## *Medi-Cal Funding Summary*
## *May 2017 Estimate Compared to FY 2017-18 Appropriation*
## *Fiscal Year 2017 - 2018*

### TOTAL FUNDS

| | May 2017 Estimate | FY 2017-18 Appropriation | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0001/0890(3) | $67,566,482,000 | $69,136,479,000 | $1,569,997,000 |
| 4260-101-0080 CLPP Funds | $725,000 | $725,000 | $0 |
| 4260-101-0232 Prop 99 Hospital Srvc. Acct. | $111,400,000 | $111,400,000 | $0 |
| 4260-101-0233 Prop 99 Physician Srvc. Acct | $40,220,000 | $40,220,000 | $0 |
| 4260-101-0236 Prop 99 Unallocated Account | $56,904,000 | $56,904,000 | $0 |
| 4260-101-0313 Major Risk Medical Ins Fund | $0 | $0 | $0 |
| 4260-101-3156 MCO Tax Fund MRMIB | $99,407,000 | $99,407,000 | $0 |
| 4260-101-3168 Emergency Air Transportation Fund | $7,890,000 | $7,890,000 | $0 |
| 4260-101-3305 Healthcare Treatment Fund | $1,257,166,000 | $1,257,166,000 | $0 |
| 4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $46,633,000 | $46,633,000 | $0 |
| 4260-102-0001/0890 Capital Debt | $165,619,000 | $165,619,000 | $0 |
| 4260-104-0001 NDPH Hosp Supp * | $1,900,000 | $1,900,000 | $0 |
| 4260-601-3096 NDPH Suppl | $1,900,000 | $1,900,000 | $0 |
| 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 | $127,550,000 | $127,550,000 | $0 |
| 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 | $19,496,000 | $19,496,000 | $0 |
| 4260-113-0001/0890 Healthy Families | $3,020,483,000 | $3,020,483,000 | $0 |
| 4260-601-0942142 Local Trauma Centers | $44,845,000 | $44,845,000 | $0 |
| 4260-601-0942 Home Health Program Account | $0 | $0 | $0 |
| 4260-601-3156 MCO Tax Fund | $328,610,000 | $328,610,000 | $0 |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $800,000,000 | $800,000,000 | $0 |
| 4260-601-3213 LTC QA Fund | $482,975,000 | $482,975,000 | $0 |
| 4260-601-3293 MCO Tax Fund 2016 | $2,392,507,000 | $2,392,507,000 | $0 |
| 4260-601-7502 Demonstration DSH Fund | $148,011,000 | $148,011,000 | $0 |
| 4260-601-7503 Health Care Support Fund | $324,393,000 | $324,393,000 | $0 |
| 4260-601-8107 Whole Person Care Pilot Fund | $360,000,000 | $360,000,000 | $0 |
| 4260-601-8108 Global Payment Program Fund | $1,152,567,000 | $1,152,567,000 | $0 |
| 4260-602-0309 Perinatal Insurance Fund | $10,997,000 | $10,997,000 | $0 |
| 4260-605-0001 SNF Quality & Accountability * | $48,928,000 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,122,000 | $43,122,000 | $0 |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $177,411,000 | $177,411,000 | $0 |
| 4260-610-0995 Reimbursements | $4,885,881,000 | $4,947,529,000 | $61,648,000 |
| 4260-611-3158/0890 Hospital Quality Assurance | $16,840,000,000 | $16,840,000,000 | $0 |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $116,250,000 | $116,250,000 | $0 |
| **TOTAL MEDI-CAL Benefits** | **$100,629,444,000** | **$102,261,089,000** | **$1,631,645,000** |
| | | | |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001/0890(1) | $4,518,300,000 | $4,518,300,000 | $0 |
| 4260-106-0890(1) Money Follow Person Fed. Grant | $688,000 | $688,000 | $0 |
| 4260-107-0890 Prevention of Chronic Disease (MICPD) | $0 | $0 | $0 |
| 4260-113-0001/0890 Healthy Families | $32,587,000 | $32,587,000 | $0 |
| 4260-117-0001/0890 HIPPA | $10,581,000 | $10,581,000 | $0 |
| 4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct. | $5,856,000 | $5,856,000 | $0 |
| 4260-601-0942 Home Health Program Account | $317,000 | $317,000 | $0 |
| 4260-602-0313 Major Risk Medical Ins Fund | $0 | $0 | $0 |
| 4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $1,419,000 | $1,419,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability Admin. | $3,907,000 | $3,907,000 | $0 |
| 4260-610-0995 Reimbursements | $692,000 | $692,000 | $0 |
| **TOTAL COUNTY ADMIN.** | **$4,574,347,000** | **$4,574,347,000** | **$0** |
| | | | |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001/0890(2) | $403,121,000 | $403,121,000 | $0 |
| 4260-113-0001/0890 Healthy Families | $5,816,000 | $5,816,000 | $0 |
| 4260-117-0001/0890 HIPAA | $14,293,000 | $14,293,000 | $0 |
| 4260-610-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIARY** | **$423,230,000** | **$423,230,000** | **$0** |
| | | | |
| **GRAND TOTAL - ALL FUNDS** | **$105,627,021,000** | **$107,258,666,000** | **$1,631,645,000** |

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

***Medi-Cal Funding Summary***
***May 2017 Estimate Compared to FY 2017-18 Appropriation***
***Fiscal Year 2017 - 2018***

**STATE FUNDS**

| | May 2017 Estimate | FY 2017-18 Appropriation | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0001(3) * | $16,507,594,000 | $17,428,661,000 | $921,067,000 |
| 4260-101-0080 CLPP Funds | $725,000 | $725,000 | $0 |
| 4260-101-0232 Prop 99 Hospital Srvc. Acct. | $111,400,000 | $111,400,000 | $0 |
| 4260-101-0233 Prop 99 Physician Srvc. Acct | $40,220,000 | $40,220,000 | $0 |
| 4260-101-0236 Prop 99 Unallocated Account | $56,904,000 | $56,904,000 | $0 |
| 4260-101-0313 Major Risk Medical Ins Fund | $0 | $0 | $0 |
| 4260-101-3156 MCO Tax Fund MRMIB | $99,407,000 | $99,407,000 | $0 |
| 4260-101-3168 Emergency Air Transportation Fund | $7,890,000 | $7,890,000 | $0 |
| 4260-101-3305 Healthcare Treatment Fund | $1,257,166,000 | $1,257,166,000 | $0 |
| 4260-101-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $46,633,000 | $46,633,000 | $0 |
| 4260-102-0001 Capital Debt * | $82,809,000 | $82,809,000 | $0 |
| 4260-104-0001 NDPH Hosp Supp * | $1,900,000 | $1,900,000 | $0 |
| 4260-601-3096 NDPH Suppl | $1,900,000 | $1,900,000 | $0 |
| 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 | $127,550,000 | $127,550,000 | $0 |
| 4260-698-3097 Private Hosp Supp (Less Funded by GF) | ($118,400,000) | ($118,400,000) | $0 |
| 4260-113-0001 Healthy Families * | $718,959,000 | $718,959,000 | $0 |
| 4260-601-0942142 Local Trauma Centers | $44,845,000 | $44,845,000 | $0 |
| 4260-601-0942 Home Health Program Account | $0 | $0 | $0 |
| 4260-601-3156 MCO Tax Fund | $328,610,000 | $328,610,000 | $0 |
| 4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund | $800,000,000 | $800,000,000 | $0 |
| 4260-601-3213 LTC QA Fund | $482,975,000 | $482,975,000 | $0 |
| 4260-601-3293 MCO Tax Fund 2016 | $2,392,507,000 | $2,392,507,000 | $0 |
| 4260-601-8107 Whole Person Care Pilot Fund | $360,000,000 | $360,000,000 | $0 |
| 4260-601-8108 Global Payment Program Fund | $1,152,567,000 | $1,152,567,000 | $0 |
| 4260-602-0309 Perinatal Insurance Fund | $10,997,000 | $10,997,000 | $0 |
| 4260-605-0001 SNF Quality & Accountability * | $48,928,000 | $48,928,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability | $43,122,000 | $43,122,000 | $0 |
| 4260-698-3167 SNF Qual & Acct. (Less Funded by GF) | ($48,928,000) | ($48,928,000) | $0 |
| 4260-606-0834 SB 1100 DSH | $177,411,000 | $177,411,000 | $0 |
| 4260-610-0995 Reimbursements | $4,885,881,000 | $4,947,529,000 | $61,648,000 |
| 4260-611-3158 Hospital Quality Assurance Revenue | $6,382,189,000 | $6,382,189,000 | $0 |
| 4260-611-3201 LIHP MCE Out-of-Network ER Svcs. | $116,250,000 | $116,250,000 | $0 |
| **TOTAL MEDI-CAL Benefits** | **$36,236,511,000** | **$37,219,226,000** | **$982,715,000** |
| **Total Benefits General Fund *** | **$17,478,590,000** | **$18,399,657,000** | **$921,067,000** |
| | | | |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0001(1) * | $946,049,000 | $946,049,000 | $0 |
| 4260-113-0001 Healthy Families * | $12,804,000 | $12,804,000 | $0 |
| 4260-117-0001 HIPAA * | $1,708,000 | $1,708,000 | $0 |
| 4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct. | $5,856,000 | $5,856,000 | $0 |
| 4260-601-0942 Home Health Program Account | $317,000 | $317,000 | $0 |
| 4260-602-0313 Major Risk Medical Ins Fund | $0 | $0 | $0 |
| 4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund | $1,419,000 | $1,419,000 | $0 |
| 4260-605-3167 SNF Quality & Accountability Admin. | $3,907,000 | $3,907,000 | $0 |
| 4260-610-0995 Reimbursements | $692,000 | $692,000 | $0 |
| **TOTAL COUNTY ADMIN.** | **$972,752,000** | **$972,752,000** | **$0** |
| **Total Co. Admin. General Fund *** | **$960,561,000** | **$960,561,000** | **$0** |
| | | | |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0001(2) * | $150,157,000 | $150,157,000 | $0 |
| 4260-113-0001 Healthy Families * | $1,701,000 | $1,701,000 | $0 |
| 4260-117-0001 HIPAA * | $2,681,000 | $2,681,000 | $0 |
| 4260-610-0995 Reimbursements | $0 | $0 | $0 |
| **TOTAL FISCAL INTERMEDIARY** | **$154,539,000** | **$154,539,000** | **$0** |
| **Total FI General Fund *** | **$154,539,000** | **$154,539,000** | **$0** |
| | | | |
| **GRAND TOTAL - STATE FUNDS** | **$37,363,802,000** | **$38,346,517,000** | **$982,715,000** |
| **Grand Total General Fund*** | **$18,593,690,000** | **$19,514,757,000** | **$921,067,000** |

