,997,500	$21,073,000
FEDERAL FUNDS	$18,997,500	$21,073,000

DESCRIPTION

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

Authority:
AB 668 (Chapter 896, Statutes of 1998)

Interdependent Policy Changes:
PC 25 California Community Transitions Costs

Background:
AB 668 authorized additional hours on behalf of eligible PCS program recipients if they needed more than the monthly hours allowed under the In-Home Supportive Services Program (IHSS) and qualified for the Medi-Cal Skilled Nursing Facility (NF) Level of Care Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (S/A), and In-Home Medical Care Waivers were merged into two waivers called the Nursing Facility/Acute Hospital (NF/AH) Waiver and the In-Home Operations (IHO) Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific level of care (LOC) criteria. Waiver Personal Care Services (WPCS) under these two waivers include services that differ from those in the State Plan which allow beneficiaries to remain at home. Although there is no longer a requirement that waiver consumers receive a maximum of 283 hours of IHSS prior to receiving WPCS, waiver consumers must first utilize authorized State Plan IHSS hours prior to accessing this waiver service. These services are provided by the counties' IHSS program providers and paid via an interagency agreement with the Department or will be provided by home health agencies and other qualified HCBS waiver provider types paid via the Medi-Cal fiscal intermediary.

Reason for Change from Prior Estimate:
The costs for FY 2012-13 have increased due to growth in the average number of WPCS hours used per beneficiary.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 179

Methodology:

1. Assume the number of current NF A/B Level of Care (LOC) Waiver beneficiaries using Waiver PCS is estimated to increase by an average of 15 per month in FY 2012-13 and FY 2013-14.

2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by one per month in FY 2012-13 and FY 2013-14.

3. The Department expects to enroll 360 beneficiaries during FY 2012-13 and FY 2013-14 into the California Community Transitions (CCT) Demonstration Project. Based on actual data, 25% of the beneficiaries are expected to use Waiver PCS.

4. The average cost/hour is $10.00 for FY 2012-13 and FY 2013-14.

Funding:

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	7/1989
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	93

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$3,661,000	$1,865,000
- STATE FUNDS	$1,830,500	$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,661,000	$1,865,000
STATE FUNDS	$1,830,500	$932,500
FEDERAL FUNDS	$1,830,500	$932,500

DESCRIPTION

Purpose:
This policy change estimates the cost of Medi-Cal lawsuit judgments, settlements, and attorney fees that are not shown in other policy changes.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
State Legislature appropriates State dollars to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all lawsuit settlements approved by the Legislature and the Governor.

Reason for Change from Prior Estimate:
Additional lawsuit settlements.

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 184

Methodology:

	Committed 2012-13	Balance 2012-13	Budgeted 2012-13	Budgeted 2013-14
Attorney Fees <$5,000	$0	$50,000	$50,000 *	$50,000 *
Provider Settlements <$75,000	$327,000	$1,273,000	$1,600,000 *	$1,600,000 *
Beneficiary Settlements <$ 2,000	$0	$15,000	$15,000 *	$15,000 *
Small Claims Court	$0	$200,000	$200,000 *	$200,000 *
Other Attorney Fees	$216,000	$0	$216,000	$0
Other Provider Settlements	$1,580,000	$0	$1,580,000	$0
Other Beneficiary Settlements	$0	$0	$0	$0
TOTALS	$2,123,000	$1,538,000	**$3,661,000** *	**$1,865,000** *

* Represents potential totals.

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	1/1993
ANALYST:	Taryn Gerald
FISCAL REFERENCE NUMBER:	91

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$2,503,000	$2,307,000
- STATE FUNDS	$1,251,500	$1,153,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,503,000	$2,307,000
STATE FUNDS	$1,251,500	$1,153,500
FEDERAL FUNDS	$1,251,500	$1,153,500

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 19.1916
California Code of Regulations 50788

Interdependent Policy Changes:
Not Applicable

Background:
The Department pays the premium cost of private health insurance for high-risk beneficiaries under the HIPP program when payment of such premiums is cost effective. Premium costs are budgeted separately from other Medi-Cal benefits since premiums are paid outside of the regular Medi-Cal claims payment procedures.

Reason for Change from Prior Estimate:
The previous estimate assumed a continuous decline in enrollment. Current data reflects enrollment has leveled out.

Methodology:
1. The average monthly premium cost is estimated to be $507.50 in FY 2012-13 and $466.63 in FY 2013-14.

2. The average monthly HIPP enrollment is estimated to be 411 in FY 2012-13 and 412 in FY 2013-14.

3. Costs for FY 2012-13 and FY 2013-14 are estimated to be:

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

FY 2012-13: $507.50 x 411 x 12 Months = **$2,503,000 TF ($1,251,500 GF)**

FY 2013-14: $466.63 x 412 x 12 Months = **$2,307,000 TF ($1,153,500 GF)**

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

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	7/1997
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1083

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	$1,769,000	$1,330,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,769,000	$1,330,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,769,000	$1,330,000

DESCRIPTION

Purpose:
The 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 match with the federal funds for case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an IA.

Reason for Change from Prior Estimate:
The increase in FY 2012-13 is due to additional FY 2010-11 payments to be paid out in FY 2012-13.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 187

Methodology:

1. Annual expenditures on the accrual basis are $1,028,000. 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.

FY 2012-13	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,769,000**	$1,769,000

FY 2013-14	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,330,000**	$1,330,000

Funding:

Title XIX FFP (4260-101-0890)

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/1987
ANALYST:	Celine Donaldson
FISCAL REFERENCE NUMBER:	127

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	-$236,954,000	-$240,243,000
- STATE FUNDS	-$140,554,000	-$142,505,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$236,954,000	-$240,243,000
STATE FUNDS	-$140,554,000	-$142,505,000
FEDERAL FUNDS	-$96,400,000	-$97,738,000

DESCRIPTION

Purpose:
This policy change estimates the collection from estates, providers, and other insurance to offset the cost of services provided by Medi-Cal.

Authority:
Welfare & Institutions Code 14124.70 – 14124.79, 14009, and 14007.9
Title 22, California Code of Regulations 50781-50791

Interdependent Policy Changes:
Not Applicable

Background:
Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances.

Reason for Change from Prior Estimate:
Actual values for February through July 2012 were lower than previously estimated.

Methodology:
1. Recoveries are estimated using the trend in the monthly recoveries for July 2009 – July 2012.

2. The General Fund ratio for collections is estimated to be 59.32% in FY 2012-13 and FY 2013-14.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 202

	In Thousands	
Estimated Base Recoveries	**FY 2012-13**	**FY 2013-14**
Personal Injury Collections	($45,419)	($45,334)
Workers' Comp. Contract	($2,700)	($2,700)
H.I. Contingency Contract	($70,000)	($70,000)
General Collections	($118,835)	($122,209)
TOTAL	**($236,954)**	**($240,243)**

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