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

## *Medi-Cal Funding Summary*
## *May 2017 Estimate Compared to FY 2017-18 Appropriation*
## *Fiscal Year 2017 - 2018*

### FEDERAL FUNDS

| | May 2017 Estimate | FY 2017-18 Appropriation | Difference Incr./(Decr.) |
|---|---|---|---|
| **MEDI-CAL Benefits:** | | | |
| 4260-101-0890(3) | $51,058,888,000 | $51,707,818,000 | $648,930,000 |
| 4260-102-0890 Capital Debt | $82,810,000 | $82,810,000 | $0 |
| 4260-106-0890 Money Follows Person Federal Grant | $19,496,000 | $19,496,000 | $0 |
| 4260-113-0890 Health Families | $2,301,524,000 | $2,301,524,000 | $0 |
| 4260-601-7502 Demonstration DSH Fund | $148,011,000 | $148,011,000 | $0 |
| 4260-601-7503 Health Care Support Fund | $324,393,000 | $324,393,000 | $0 |
| 4260-611-0890 Hospital Quality Assurance | $10,457,811,000 | $10,457,811,000 | $0 |
| **TOTAL MEDI-CAL Benefits** | **$64,392,933,000** | **$65,041,863,000** | **$648,930,000** |
| | | | |
| **COUNTY ADMINISTRATION:** | | | |
| 4260-101-0890(1) | $3,572,251,000 | $3,572,251,000 | $0 |
| 4260-106-0890(1) Money Follows Person Fed. Grant | $688,000 | $688,000 | $0 |
| 4260-107-0890 Prevention of Chronic Disease (MIPCD) | $0 | $0 | $0 |
| 4260-113-0890 Healthy Families | $19,783,000 | $19,783,000 | $0 |
| 4260-117-0890 HIPAA | $8,873,000 | $8,873,000 | $0 |
| **TOTAL COUNTY ADMIN.** | **$3,601,595,000** | **$3,601,595,000** | **$0** |
| | | | |
| **FISCAL INTERMEDIARY:** | | | |
| 4260-101-0890(2) | $252,964,000 | $252,964,000 | $0 |
| 4260-113-0890 Healthy Families | $4,115,000 | $4,115,000 | $0 |
| 4260-117-0890 HIPAA | $11,612,000 | $11,612,000 | $0 |
| **TOTAL FISCAL INTERMEDIARY** | **$268,691,000** | **$268,691,000** | **$0** |
| | | | |
| **GRAND TOTAL - FEDERAL FUNDS** | **$68,263,219,000** | **$68,912,149,000** | **$648,930,000** |

# MEDI-CAL PROGRAM ESTIMATE SUMMARY
# FISCAL YEAR 2017-18

| | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|
| **I. BASE ESTIMATES** | | | | |
| A. B/Y FFS BASE | $17,394,954,530 | $8,697,477,260 | $8,697,477,260 | $0 |
| B. B/Y BASE POLICY CHANGES | $46,844,215,000 | $32,331,076,110 | $13,691,910,890 | $821,228,000 |
| C. BASE ADJUSTMENTS | ($136,943,000) | ($171,223,650) | $34,280,650 | $0 |
| **D. ADJUSTED BASE** | **$64,102,226,530** | **$40,857,329,720** | **$22,423,668,810** | **$821,228,000** |
| **II. REGULAR POLICY CHANGES** | | | | |
| A. ELIGIBILITY | $158,321,930 | ($854,887,920) | $974,484,850 | $38,725,000 |
| B. AFFORDABLE CARE ACT | $2,809,003,000 | $2,345,495,250 | $507,229,750 | ($43,722,000) |
| C. BENEFITS | $1,234,440,940 | $926,229,600 | $288,322,350 | $19,889,000 |
| D. PHARMACY | ($2,315,852,570) | ($1,552,069,600) | ($763,782,960) | $0 |
| E. DRUG MEDI-CAL | $594,737,000 | $469,835,360 | $124,901,640 | $0 |
| F. MENTAL HEALTH | $314,763,000 | $279,717,500 | $34,845,500 | $200,000 |
| G. WAIVER--MH/UCD & BTR | $5,586,007,000 | $3,051,803,500 | $63,730,500 | $2,470,473,000 |
| H. MANAGED CARE | $7,835,145,430 | $2,711,743,830 | ($612,478,400) | $5,735,880,000 |
| I. PROVIDER RATES | $412,897,640 | $702,639,450 | ($780,606,810) | $490,865,000 |
| J. SUPPLEMENTAL PMNTS. | $21,243,389,000 | $13,868,692,500 | $622,032,000 | $6,752,664,500 |
| K. OTHER | $286,009,870 | $2,235,333,300 | ($4,482,689,440) | $2,533,366,000 |
| **L. TOTAL CHANGES** | **$38,158,862,240** | **$24,184,532,770** | **($4,024,011,030)** | **$17,998,340,500** |
| **III. TOTAL MEDI-CAL ESTIMATE** | **$102,261,088,760** | **$65,041,862,490** | **$18,399,657,770** | **$18,819,568,500** |

# SUMMARY OF REGULAR POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **ELIGIBILITY** | | | | |
| 3 | MEDI-CAL STATE INMATE PROGRAMS | $117,057,000 | $117,057,000 | $0 | $0 |
| 5 | BREAST AND CERVICAL CANCER TREATMENT | $69,000,000 | $32,200,000 | $36,800,000 | $0 |
| 6 | MEDI-CAL COUNTY INMATE PROGRAMS | $301,867,000 | $264,389,450 | $37,477,550 | $0 |
| 9 | STATE-ONLY BCCTP COVERAGE EXTENSION | $1,643,590 | $0 | $1,643,590 | $0 |
| 10 | NON-OTLICP CHIP | $401,000,000 | $479,752,490 | ($78,752,490) | $0 |
| 11 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | ($899,150,000) | $899,150,000 | $0 |
| 12 | SCHIP FUNDING FOR PRENATAL CARE | $0 | $68,261,600 | ($68,261,600) | $0 |
| 14 | PARIS-VETERANS | ($6,007,670) | ($1,896,390) | ($4,111,280) | $0 |
| 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($144,192,000) | ($114,325,980) | ($29,866,020) | $0 |
| 16 | OTLICP PREMIUMS | ($66,749,000) | ($58,739,120) | ($8,009,880) | $0 |
| 219 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | $0 | ($37,456,000) | $37,456,000 |
| 221 | MEC OPTIONAL EXPANSION ADJUSTMENT | ($515,297,000) | ($742,436,970) | $225,870,970 | $1,269,000 |
| | **ELIGIBILITY SUBTOTAL** | **$158,321,930** | **($854,887,920)** | **$974,484,850** | **$38,725,000** |
| | **AFFORDABLE CARE ACT** | | | | |
| 17 | COMMUNITY FIRST CHOICE OPTION | $2,535,500,000 | $2,535,500,000 | $0 | $0 |
| 19 | HEALTH INSURER FEE | $502,274,000 | $332,631,940 | $169,642,060 | $0 |
| 20 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $19,463,000 | $19,463,000 | $0 | $0 |
| 22 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $2,000,000 | $2,000,000 | $0 | $0 |
| 23 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | $2,026,000 | ($2,026,000) | $0 |
| 25 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | $36,365,640 | ($36,365,640) | $0 |
| 26 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 |
| 28 | ACA DSH REDUCTION | ($137,873,000) | ($73,170,000) | ($16,177,000) | ($48,526,000) |
| 209 | TITLE XXI FEDERAL MATCH REDUCTION | ($112,361,000) | ($509,321,330) | $392,156,330 | $4,804,000 |
| | **AFFORDABLE CARE ACT SUBTOTAL** | **$2,809,003,000** | **$2,345,495,250** | **$507,229,750** | **($43,722,000)** |
| | **BENEFITS** | | | | |
| 1 | FAMILY PACT PROGRAM | $310,264,000 | $235,636,200 | $74,627,800 | $0 |
| 29 | BEHAVIORAL HEALTH TREATMENT | $213,817,000 | $120,418,260 | $93,398,740 | $0 |
| 30 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $245,649,000 | $245,649,000 | $0 | $0 |
| 31 | BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION | $101,325,000 | $57,064,740 | $44,260,260 | $0 |
| 32 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $131,106,000 | $131,106,000 | $0 | $0 |
| 33 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $19,889,000 | $0 | $19,889,000 |
| 34 | CCS DEMONSTRATION PROJECT | $36,847,000 | $20,074,220 | $16,772,780 | $0 |

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

# SUMMARY OF REGULAR POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **BENEFITS** | | | | |
| 35 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $19,680,000 | $17,038,000 | $2,642,000 | $0 |
| 36 | IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT | $4,626,730 | $2,411,840 | $2,214,890 | $0 |
| 38 | YOUTH REGIONAL TREATMENT CENTERS | $5,825,000 | $5,796,000 | $29,000 | $0 |
| 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $3,530,790 | $1,881,690 | $1,649,100 | $0 |
| 40 | DENTAL CHILDREN'S OUTREACH AGES 0-3 | $5,724,000 | $2,862,000 | $2,862,000 | $0 |
| 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $2,458,000 | $2,458,000 | $0 | $0 |
| 42 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $6,490,000 | $3,245,000 | $3,245,000 | $0 |
| 43 | END OF LIFE SERVICES | $659,980 | $0 | $659,980 | $0 |
| 44 | DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM | $725,000 | $362,500 | $362,500 | $0 |
| 45 | MEDICAL MANAGEMENT AND TREATMENT FOR ALD | $124,340 | $68,190 | $56,160 | $0 |
| 46 | ALLIED DENTAL PROFESSIONALS ENROLLMENT | $763,000 | $381,500 | $381,500 | $0 |
| 48 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $56,000 | $56,000 | $0 | $0 |
| 51 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($2,867,130) | ($1,571,490) | ($1,295,640) | $0 |
| 52 | SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES | ($3,201,000) | ($1,600,500) | ($1,600,500) | $0 |
| 53 | WOMEN'S HEALTH SERVICES | ($7,932,000) | ($6,144,500) | ($1,787,500) | $0 |
| 208 | ANNUAL CONTRACEPTIVE COVERAGE | $36,371,230 | $28,167,950 | $8,203,280 | $0 |
| 229 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $11,163,000 | $6,251,000 | $4,912,000 | $0 |
| 231 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $69,458,000 | $34,729,000 | $34,729,000 | $0 |
| 234 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $2,000,000 | $0 | $2,000,000 | $0 |
| | **BENEFITS SUBTOTAL** | **$1,234,440,940** | **$926,229,600** | **$288,322,350** | **$19,889,000** |
| | **PHARMACY** | | | | |
| 55 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $69,438,430 | $37,712,660 | $31,725,780 | $0 |
| 56 | NON FFP DRUGS | $0 | ($69,500) | $69,500 | $0 |
| 57 | BCCTP DRUG REBATES | ($11,263,000) | ($7,717,850) | ($3,545,150) | $0 |
| 58 | FAMILY PACT DRUG REBATES | ($17,183,000) | ($15,050,600) | ($2,132,400) | $0 |
| 59 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($12,458,000) | $0 |
| 61 | STATE SUPPLEMENTAL DRUG REBATES | ($192,285,000) | ($126,861,210) | ($65,423,790) | $0 |
| 62 | FEDERAL DRUG REBATE PROGRAM | ($2,139,644,000) | ($1,427,625,100) | ($712,018,900) | $0 |
| | **PHARMACY SUBTOTAL** | **($2,315,852,570)** | **($1,552,069,600)** | **($763,782,960)** | **$0** |
| | **DRUG MEDI-CAL** | | | | |
| 64 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $580,548,000 | $456,183,260 | $124,364,740 | $0 |

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

# SUMMARY OF REGULAR POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **DRUG MEDI-CAL** | | | | |
| 69 | DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT | $14,189,000 | $13,652,100 | $536,900 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$594,737,000** | **$469,835,360** | **$124,901,640** | **$0** |
| | **MENTAL HEALTH** | | | | |
| 72 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $253,505,000 | $253,505,000 | $0 | $0 |
| 73 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $23,308,000 | $10,884,500 | $12,423,500 | $0 |
| 74 | PATHWAYS TO WELL-BEING | $17,201,000 | $17,201,000 | $0 | $0 |
| 75 | LATE CLAIMS FOR SMHS | $4,000 | $0 | $4,000 | $0 |
| 76 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | $0 | $0 | ($200,000) | $200,000 |
| 78 | CHART REVIEW | ($1,485,000) | ($1,485,000) | $0 | $0 |
| 79 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | $20,758,000 | ($388,000) | $21,146,000 | $0 |
| 217 | TRANSITIONAL SMHS CLAIMS | $1,472,000 | $0 | $1,472,000 | $0 |
| | **MENTAL HEALTH SUBTOTAL** | **$314,763,000** | **$279,717,500** | **$34,845,500** | **$200,000** |
| | **WAIVER--MH/UCD & BTR** | | | | |
| 80 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,600,000,000 | $800,000,000 | $0 | $800,000,000 |
| 81 | GLOBAL PAYMENT PROGRAM | $2,388,446,000 | $1,194,223,000 | $0 | $1,194,223,000 |
| 82 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $720,000,000 | $360,000,000 | $0 | $360,000,000 |
| 83 | BTR - LIHP - MCE | $198,363,000 | $198,363,000 | $0 | $0 |
| 84 | LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND | $232,500,000 | $116,250,000 | $0 | $116,250,000 |
| 85 | BTR - LOW INCOME HEALTH PROGRAM - HCCI | $231,547,000 | $231,547,000 | $0 | $0 |
| 86 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $141,905,000 | $70,952,500 | $70,952,500 | $0 |
| 87 | MH/UCD—HEALTH CARE COVERAGE INITIATIVE | $23,509,000 | $23,509,000 | $0 | $0 |
| 88 | MH/UCD—STABILIZATION FUNDING | $55,400,000 | $0 | $55,400,000 | $0 |
| 89 | MH/UCD—SAFETY NET CARE POOL | ($6,723,000) | ($6,723,000) | $0 | $0 |
| 92 | UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG | $1,060,000 | $1,060,000 | $0 | $0 |
| 95 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM | $0 | $75,000,000 | ($75,000,000) | $0 |
| 222 | CMS DEFERRED CLAIMS | $0 | ($12,378,000) | $12,378,000 | $0 |
| | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$5,586,007,000** | **$3,051,803,500** | **$63,730,500** | **$2,470,473,000** |
| | **MANAGED CARE** | | | | |
| 98 | CCI-MANAGED CARE PAYMENTS | $4,524,106,210 | $2,262,053,100 | $2,262,053,100 | $0 |
| 100 | MANAGED CARE PUBLIC HOSPITAL IGTS | $2,880,095,000 | $2,408,350,000 | $0 | $471,745,000 |

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

# SUMMARY OF REGULAR POLICY CHANGES
## FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **MANAGED CARE** | | | | |
| 101 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,131,736,000 | $1,519,512,990 | $612,223,010 | $0 |
| 103 | MANAGED CARE RATE RANGE IGTS | $3,143,888,000 | $1,771,220,000 | $0 | $1,372,668,000 |
| 105 | HQAF RATE RANGE INCREASES | $232,000,000 | $116,000,000 | $0 | $116,000,000 |
| 111 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $2,977,000 | $1,642,470 | $1,334,530 | $0 |
| 112 | CAPITATED RATE ADJUSTMENT FOR FY 2017-18 | $0 | $0 | $0 | $0 |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | $0 | ($612,223,000) | $612,223,000 |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | $0 | ($1,780,284,000) | $1,780,284,000 |
| 116 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | $0 | ($13,631,000) | $13,631,000 |
| 117 | MCO TAX MANAGED CARE PLANS | $0 | $0 | ($414,386,000) | $414,386,000 |
| 118 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | $0 | ($275,965,000) | $275,965,000 |
| 119 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | $0 | ($253,242,000) | $253,242,000 |
| 120 | CENCAL HEALTH PLAN-ADDITION OF CHDP | ($940,780) | ($470,390) | ($470,390) | $0 |
| 122 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $21,304,000 | $10,840,000 | $10,464,000 | $0 |
| 123 | MANAGED CARE DRUG REBATES | ($1,066,751,000) | ($720,799,810) | ($345,951,190) | $0 |
| 124 | RETRO MC RATE ADJUSTMENTS | ($4,048,269,000) | ($4,665,379,000) | $191,374,000 | $425,736,000 |
| 220 | CCI-QUALITY WITHHOLD REPAYMENTS | $9,000,000 | $4,500,000 | $4,500,000 | $0 |
| 225 | MEDI-CAL NONMEDICAL TRANSPORTATION | $6,000,000 | $4,274,470 | $1,725,530 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$7,835,145,430** | **$2,711,743,840** | **($612,478,400)** | **$5,735,880,000** |
| | **PROVIDER RATES** | | | | |
| 125 | MEDICARE PART B ADJUSTMENT | ($160,682,000) | ($72,124,500) | ($88,557,500) | $0 |
| 126 | DENTAL RETROACTIVE RATE CHANGES | $23,693,000 | $14,597,730 | $9,095,270 | $0 |
| 127 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $171,669,480 | $106,491,030 | $65,178,450 | $0 |
| 128 | AB 1629 ANNUAL RATE ADJUSTMENTS | $144,999,930 | $72,499,960 | $72,499,960 | $0 |
| 130 | DPH INTERIM & FINAL RECONS | $137,004,000 | $137,004,000 | $0 | $0 |
| 131 | DPH INTERIM RATE GROWTH | $37,920,420 | $18,960,210 | $18,960,210 | $0 |
| 132 | LTC RATE ADJUSTMENT | $29,408,930 | $14,704,460 | $14,704,460 | $0 |
| 133 | ANNUAL MEI INCREASE FOR FQHCS/RHCS | $21,631,560 | $13,418,600 | $8,212,960 | $0 |
| 134 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $11,000,000 | $5,500,000 | ($2,390,000) | $7,890,000 |
| 135 | HOSPICE RATE INCREASES | $19,921,040 | $9,960,520 | $9,960,520 | $0 |
| 136 | DISCONTINUE PHARMACY RATE REDUCTIONS | $22,531,850 | $11,265,920 | $11,265,920 | $0 |
| 137 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $19,464,620 | $9,732,310 | $9,732,310 | $0 |
| 138 | GDSP PRENATAL SCREENING FEE INCREASE | $4,088,310 | $2,044,150 | $2,044,150 | $0 |

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

## SUMMARY OF REGULAR POLICY CHANGES
## FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **PROVIDER RATES** | | | | |
| 139 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $1,551,580 | $2,798,840 | ($1,247,260) | $0 |
| 140 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $44,390 | $22,190 | $22,190 | $0 |
| 142 | DPH INTERIM RATE | $0 | $391,438,740 | ($391,438,740) | $0 |
| 143 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | $0 | ($482,975,000) | $482,975,000 |
| 144 | LABORATORY RATE METHODOLOGY CHANGE | ($23,980,830) | ($11,990,410) | ($11,990,410) | $0 |
| 145 | REDUCTION TO RADIOLOGY RATES | ($22,711,270) | ($11,355,630) | ($11,355,630) | $0 |
| 146 | 10% PROVIDER PAYMENT REDUCTION | ($24,657,350) | ($12,328,670) | ($12,328,670) | $0 |
| | **PROVIDER RATES SUBTOTAL** | **$412,897,640** | **$702,639,450** | **($780,606,810)** | **$490,865,000** |
| | **SUPPLEMENTAL PMNTS.** | | | | |
| 129 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $86,243,000 | $43,121,500 | $48,928,000 | ($5,806,500) |
| 147 | EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS | $15,569,513,000 | $10,329,673,000 | $0 | $5,239,840,000 |
| 148 | PRIVATE HOSPITAL DSH REPLACEMENT | $573,382,000 | $286,691,000 | $286,691,000 | $0 |
| 149 | DSH PAYMENT | $444,414,000 | $300,446,000 | $17,000,000 | $126,968,000 |
| 150 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $300,261,000 | $172,711,000 | $118,400,000 | $9,150,000 |
| 151 | NDPH IGT SUPPLEMENTAL PAYMENTS | $184,924,000 | $130,052,000 | ($2,441,000) | $57,313,000 |
| 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $125,117,000 | $74,120,000 | $2,520,000 | $48,477,000 |
| 153 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $415,351,000 | $415,351,000 | $0 | $0 |
| 154 | CAPITAL PROJECT DEBT REIMBURSEMENT | $186,120,000 | $103,310,000 | $82,810,000 | $0 |
| 155 | FFP FOR LOCAL TRAUMA CENTERS | $106,601,000 | $61,756,000 | $0 | $44,845,000 |
| 156 | DPH PHYSICIAN & NON-PHYS. COST | $154,861,000 | $154,861,000 | $0 | $0 |
| 157 | HOSPITAL QAF - HOSPITAL PAYMENTS | $100,398,000 | $10,270,000 | $0 | $90,128,000 |
| 158 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $73,762,000 | $73,762,000 | $0 | $0 |
| 159 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $76,800,000 | $76,800,000 | $0 | $0 |
| 160 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH | $10,000,000 | $5,000,000 | $5,000,000 | $0 |
| 161 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH | $8,000,000 | $4,000,000 | $4,000,000 | $0 |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,631,000 | $4,631,000 | $0 | $0 |
| 163 | IGT PAYMENTS FOR HOSPITAL SERVICES | $5,613,000 | $3,613,000 | $0 | $2,000,000 |
| 164 | NDPH SUPPLEMENTAL PAYMENT | $4,950,000 | $3,050,000 | $1,900,000 | $0 |
| 165 | FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS | $465,948,000 | $465,948,000 | $0 | $0 |
| 214 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | ($57,224,000) | $57,224,000 | $0 |
| 215 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $1,187,500,000 | $593,750,000 | $0 | $593,750,000 |

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

# SUMMARY OF REGULAR POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **SUPPLEMENTAL PMNTS.** | | | | |
| 232 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $167,000,000 | $117,000,000 | $0 | $50,000,000 |
| 233 | ICF/DD SUPPLEMENTAL PAYMENTS | $54,000,000 | $27,000,000 | $0 | $27,000,000 |
| 236 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $650,000,000 | $325,000,000 | $0 | $325,000,000 |
| 237 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $280,000,000 | $140,000,000 | $0 | $140,000,000 |
| 238 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $8,000,000 | $4,000,000 | $0 | $4,000,000 |
| | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$21,243,389,000** | **$13,868,692,500** | **$622,032,000** | **$6,752,664,500** |
| | **OTHER** | | | | |
| 77 | IMD ANCILLARY SERVICES | $0 | ($29,565,000) | $29,565,000 | $0 |
| 166 | INFANT DEVELOPMENT PROGRAM | $26,305,000 | $26,305,000 | $0 | $0 |
| 174 | ARRA HITECH - PROVIDER PAYMENTS | $175,130,000 | $175,130,000 | $0 | $0 |
| 176 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $110,533,000 | $110,533,000 | $0 | $0 |
| 180 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $19,921,000 | $11,582,000 | $8,339,000 | $0 |
| 181 | OVERTIME FOR WPCS PROVIDERS | $14,686,000 | $7,343,000 | $7,343,000 | $0 |
| 182 | MEDI-CAL ESTATE RECOVERIES | $64,707,000 | $32,353,500 | $32,353,500 | $0 |
| 183 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $15,297,260 | $7,648,630 | $7,648,630 | $0 |
| 184 | WPCS WORKERS' COMPENSATION | $3,019,000 | $1,509,500 | $1,509,500 | $0 |
| 185 | INDIAN HEALTH SERVICES | $6,239,000 | $27,034,000 | ($20,795,000) | $0 |
| 189 | CDDS DENTAL SERVICES | $984,000 | $0 | $0 | $984,000 |
| 190 | NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL | $6,749,700 | $3,374,850 | $3,374,850 | $0 |
| 192 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | $0 | ($8,217,000) | $8,217,000 |
| 193 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | $1,764,846,210 | ($1,764,846,210) | $0 |
| 194 | FUNDING ADJUST.—OTLICP | $154,000 | $176,980,160 | ($176,826,160) | $0 |
| 196 | CLPP FUND | $0 | $0 | ($725,000) | $725,000 |
| 197 | CCI-TRANSFER OF IHSS COSTS TO DHCS | $0 | $0 | ($1,247,758,000) | $1,247,758,000 |
| 198 | EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | $0 | ($1,020,525,000) | $1,020,525,000 |
| 199 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | $0 | ($208,524,000) | $208,524,000 |
| 200 | MEDI-CAL RECOVERIES FIFTY PERCENT RULE | ($12,160,000) | $0 | ($12,160,000) | $0 |
| 201 | MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES | $0 | $0 | $0 | $0 |
| 205 | AUDIT SETTLEMENTS | $13,928,000 | $0 | $13,928,000 | $0 |
| 206 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($746,330) | ($373,170) | ($373,170) | $0 |
| 210 | CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT | ($157,006,760) | ($78,503,380) | ($78,503,380) | $0 |
| 212 | HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND | $0 | $0 | ($46,633,000) | $46,633,000 |

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

# SUMMARY OF REGULAR POLICY CHANGES
# FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **OTHER** | | | | |
| 224 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | ($1,730,000) | ($865,000) | ($865,000) | $0 |
| | **OTHER SUBTOTAL** | **$286,009,870** | **$2,235,333,300** | **($4,482,689,440)** | **$2,533,366,000** |
| | **GRAND TOTAL** | **$38,158,862,240** | **$24,184,532,770** | **($4,024,011,030)** | **$17,998,340,500** |

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

# MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
# FISCAL YEAR 2017-18

| SERVICE CATEGORY | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|
| **PROFESSIONAL** | $7,756,093,620 | $4,628,310,620 | $2,013,582,790 | $1,114,200,210 |
| PHYSICIANS | $1,627,897,640 | $952,334,120 | $302,899,760 | $372,663,770 |
| OTHER MEDICAL | $4,132,945,240 | $2,252,406,560 | $1,704,689,780 | $175,848,900 |
| CO. & COMM. OUTPATIENT | $1,995,250,730 | $1,423,569,940 | $5,993,250 | $565,687,540 |
| **PHARMACY** | $1,381,520,530 | $764,993,060 | $564,834,680 | $51,692,790 |
| **HOSPITAL INPATIENT** | $15,045,885,270 | $9,523,070,660 | $1,861,826,830 | $3,660,987,770 |
| COUNTY INPATIENT | $1,579,926,680 | $1,258,196,990 | $68,365,120 | $253,364,570 |
| COMMUNITY INPATIENT | $13,465,958,580 | $8,264,873,670 | $1,793,461,710 | $3,407,623,200 |
| **LONG TERM CARE** | $3,381,932,100 | $1,706,543,090 | $1,537,637,720 | $137,751,300 |
| NURSING FACILITIES | $2,920,489,220 | $1,473,723,770 | $1,353,157,860 | $93,607,590 |
| ICF-DD | $461,442,890 | $232,819,320 | $184,479,860 | $44,143,710 |
| **OTHER SERVICES** | $1,313,174,820 | $781,649,670 | $482,552,340 | $48,972,810 |
| MEDICAL TRANSPORTATION | $153,675,280 | $119,927,490 | $24,991,270 | $8,756,520 |
| OTHER SERVICES | $939,176,090 | $550,603,290 | $350,744,930 | $37,827,860 |
| HOME HEALTH | $220,323,450 | $111,118,890 | $106,816,140 | $2,388,420 |
| **TOTAL FEE-FOR-SERVICE** | **$28,878,606,340** | **$17,404,567,100** | **$6,460,434,360** | **$5,013,604,890** |
| **MANAGED CARE** | $54,006,785,840 | $33,805,543,900 | $7,743,820,500 | $12,457,421,430 |
| TWO PLAN MODEL | $34,465,412,840 | $21,598,563,970 | $4,707,684,510 | $8,159,164,360 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $11,612,574,690 | $7,267,316,820 | $1,687,869,360 | $2,657,388,510 |
| GEOGRAPHIC MANAGED CARE | $5,417,679,970 | $3,403,255,620 | $853,165,920 | $1,161,258,420 |
| PHP & OTHER MANAG. CARE | $935,840,410 | $530,356,730 | $244,371,500 | $161,112,170 |
| REGIONAL MODEL | $1,575,277,940 | $1,006,050,760 | $250,729,210 | $318,497,970 |
| **DENTAL** | $1,655,439,050 | $1,001,788,930 | $471,893,720 | $181,756,410 |
| **MENTAL HEALTH** | $2,862,222,770 | $2,678,293,640 | ($7,803,790) | $191,732,920 |
| **AUDITS/ LAWSUITS** | $15,925,040 | ($11,468,490) | $27,393,490 | $40 |
| **EPSDT SCREENS** | $40,351,300 | $21,636,700 | $17,989,600 | $725,000 |
| **MEDICARE PAYMENTS** | $5,229,331,000 | $1,444,083,710 | $3,785,247,290 | $0 |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | $0 |
| **MISC. SERVICES** | $8,879,518,630 | $7,987,677,530 | ($82,482,930) | $974,324,030 |
| **RECOVERIES** | ($301,486,000) | ($151,509,500) | ($149,976,500) | $0 |
| **DRUG MEDI-CAL** | $787,064,800 | $653,918,980 | $133,142,040 | $3,780 |
| **GRAND TOTAL MEDI-CAL** | **$102,261,088,760** | **$65,041,862,490** | **$18,399,657,770** | **$18,819,568,500** |

# MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
# CURRENT YEAR COMPARED TO BUDGET YEAR
# FISCAL YEARS 2016-17 AND 2017-18

| SERVICE CATEGORY | MAY 2017 EST. FOR 2016-17 | MAY 2017 EST. FOR 2017-18 | DOLLAR DIFFERENCE | % CHANGE |
|---|---|---|---|---|
| **PROFESSIONAL** | $6,180,417,930 | $7,756,093,620 | $1,575,675,690 | 25.49% |
| PHYSICIANS | $864,619,140 | $1,627,897,640 | $763,278,500 | 88.28% |
| OTHER MEDICAL | $3,624,343,140 | $4,132,945,240 | $508,602,100 | 14.03% |
| CO. & COMM. OUTPATIENT | $1,691,455,640 | $1,995,250,730 | $303,795,090 | 17.96% |
| **PHARMACY** | $933,726,100 | $1,381,520,530 | $447,794,440 | 47.96% |
| **HOSPITAL INPATIENT** | $12,555,104,530 | $15,045,885,270 | $2,490,780,740 | 19.84% |
| COUNTY INPATIENT | $1,232,330,040 | $1,579,926,680 | $347,596,640 | 28.21% |
| COMMUNITY INPATIENT | $11,322,774,480 | $13,465,958,580 | $2,143,184,100 | 18.93% |
| **LONG TERM CARE** | $3,371,842,700 | $3,381,932,100 | $10,089,400 | 0.30% |
| NURSING FACILITIES | $2,974,894,810 | $2,920,489,220 | ($54,405,590) | -1.83% |
| ICF-DD | $396,947,890 | $461,442,890 | $64,494,990 | 16.25% |
| **OTHER SERVICES** | $1,141,949,270 | $1,313,174,820 | $171,225,550 | 14.99% |
| MEDICAL TRANSPORTATION | $124,113,720 | $153,675,280 | $29,561,560 | 23.82% |
| OTHER SERVICES | $797,473,190 | $939,176,090 | $141,702,900 | 17.77% |
| HOME HEALTH | $220,362,360 | $220,323,450 | ($38,900) | -0.02% |
| **TOTAL FEE-FOR-SERVICE** | **$24,183,040,520** | **$28,878,606,340** | **$4,695,565,820** | **19.42%** |
| **MANAGED CARE** | $43,008,957,320 | $54,006,785,840 | $10,997,828,520 | 25.57% |
| TWO PLAN MODEL | $25,922,630,470 | $34,465,412,840 | $8,542,782,360 | 32.95% |
| COUNTY ORGANIZED HEALTH SYSTEMS | $10,287,894,590 | $11,612,574,690 | $1,324,680,090 | 12.88% |
| GEOGRAPHIC MANAGED CARE | $4,702,395,700 | $5,417,679,970 | $715,284,270 | 15.21% |
| PHP & OTHER MANAG. CARE | $749,812,430 | $935,840,410 | $186,027,980 | 24.81% |
| REGIONAL MODEL | $1,346,224,120 | $1,575,277,940 | $229,053,820 | 17.01% |
| **DENTAL** | $1,155,736,240 | $1,655,439,050 | $499,702,810 | 43.24% |
| **MENTAL HEALTH** | $2,295,747,000 | $2,862,222,770 | $566,475,770 | 24.68% |
| **AUDITS/ LAWSUITS** | ($3,962,000) | $15,925,040 | $19,887,050 | -501.94% |
| **EPSDT SCREENS** | $38,281,210 | $40,351,300 | $2,070,090 | 5.41% |
| **MEDICARE PAYMENTS** | $4,996,479,000 | $5,229,331,000 | $232,852,000 | 4.66% |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | 0.00% |
| **MISC. SERVICES** | $8,986,989,470 | $8,879,518,630 | ($107,470,840) | -1.20% |
| **RECOVERIES** | ($309,233,000) | ($301,486,000) | $7,747,000 | -2.51% |
| **DRUG MEDI-CAL** | $205,419,000 | $787,064,800 | $581,645,800 | 283.15% |
| **GRAND TOTAL MEDI-CAL** | **$84,764,784,760** | **$102,261,088,760** | **$17,496,304,000** | **20.64%** |
| **GENERAL FUNDS** | **$17,972,051,680** | **$18,399,657,770** | **$427,606,090** | **2.38%** |
| **OTHER STATE FUNDS** | **$12,562,985,000** | **$18,819,568,500** | **$6,256,583,500** | **49.80%** |

# MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| SERVICE CATEGORY | NOV. 2016 EST. FOR 2017-18 | MAY 2017 EST. FOR 2017-18 | DOLLAR DIFFERENCE | % CHANGE |
|---|---|---|---|---|
| **PROFESSIONAL** | $7,738,570,830 | $7,756,093,620 | $17,522,790 | 0.23% |
| PHYSICIANS | $918,149,500 | $1,627,897,640 | $709,748,140 | 77.30% |
| OTHER MEDICAL | $3,894,594,890 | $4,132,945,240 | $238,350,350 | 6.12% |
| CO. & COMM. OUTPATIENT | $2,925,826,440 | $1,995,250,730 | ($930,575,710) | -31.81% |
| **PHARMACY** | $1,596,755,160 | $1,381,520,530 | ($215,234,630) | -13.48% |
| **HOSPITAL INPATIENT** | $15,772,947,960 | $15,045,885,270 | ($727,062,690) | -4.61% |
| COUNTY INPATIENT | $3,325,669,730 | $1,579,926,680 | ($1,745,743,040) | -52.49% |
| COMMUNITY INPATIENT | $12,447,278,230 | $13,465,958,580 | $1,018,680,350 | 8.18% |
| **LONG TERM CARE** | $3,255,326,970 | $3,381,932,100 | $126,605,130 | 3.89% |
| NURSING FACILITIES | $2,865,832,340 | $2,920,489,220 | $54,656,880 | 1.91% |
| ICF-DD | $389,494,630 | $461,442,890 | $71,948,260 | 18.47% |
| **OTHER SERVICES** | $1,113,988,120 | $1,313,174,820 | $199,186,700 | 17.88% |
| MEDICAL TRANSPORTATION | $177,311,410 | $153,675,280 | ($23,636,130) | -13.33% |
| OTHER SERVICES | $703,680,620 | $939,176,090 | $235,495,470 | 33.47% |
| HOME HEALTH | $232,996,090 | $220,323,450 | ($12,672,640) | -5.44% |
| **TOTAL FEE-FOR-SERVICE** | **$29,477,589,040** | **$28,878,606,340** | **($598,982,700)** | **-2.03%** |
| **MANAGED CARE** | $47,969,779,230 | $54,006,785,840 | $6,037,006,610 | 12.59% |
| TWO PLAN MODEL | $29,445,445,580 | $34,465,412,840 | $5,019,967,260 | 17.05% |
| COUNTY ORGANIZED HEALTH SYSTEMS | $11,099,919,530 | $11,612,574,690 | $512,655,160 | 4.62% |
| GEOGRAPHIC MANAGED CARE | $5,035,262,610 | $5,417,679,970 | $382,417,350 | 7.59% |
| PHP & OTHER MANAG. CARE | $853,827,010 | $935,840,410 | $82,013,390 | 9.61% |
| REGIONAL MODEL | $1,535,324,500 | $1,575,277,940 | $39,953,440 | 2.60% |
| **DENTAL** | $1,421,347,230 | $1,655,439,050 | $234,091,820 | 16.47% |
| **MENTAL HEALTH** | $2,703,741,580 | $2,862,222,770 | $158,481,190 | 5.86% |
| **AUDITS/ LAWSUITS** | $3,865,000 | $15,925,040 | $12,060,040 | 312.03% |
| **EPSDT SCREENS** | $54,147,000 | $40,351,300 | ($13,795,700) | -25.48% |
| **MEDICARE PAYMENTS** | $5,338,730,000 | $5,229,331,000 | ($109,399,000) | -2.05% |
| **STATE HOSP./DEVELOPMENTAL CNTRS.** | $207,330,000 | $207,330,000 | $0 | 0.00% |
| **MISC. SERVICES** | $10,101,215,210 | $8,879,518,630 | ($1,221,696,580) | -12.09% |
| **RECOVERIES** | ($311,818,000) | ($301,486,000) | $10,332,000 | -3.31% |
| **DRUG MEDI-CAL** | $822,297,000 | $787,064,800 | ($35,232,210) | -4.28% |
| **GRAND TOTAL MEDI-CAL** | **$97,788,223,300** | **$102,261,088,760** | **$4,472,865,460** | **4.57%** |
| **GENERAL FUNDS** | **$18,118,289,040** | **$18,399,657,770** | **$281,368,740** | **1.55%** |
| **OTHER STATE FUNDS** | **$16,693,069,840** | **$18,819,568,500** | **$2,126,498,660** | **12.74%** |

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **ELIGIBILITY** | | | | | | |
| 3 | 3 | MEDI-CAL STATE INMATE PROGRAMS | $324,837,000 | $0 | $117,057,000 | $0 | ($207,780,000) | $0 |
| 5 | 5 | BREAST AND CERVICAL CANCER TREATMENT | $71,126,000 | $37,702,350 | $69,000,000 | $36,800,000 | ($2,126,000) | ($902,350) |
| 6 | 6 | MEDI-CAL COUNTY INMATE PROGRAMS | $88,194,000 | $0 | $301,867,000 | $37,477,550 | $213,673,000 | $37,477,550 |
| 9 | 9 | STATE-ONLY BCCTP COVERAGE EXTENSION | $1,625,000 | $1,625,000 | $1,696,000 | $1,696,000 | $71,000 | $71,000 |
| 10 | 10 | NON-OTLICP CHIP | $0 | ($497,931,100) | $401,000,000 | ($78,752,490) | $401,000,000 | $419,178,610 |
| 11 | 11 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | $693,904,000 | $0 | $899,150,000 | $0 | $205,246,000 |
| 12 | 12 | SCHIP FUNDING FOR PRENATAL CARE | $0 | ($65,386,640) | $0 | ($68,261,600) | $0 | ($2,874,960) |
| 14 | 14 | PARIS-VETERANS | ($15,357,890) | ($7,678,940) | ($24,361,990) | ($16,671,840) | ($9,004,100) | ($8,992,900) |
| 15 | 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($140,029,000) | ($29,957,000) | ($144,192,000) | ($29,866,020) | ($4,163,000) | $90,980 |
| 16 | 16 | OTLICP PREMIUMS | ($69,672,000) | ($8,360,640) | ($66,749,000) | ($8,009,880) | $2,923,000 | $350,760 |
| -- | 219 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | $0 | $0 | ($37,456,000) | $0 | ($37,456,000) |
| -- | 221 | MEC OPTIONAL EXPANSION ADJUSTMENT | $0 | $0 | ($515,297,000) | $225,870,970 | ($515,297,000) | $225,870,970 |
| 2 | -- | UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION | $354,358,000 | $279,533,000 | $0 | $0 | ($354,358,000) | ($279,533,000) |
| 7 | -- | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $6,013,000 | $721,560 | $0 | $0 | ($6,013,000) | ($721,560) |
| 13 | -- | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN | $0 | ($15,951,280) | $0 | $0 | $0 | $15,951,280 |
| 27 | -- | TRANSITION OF NQI ADULTS TO COVERED CALIFORNIA | ($120,810,000) | ($48,035,000) | $0 | $0 | $120,810,000 | $48,035,000 |
| | | **ELIGIBILITY SUBTOTAL** | **$500,284,110** | **$340,185,310** | **$140,020,010** | **$961,976,690** | **($360,264,100)** | **$621,791,380** |
| | | **AFFORDABLE CARE ACT** | | | | | | |
| 17 | 17 | COMMUNITY FIRST CHOICE OPTION | $3,366,480,000 | $0 | $2,535,500,000 | $0 | ($830,980,000) | $0 |
| 19 | 19 | HEALTH INSURER FEE | $445,644,000 | $152,482,860 | $502,274,000 | $169,642,060 | $56,630,000 | $17,159,200 |
| 20 | 20 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $63,306,000 | $0 | $19,463,000 | $0 | ($43,843,000) | $0 |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **AFFORDABLE CARE ACT** | | | | | | |
| -- | 22 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $0 | $0 | $2,000,000 | $0 | $2,000,000 | $0 |
| 23 | 23 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | ($2,230,000) | $0 | ($2,026,000) | $0 | $204,000 |
| 25 | 25 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | ($85,498,450) | $0 | ($36,365,640) | $0 | $49,132,810 |
| 26 | 26 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 | $0 | $0 |
| 28 | 28 | ACA DSH REDUCTION | ($137,873,000) | ($16,177,000) | ($137,873,000) | ($16,177,000) | $0 | $0 |
| 209 | 209 | TITLE XXI FEDERAL MATCH REDUCTION | ($55,965,000) | $530,898,190 | ($112,361,000) | $392,156,330 | ($56,396,000) | ($138,741,860) |
| 18 | -- | ACA OPTIONAL EXPANSION | $2,553,413,000 | $128,596,670 | $0 | $0 | ($2,553,413,000) | ($128,596,670) |
| 21 | -- | ACA MANDATORY EXPANSION | $253,714,000 | $108,927,840 | $0 | $0 | ($253,714,000) | ($108,927,840) |
| | | **AFFORDABLE CARE ACT SUBTOTAL** | **$6,488,719,000** | **$817,000,110** | **$2,809,003,000** | **$507,229,750** | **($3,679,716,000)** | **($309,770,360)** |
| | | **BENEFITS** | | | | | | |
| 1 | 1 | FAMILY PACT PROGRAM | $346,263,000 | $83,286,700 | $310,264,000 | $74,627,800 | ($35,999,000) | ($8,658,900) |
| 29 | 29 | BEHAVIORAL HEALTH TREATMENT | $379,057,000 | $163,971,980 | $213,817,000 | $93,398,740 | ($165,240,000) | ($70,573,240) |
| 30 | 30 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $217,338,000 | $0 | $245,649,000 | $0 | $28,311,000 | $0 |
| 31 | 31 | BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION | $275,070,000 | $118,989,480 | $101,325,000 | $44,260,260 | ($173,745,000) | ($74,729,220) |
| 32 | 32 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $133,369,000 | $0 | $131,106,000 | $0 | ($2,263,000) | $0 |
| 33 | 33 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $29,374,000 | $0 | $39,778,000 | $0 | $10,404,000 | $0 |
| 34 | 34 | CCS DEMONSTRATION PROJECT | $37,154,000 | $16,944,520 | $36,847,000 | $16,772,780 | ($307,000) | ($171,740) |
| 35 | 35 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $19,181,000 | $2,515,000 | $19,680,000 | $2,642,000 | $499,000 | $127,000 |
| 36 | 36 | IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT | $17,312,000 | $8,307,920 | $16,372,000 | $7,837,540 | ($940,000) | ($470,380) |
| 38 | 38 | YOUTH REGIONAL TREATMENT CENTERS | $5,618,000 | $159,000 | $5,825,000 | $29,000 | $207,000 | ($130,000) |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
## MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
## FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **BENEFITS** | | | | | | |
| 39 | 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $4,045,000 | $1,849,100 | $4,415,140 | $2,062,140 | $370,140 | $213,040 |
| 40 | 40 | DENTAL CHILDREN'S OUTREACH AGES 0-3 | $5,724,000 | $2,862,000 | $5,724,000 | $2,862,000 | $0 | $0 |
| 41 | 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $2,475,000 | $0 | $2,458,000 | $0 | ($17,000) | $0 |
| 42 | 42 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $2,804,000 | $1,402,000 | $6,490,000 | $3,245,000 | $3,686,000 | $1,843,000 |
| 43 | 43 | END OF LIFE SERVICES | $2,336,900 | $2,336,900 | $659,980 | $659,980 | ($1,676,910) | ($1,676,910) |
| 44 | 44 | DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM | $640,000 | $320,000 | $725,000 | $362,500 | $85,000 | $42,500 |
| 45 | 45 | MEDICAL MANAGEMENT AND TREATMENT FOR ALD | $440,000 | $199,100 | $440,000 | $198,720 | $0 | ($380) |
| 46 | 46 | ALLIED DENTAL PROFESSIONALS ENROLLMENT | $710,000 | $355,000 | $763,000 | $381,500 | $53,000 | $26,500 |
| 48 | 48 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $48,000 | $0 | $56,000 | $0 | $8,000 | $0 |
| 51 | 51 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($7,331,000) | ($3,319,320) | ($4,305,000) | ($1,945,400) | $3,026,000 | $1,373,920 |
| 52 | 52 | SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES | ($2,770,000) | ($1,385,000) | ($3,201,000) | ($1,600,500) | ($431,000) | ($215,500) |
| 53 | 53 | WOMEN'S HEALTH SERVICES | ($7,921,000) | ($1,782,000) | ($7,932,000) | ($1,787,500) | ($11,000) | ($5,500) |
| 208 | 208 | ANNUAL CONTRACEPTIVE COVERAGE | $33,593,130 | $7,576,700 | $36,371,230 | $8,203,280 | $2,778,100 | $626,580 |
| -- | 229 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $0 | $0 | $11,163,000 | $4,912,000 | $11,163,000 | $4,912,000 |
| -- | 231 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $0 | $0 | $69,458,000 | $34,729,000 | $69,458,000 | $34,729,000 |
| -- | 234 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $0 | $0 | $2,000,000 | $2,000,000 | $2,000,000 | $2,000,000 |
| 37 | -- | ACUPUNCTURE SERVICES RESTORATION | $5,119,000 | $1,741,590 | $0 | $0 | ($5,119,000) | ($1,741,590) |
| 47 | -- | CHDP PROGRAM DENTAL REFERRAL | $193,000 | $87,380 | $0 | $0 | ($193,000) | ($87,380) |
| 50 | -- | WHOLE CHILD MODEL IMPLEMENTATION | $45,057,000 | $21,142,260 | $0 | $0 | ($45,057,000) | ($21,142,260) |
| | | **BENEFITS SUBTOTAL** | **$1,544,899,020** | **$427,560,300** | **$1,245,948,360** | **$293,850,840** | **($298,950,670)** | **($133,709,460)** |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **PHARMACY** | | | | | | |
| 55 | 55 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $38,071,000 | $18,090,440 | $84,331,350 | $38,530,210 | $46,260,350 | $20,439,770 |
| 56 | 56 | NON FFP DRUGS | $0 | $92,000 | $0 | $69,500 | $0 | ($22,500) |
| 57 | 57 | BCCTP DRUG REBATES | ($10,779,000) | ($3,373,650) | ($11,263,000) | ($3,545,150) | ($484,000) | ($171,500) |
| 58 | 58 | FAMILY PACT DRUG REBATES | ($16,037,000) | ($1,751,800) | ($17,183,000) | ($2,132,400) | ($1,146,000) | ($380,600) |
| 59 | 59 | MEDICAL SUPPLY REBATES | ($26,880,000) | ($13,440,000) | ($24,916,000) | ($12,458,000) | $1,964,000 | $982,000 |
| 61 | 61 | STATE SUPPLEMENTAL DRUG REBATES | ($193,190,000) | ($71,603,950) | ($192,285,000) | ($65,423,790) | $905,000 | $6,180,160 |
| 62 | 62 | FEDERAL DRUG REBATE PROGRAM | ($2,147,336,000) | ($727,862,340) | ($2,139,644,000) | ($712,018,900) | $7,692,000 | $15,843,440 |
| | | **PHARMACY SUBTOTAL** | **($2,356,151,000)** | **($799,849,300)** | **($2,300,959,650)** | **($756,978,530)** | **$55,191,350** | **$42,870,770** |
| | | **DRUG MEDI-CAL** | | | | | | |
| 64 | 64 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $661,857,000 | $141,605,130 | $580,548,000 | $124,364,740 | ($81,309,000) | ($17,240,390) |
| -- | 69 | DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT | $0 | $0 | $14,189,000 | $536,900 | $14,189,000 | $536,900 |
| | | **DRUG MEDI-CAL SUBTOTAL** | **$661,857,000** | **$141,605,130** | **$594,737,000** | **$124,901,640** | **($67,120,000)** | **($16,703,490)** |
| | | **MENTAL HEALTH** | | | | | | |
| 72 | 72 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $86,410,000 | $0 | $253,505,000 | $0 | $167,095,000 | $0 |
| 73 | 73 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $24,410,000 | $12,962,500 | $23,308,000 | $12,423,500 | ($1,102,000) | ($539,000) |
| 74 | 74 | PATHWAYS TO WELL-BEING | $16,156,000 | $0 | $17,201,000 | $0 | $1,045,000 | $0 |
| 75 | 75 | LATE CLAIMS FOR SMHS | $1,731,000 | $1,731,000 | $4,000 | $4,000 | ($1,727,000) | ($1,727,000) |
| 76 | 76 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | $0 | ($200,000) | $0 | ($200,000) | $0 | $0 |
| 78 | 78 | CHART REVIEW | ($1,543,000) | $0 | ($1,485,000) | $0 | $58,000 | $0 |
| 79 | 79 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | $988,000 | $988,000 | $20,758,000 | $21,146,000 | $19,770,000 | $20,158,000 |
| -- | 217 | TRANSITIONAL SMHS CLAIMS | $0 | $0 | $1,472,000 | $1,472,000 | $1,472,000 | $1,472,000 |
| | | **MENTAL HEALTH SUBTOTAL** | **$128,152,000** | **$15,481,500** | **$314,763,000** | **$34,845,500** | **$186,611,000** | **$19,364,000** |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **WAIVER--MH/UCD & BTR** | | | | | | |
| 80 | 80 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $1,600,000,000 | $0 | $1,600,000,000 | $0 | $0 | $0 |
| 81 | 81 | GLOBAL PAYMENT PROGRAM | $2,336,264,000 | $0 | $2,388,446,000 | $0 | $52,182,000 | $0 |
| 82 | 82 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $720,000,000 | $0 | $720,000,000 | $0 | $0 | $0 |
| -- | 83 | BTR - LIHP - MCE | $0 | $0 | $198,363,000 | $0 | $198,363,000 | $0 |
| -- | 84 | LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND | $0 | $0 | $232,500,000 | $0 | $232,500,000 | $0 |
| -- | 85 | BTR - LOW INCOME HEALTH PROGRAM - HCCI | $0 | $0 | $231,547,000 | $0 | $231,547,000 | $0 |
| 86 | 86 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $134,127,000 | $67,063,500 | $141,905,000 | $70,952,500 | $7,778,000 | $3,889,000 |
| -- | 87 | MH/UCD—HEALTH CARE COVERAGE INITIATIVE | $0 | $0 | $23,509,000 | $0 | $23,509,000 | $0 |
| 88 | 88 | MH/UCD—STABILIZATION FUNDING | $55,400,000 | $55,400,000 | $55,400,000 | $55,400,000 | $0 | $0 |
| 89 | 89 | MH/UCD—SAFETY NET CARE POOL | ($6,723,000) | $0 | ($6,723,000) | $0 | $0 | $0 |
| 92 | 92 | UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG | $1,223,000 | $0 | $1,060,000 | $0 | ($163,000) | $0 |
| 95 | 95 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM | $0 | ($75,000,000) | $0 | ($75,000,000) | $0 | $0 |
| -- | 222 | CMS DEFERRED CLAIMS | $0 | $0 | $0 | $12,378,000 | $0 | $12,378,000 |
| | | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$4,840,291,000** | **$47,463,500** | **$5,586,007,000** | **$63,730,500** | **$745,716,000** | **$16,267,000** |
| | | **MANAGED CARE** | | | | | | |
| 98 | 98 | CCI-MANAGED CARE PAYMENTS | $8,430,740,000 | $4,215,370,000 | $9,936,539,000 | $4,968,269,500 | $1,505,799,000 | $752,899,500 |
| 100 | 100 | MANAGED CARE PUBLIC HOSPITAL IGTS | $533,355,000 | $0 | $2,880,095,000 | $0 | $2,346,740,000 | $0 |
| 101 | 101 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $2,131,736,000 | $761,789,240 | $2,131,736,000 | $612,223,010 | $0 | ($149,566,230) |
| 103 | 103 | MANAGED CARE RATE RANGE IGTS | $2,117,021,000 | $0 | $3,143,888,000 | $0 | $1,026,867,000 | $0 |
| 105 | 105 | HQAF RATE RANGE INCREASES | $168,000,000 | $0 | $232,000,000 | $0 | $64,000,000 | $0 |

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# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **MANAGED CARE** | | | | | | |
| 111 | 111 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $2,141,000 | $1,000,630 | $2,977,000 | $1,334,530 | $836,000 | $333,900 |
| 112 | 112 | CAPITATED RATE ADJUSTMENT FOR FY 2017-18 | $338,535,000 | $9,567,360 | $0 | $0 | ($338,535,000) | ($9,567,360) |
| 114 | 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | ($761,789,000) | $0 | ($612,223,000) | $0 | $149,566,000 |
| 115 | 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | ($1,630,718,000) | $0 | ($1,780,284,000) | $0 | ($149,566,000) |
| -- | 116 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | $0 | $0 | ($13,631,000) | $0 | ($13,631,000) |
| -- | 117 | MCO TAX MANAGED CARE PLANS | $0 | $0 | $0 | ($414,386,000) | $0 | ($414,386,000) |
| 118 | 118 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | ($168,266,000) | $0 | ($275,965,000) | $0 | ($107,699,000) |
| 119 | 119 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | ($105,186,000) | $0 | ($253,242,000) | $0 | ($148,056,000) |
| 120 | 120 | CENCAL HEALTH PLAN-ADDITION OF CHDP | ($3,450,000) | ($1,725,000) | ($3,329,000) | ($1,664,500) | $121,000 | $60,500 |
| -- | 122 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $0 | $0 | $21,304,000 | $10,464,000 | $21,304,000 | $10,464,000 |
| 123 | 123 | MANAGED CARE DRUG REBATES | ($1,066,751,000) | ($345,951,190) | ($1,066,751,000) | ($345,951,190) | $0 | $0 |
| 124 | 124 | RETRO MC RATE ADJUSTMENTS | ($3,100,789,000) | ($44,868,000) | ($4,048,269,000) | $191,374,000 | ($947,480,000) | $236,242,000 |
| -- | 220 | CCI-QUALITY WITHHOLD REPAYMENTS | $0 | $0 | $9,000,000 | $4,500,000 | $9,000,000 | $4,500,000 |
| -- | 225 | MEDI-CAL NONMEDICAL TRANSPORTATION | $0 | $0 | $6,000,000 | $1,725,530 | $6,000,000 | $1,725,530 |
| 109 | -- | NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS | $2,000,000 | $2,000,000 | $0 | $0 | ($2,000,000) | ($2,000,000) |
| 113 | -- | HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS | $15,357,000 | $0 | $0 | $0 | ($15,357,000) | $0 |
| | | **MANAGED CARE SUBTOTAL** | **$9,567,895,000** | **$1,931,224,040** | **$13,245,190,000** | **$2,092,543,880** | **$3,677,295,000** | **$161,319,840** |
| | | **PROVIDER RATES** | | | | | | |
| 125 | 125 | MEDICARE PART B ADJUSTMENT | $53,097,000 | $29,209,500 | ($160,682,000) | ($88,557,500) | ($213,779,000) | ($117,767,000) |
| 126 | 126 | DENTAL RETROACTIVE RATE CHANGES | $64,843,000 | $20,715,080 | $23,693,000 | $9,095,270 | ($41,150,000) | ($11,619,810) |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **PROVIDER RATES** | | | | | | |
| 127 | 127 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $174,069,280 | $67,323,480 | $199,430,150 | $75,718,460 | $25,360,870 | $8,394,980 |
| 128 | 128 | AB 1629 ANNUAL RATE ADJUSTMENTS | $165,625,530 | $82,812,760 | $174,846,170 | $87,423,090 | $9,220,640 | $4,610,320 |
| 130 | 130 | DPH INTERIM & FINAL RECONS | $50,956,000 | $0 | $137,004,000 | $0 | $86,048,000 | $0 |
| 131 | 131 | DPH INTERIM RATE GROWTH | $81,807,560 | $40,903,780 | $37,920,420 | $18,960,210 | ($43,887,150) | ($21,943,570) |
| 132 | 132 | LTC RATE ADJUSTMENT | $48,460,000 | $24,230,000 | $31,718,000 | $15,859,000 | ($16,742,000) | ($8,371,000) |
| 133 | 133 | ANNUAL MEI INCREASE FOR FQHCS/RHCS | $45,732,120 | $17,639,360 | $51,405,790 | $19,517,480 | $5,673,660 | $1,878,120 |
| 134 | 134 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $11,000,000 | ($1,538,000) | $11,000,000 | ($2,390,000) | $0 | ($852,000) |
| 135 | 135 | HOSPICE RATE INCREASES | $20,787,850 | $10,393,930 | $21,480,520 | $10,740,260 | $692,670 | $346,340 |
| 136 | 136 | DISCONTINUE PHARMACY RATE REDUCTIONS | $25,081,740 | $12,540,870 | $22,531,850 | $11,265,920 | ($2,549,890) | ($1,274,940) |
| 137 | 137 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $3,804,680 | $1,902,340 | $19,464,620 | $9,732,310 | $15,659,940 | $7,829,970 |
| 138 | 138 | GDSP PRENATAL SCREENING FEE INCREASE | $2,299,420 | $1,149,710 | $4,088,310 | $2,044,150 | $1,788,880 | $894,440 |
| 139 | 139 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $1,570,720 | ($1,196,890) | $1,551,580 | ($1,247,260) | ($19,150) | ($50,370) |
| 140 | 140 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $43,520 | $21,760 | $44,390 | $22,190 | $870 | $440 |
| 142 | 142 | DPH INTERIM RATE | $0 | ($402,454,430) | $0 | ($391,438,740) | $0 | $11,015,690 |
| 143 | 143 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | ($484,587,000) | $0 | ($482,975,000) | $0 | $1,612,000 |
| 144 | 144 | LABORATORY RATE METHODOLOGY CHANGE | ($42,897,690) | ($21,448,850) | ($23,980,830) | ($11,990,410) | $18,916,860 | $9,458,430 |
| 145 | 145 | REDUCTION TO RADIOLOGY RATES | ($85,211,820) | ($42,605,910) | ($22,711,270) | ($11,355,630) | $62,500,550 | $31,250,280 |
| 146 | 146 | 10% PROVIDER PAYMENT REDUCTION | ($199,140,000) | ($99,570,000) | ($205,136,000) | ($102,568,000) | ($5,996,000) | ($2,998,000) |
| | | **PROVIDER RATES SUBTOTAL** | **$421,928,920** | **($744,558,500)** | **$323,668,690** | **($832,144,210)** | **($98,260,230)** | **($87,585,710)** |
| | | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 129 | 129 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $81,992,000 | $48,928,000 | $86,243,000 | $48,928,000 | $4,251,000 | $0 |

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# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 147 | 147 | EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS | $13,398,333,000 | $0 | $15,569,513,000 | $0 | $2,171,180,000 | $0 |
| 148 | 148 | PRIVATE HOSPITAL DSH REPLACEMENT | $573,232,000 | $286,616,000 | $573,382,000 | $286,691,000 | $150,000 | $75,000 |
| 149 | 149 | DSH PAYMENT | $444,414,000 | $17,000,000 | $444,414,000 | $17,000,000 | $0 | $0 |
| 150 | 150 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $255,100,000 | $100,150,000 | $300,261,000 | $118,400,000 | $45,161,000 | $18,250,000 |
| 151 | 151 | NDPH IGT SUPPLEMENTAL PAYMENTS | $124,886,000 | ($5,466,000) | $184,924,000 | ($2,441,000) | $60,038,000 | $3,025,000 |
| 152 | 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $113,789,190 | $6,545,510 | $125,117,000 | $2,520,000 | $11,327,810 | ($4,025,510) |
| 153 | 153 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $383,174,000 | $0 | $415,351,000 | $0 | $32,177,000 | $0 |
| 154 | 154 | CAPITAL PROJECT DEBT REIMBURSEMENT | $139,307,000 | $59,403,500 | $186,120,000 | $82,810,000 | $46,813,000 | $23,406,500 |
| 155 | 155 | FFP FOR LOCAL TRAUMA CENTERS | $86,000,000 | $0 | $106,601,000 | $0 | $20,601,000 | $0 |
| 156 | 156 | DPH PHYSICIAN & NON-PHYS. COST | $150,948,000 | $0 | $154,861,000 | $0 | $3,913,000 | $0 |
| -- | 157 | HOSPITAL QAF - HOSPITAL PAYMENTS | $0 | $0 | $100,398,000 | $0 | $100,398,000 | $0 |
| 158 | 158 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $61,364,000 | $0 | $73,762,000 | $0 | $12,398,000 | $0 |
| 159 | 159 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $88,500,000 | $0 | $76,800,000 | $0 | ($11,700,000) | $0 |
| 160 | 160 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH | $10,000,000 | $5,000,000 | $10,000,000 | $5,000,000 | $0 | $0 |
| 161 | 161 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH | $8,000,000 | $4,000,000 | $8,000,000 | $4,000,000 | $0 | $0 |
| 162 | 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,232,000 | $0 | $4,631,000 | $0 | $399,000 | $0 |
| 163 | 163 | IGT PAYMENTS FOR HOSPITAL SERVICES | $4,000,000 | $0 | $5,613,000 | $0 | $1,613,000 | $0 |
| 164 | 164 | NDPH SUPPLEMENTAL PAYMENT | $3,800,000 | $1,773,000 | $4,950,000 | $1,900,000 | $1,150,000 | $127,000 |
| 165 | 165 | FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS | $419,526,000 | $0 | $465,948,000 | $0 | $46,422,000 | $0 |
| -- | 214 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | $0 | $0 | $57,224,000 | $0 | $57,224,000 |

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# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|---|
| | | | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **SUPPLEMENTAL PMNTS.** | | | | | | |
| -- | 215 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $0 | $0 | $1,187,500,000 | $0 | $1,187,500,000 | $0 |
| -- | 232 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $0 | $0 | $167,000,000 | $0 | $167,000,000 | $0 |
| -- | 233 | ICF/DD SUPPLEMENTAL PAYMENTS | $0 | $0 | $54,000,000 | $0 | $54,000,000 | $0 |
| -- | 236 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $0 | $0 | $650,000,000 | $0 | $650,000,000 | $0 |
| -- | 237 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $0 | $0 | $280,000,000 | $0 | $280,000,000 | $0 |
| -- | 238 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $0 | $0 | $8,000,000 | $0 | $8,000,000 | $0 |
| | | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$16,350,597,190** | **$523,950,010** | **$21,243,389,000** | **$622,032,000** | **$4,892,791,810** | **$98,081,990** |
| | | **OTHER** | | | | | | |
| 77 | 77 | IMD ANCILLARY SERVICES | $0 | $20,542,000 | $0 | $29,565,000 | $0 | $9,023,000 |
| 166 | 166 | INFANT DEVELOPMENT PROGRAM | $27,936,000 | $0 | $26,305,000 | $0 | ($1,631,000) | $0 |
| 174 | 174 | ARRA HITECH - PROVIDER PAYMENTS | $115,840,000 | $0 | $175,130,000 | $0 | $59,290,000 | $0 |
| 176 | 176 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $58,228,000 | $0 | $110,533,000 | $0 | $52,305,000 | $0 |
| 180 | 180 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $11,676,000 | $5,957,000 | $19,921,000 | $8,339,000 | $8,245,000 | $2,382,000 |
| 181 | 181 | OVERTIME FOR WPCS PROVIDERS | $10,099,000 | $5,049,500 | $14,686,000 | $7,343,000 | $4,587,000 | $2,293,500 |
| 182 | 182 | MEDI-CAL ESTATE RECOVERIES | $57,687,000 | $28,843,500 | $64,707,000 | $32,353,500 | $7,020,000 | $3,510,000 |
| 183 | 183 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $15,184,000 | $7,592,000 | $15,297,260 | $7,648,630 | $113,260 | $56,630 |
| 184 | 184 | WPCS WORKERS' COMPENSATION | $2,501,000 | $1,250,500 | $3,019,000 | $1,509,500 | $518,000 | $259,000 |
| 185 | 185 | INDIAN HEALTH SERVICES | $4,456,000 | ($20,795,000) | $6,239,000 | ($20,795,000) | $1,783,000 | $0 |
| 189 | 189 | CDDS DENTAL SERVICES | $984,000 | $0 | $984,000 | $0 | $0 | $0 |
| 190 | 190 | NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL | $9,829,340 | $4,914,670 | $6,749,700 | $3,374,850 | ($3,079,640) | ($1,539,820) |
| 192 | 192 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | ($6,509,000) | $0 | ($8,217,000) | $0 | ($1,708,000) |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **OTHER** | | | | | | |
| 193 | 193 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | ($1,697,749,400) | $0 | ($1,764,846,210) | $0 | ($67,096,810) |
| 194 | 194 | FUNDING ADJUST.—OTLICP | $0 | ($154,495,910) | $154,000 | ($176,826,160) | $154,000 | ($22,330,250) |
| 196 | 196 | CLPP FUND | $0 | ($725,000) | $0 | ($725,000) | $0 | $0 |
| 197 | 197 | CCI-TRANSFER OF IHSS COSTS TO DHCS | $0 | ($881,455,000) | $0 | ($1,247,758,000) | $0 | ($366,303,000) |
| 198 | 198 | EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | ($1,056,250,000) | $0 | ($1,020,525,000) | $0 | $35,725,000 |
| 199 | 199 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | ($206,254,000) | $0 | ($208,524,000) | $0 | ($2,270,000) |
| 200 | 200 | MEDI-CAL RECOVERIES FIFTY PERCENT RULE | ($12,160,000) | ($12,160,000) | ($12,160,000) | ($12,160,000) | $0 | $0 |
| 201 | 201 | MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES | ($20,000,000) | ($10,000,000) | ($2,000,000) | ($1,000,000) | $18,000,000 | $9,000,000 |
| -- | 205 | AUDIT SETTLEMENTS | $0 | $0 | $13,928,000 | $13,928,000 | $13,928,000 | $13,928,000 |
| 206 | 206 | INTEGRATION OF THE SF CLSB INTO THE ALW | ($746,330) | ($373,170) | ($746,330) | ($373,170) | $0 | $0 |
| 210 | 210 | CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT | ($362,750,000) | ($181,375,000) | ($332,853,000) | ($166,426,500) | $29,897,000 | $14,948,500 |
| 212 | 212 | HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND | $0 | ($65,700,000) | $0 | ($46,633,000) | $0 | $19,067,000 |
| -- | 224 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | $0 | $0 | ($1,730,000) | ($865,000) | ($1,730,000) | ($865,000) |
| | | **OTHER SUBTOTAL** | **($81,235,990)** | **($4,219,692,300)** | **$108,163,630** | **($4,571,612,560)** | **$189,399,620** | **($351,920,250)** |
| | | **GRAND TOTAL** | **$38,067,236,250** | **($1,519,630,210)** | **$43,309,930,040** | **($1,459,624,490)** | **$5,242,693,780** | **$60,005,720** |

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 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **ELIGIBILITY** | | | | | | |
| 3 | MEDI-CAL STATE INMATE PROGRAMS | $77,936,000 | $0 | $117,057,000 | $0 | $39,121,000 | $0 |
| 5 | BREAST AND CERVICAL CANCER TREATMENT | $67,000,000 | $36,100,000 | $69,000,000 | $36,800,000 | $2,000,000 | $700,000 |
| 6 | MEDI-CAL COUNTY INMATE PROGRAMS | $27,385,000 | $9,345,500 | $301,867,000 | $37,477,550 | $274,482,000 | $28,132,050 |
| 9 | STATE-ONLY BCCTP COVERAGE EXTENSION | $551,000 | $551,000 | $1,696,000 | $1,696,000 | $1,145,000 | $1,145,000 |
| 10 | NON-OTLICP CHIP | $0 | $53,229,010 | $401,000,000 | ($78,752,490) | $401,000,000 | ($131,981,500) |
| 11 | NON-EMERGENCY FUNDING ADJUSTMENT | $0 | $985,633,000 | $0 | $899,150,000 | $0 | ($86,483,000) |
| 12 | SCHIP FUNDING FOR PRENATAL CARE | $0 | ($63,757,760) | $0 | ($68,261,600) | $0 | ($4,503,840) |
| 13 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN | $0 | $5,313,000 | $0 | $0 | $0 | ($5,313,000) |
| 14 | PARIS-VETERANS | ($11,520,120) | ($5,760,060) | ($24,361,990) | ($16,671,840) | ($12,841,870) | ($10,911,790) |
| 15 | MINIMUM WAGE INCREASE - CASELOAD SAVINGS | ($7,714,000) | ($1,508,000) | ($144,192,000) | ($29,866,020) | ($136,478,000) | ($28,358,020) |
| 16 | OTLICP PREMIUMS | ($67,447,000) | ($8,093,640) | ($66,749,000) | ($8,009,880) | $698,000 | $83,760 |
| 219 | MEDI-CAL COUNTY INMATE REIMBURSEMENT | $0 | $0 | $0 | ($37,456,000) | $0 | ($37,456,000) |
| 221 | MEC OPTIONAL EXPANSION ADJUSTMENT | $0 | $0 | ($515,297,000) | $225,870,970 | ($515,297,000) | $225,870,970 |
| | **ELIGIBILITY SUBTOTAL** | **$86,190,880** | **$1,011,052,050** | **$140,020,010** | **$961,976,690** | **$53,829,130** | **($49,075,370)** |
| | **AFFORDABLE CARE ACT** | | | | | | |
| 17 | COMMUNITY FIRST CHOICE OPTION | $2,045,900,000 | $0 | $2,535,500,000 | $0 | $489,600,000 | $0 |
| 19 | HEALTH INSURER FEE | $220,166,000 | $74,748,810 | $502,274,000 | $169,642,060 | $282,108,000 | $94,893,250 |
| 20 | HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS | $101,925,000 | $0 | $19,463,000 | $0 | ($82,462,000) | $0 |
| 22 | PAYMENTS TO PRIMARY CARE PHYSICIANS | $8,000,000 | $0 | $2,000,000 | $0 | ($6,000,000) | $0 |
| 23 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES | $0 | $1,181,000 | $0 | ($2,026,000) | $0 | ($3,207,000) |
| 24 | STATE-ONLY FORMER FOSTER CARE PROGRAM | $0 | $398,000 | $0 | $0 | $0 | ($398,000) |
| 25 | HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST. | $0 | ($39,616,200) | $0 | ($36,365,640) | $0 | $3,250,560 |

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 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **AFFORDABLE CARE ACT** | | | | | | |
| 26 | ACA MAGI SAVINGS | $0 | $0 | $0 | $0 | $0 | $0 |
| 28 | ACA DSH REDUCTION | $0 | $0 | ($137,873,000) | ($16,177,000) | ($137,873,000) | ($16,177,000) |
| 209 | TITLE XXI FEDERAL MATCH REDUCTION | $0 | $0 | ($112,361,000) | $392,156,330 | ($112,361,000) | $392,156,330 |
| | **AFFORDABLE CARE ACT SUBTOTAL** | **$2,375,991,000** | **$36,711,610** | **$2,809,003,000** | **$507,229,750** | **$433,012,000** | **$470,518,140** |
| | **BENEFITS** | | | | | | |
| 1 | FAMILY PACT PROGRAM | $316,502,000 | $76,127,800 | $310,264,000 | $74,627,800 | ($6,238,000) | ($1,500,000) |
| 29 | BEHAVIORAL HEALTH TREATMENT | $235,807,000 | $104,586,100 | $213,817,000 | $93,398,740 | ($21,990,000) | ($11,187,360) |
| 30 | ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS | $379,487,000 | $0 | $245,649,000 | $0 | ($133,838,000) | $0 |
| 31 | BEHAVIORAL HEALTH TREATMENT - DDS TRANSITION | $86,168,000 | $37,639,740 | $101,325,000 | $44,260,260 | $15,157,000 | $6,620,520 |
| 32 | LOCAL EDUCATION AGENCY (LEA) PROVIDERS | $123,498,000 | $78,000 | $131,106,000 | $0 | $7,608,000 | ($78,000) |
| 33 | MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA | $39,778,000 | $0 | $39,778,000 | $0 | $0 | $0 |
| 34 | CCS DEMONSTRATION PROJECT | $32,792,000 | $14,906,240 | $36,847,000 | $16,772,780 | $4,055,000 | $1,866,540 |
| 35 | CALIFORNIA COMMUNITY TRANSITIONS COSTS | $19,545,000 | $2,534,000 | $19,680,000 | $2,642,000 | $135,000 | $108,000 |
| 36 | IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT | $12,685,570 | $6,072,780 | $16,372,000 | $7,837,540 | $3,686,430 | $1,764,760 |
| 38 | YOUTH REGIONAL TREATMENT CENTERS | $4,259,000 | $62,000 | $5,825,000 | $29,000 | $1,566,000 | ($33,000) |
| 39 | PEDIATRIC PALLIATIVE CARE WAIVER | $2,589,530 | $1,915,870 | $4,415,140 | $2,062,140 | $1,825,610 | $146,270 |
| 40 | DENTAL CHILDREN'S OUTREACH AGES 0-3 | $3,180,000 | $1,590,000 | $5,724,000 | $2,862,000 | $2,544,000 | $1,272,000 |
| 41 | CCT FUND TRANSFER TO CDSS AND CDDS | $1,825,000 | $0 | $2,458,000 | $0 | $633,000 | $0 |
| 42 | DENTAL TRANSFORMATION INITIATIVE UTILIZATION | $4,538,000 | $2,269,000 | $6,490,000 | $3,245,000 | $1,952,000 | $976,000 |
| 43 | END OF LIFE SERVICES | $23,910 | $23,910 | $659,980 | $659,980 | $636,080 | $636,080 |
| 44 | DENTAL BENEFICIARY OUTREACH AND EDUCATION PROGRAM | $53,000 | $26,500 | $725,000 | $362,500 | $672,000 | $336,000 |
| 45 | MEDICAL MANAGEMENT AND TREATMENT FOR ALD | $335,460 | $151,210 | $440,000 | $198,720 | $104,540 | $47,510 |

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## COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
## CURRENT YEAR COMPARED TO BUDGET YEAR
## FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **BENEFITS** | | | | | | |
| 46 | ALLIED DENTAL PROFESSIONALS ENROLLMENT | $252,000 | $126,000 | $763,000 | $381,500 | $511,000 | $255,500 |
| 48 | SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER | $153,000 | $0 | $56,000 | $0 | ($97,000) | $0 |
| 49 | QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS | $97,000 | $0 | $0 | $0 | ($97,000) | $0 |
| 51 | PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS | ($1,071,000) | ($483,060) | ($4,305,000) | ($1,945,400) | ($3,234,000) | ($1,462,340) |
| 52 | SRP PRIOR AUTH. & PREVENTIVE DENTAL SERVICES | ($3,168,000) | ($1,584,000) | ($3,201,000) | ($1,600,500) | ($33,000) | ($16,500) |
| 53 | WOMEN'S HEALTH SERVICES | ($5,897,260) | ($1,330,010) | ($7,932,000) | ($1,787,500) | ($2,034,740) | ($457,490) |
| 208 | ANNUAL CONTRACEPTIVE COVERAGE | $3,749,630 | $845,820 | $36,371,230 | $8,203,280 | $32,621,600 | $7,357,460 |
| 229 | BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION | $0 | $0 | $11,163,000 | $4,912,000 | $11,163,000 | $4,912,000 |
| 231 | FULL RESTORATION OF ADULT DENTAL BENEFITS | $0 | $0 | $69,458,000 | $34,729,000 | $69,458,000 | $34,729,000 |
| 234 | MEDICALLY TAILORED MEALS PILOT PROGRAM | $0 | $0 | $2,000,000 | $2,000,000 | $2,000,000 | $2,000,000 |
| | **BENEFITS SUBTOTAL** | **$1,257,181,840** | **$245,557,900** | **$1,245,948,360** | **$293,850,840** | **($11,233,480)** | **$48,292,940** |
| | **PHARMACY** | | | | | | |
| 55 | NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS | $26,086,750 | $12,045,520 | $84,331,350 | $38,530,210 | $58,244,600 | $26,484,690 |
| 56 | NON FFP DRUGS | $0 | $39,000 | $0 | $69,500 | $0 | $30,500 |
| 57 | BCCTP DRUG REBATES | ($12,486,000) | ($3,947,650) | ($11,263,000) | ($3,545,150) | $1,223,000 | $402,500 |
| 58 | FAMILY PACT DRUG REBATES | ($20,748,000) | ($2,585,000) | ($17,183,000) | ($2,132,400) | $3,565,000 | $452,600 |
| 59 | MEDICAL SUPPLY REBATES | ($24,916,000) | ($12,458,000) | ($24,916,000) | ($12,458,000) | $0 | $0 |
| 60 | LITIGATION SETTLEMENTS | ($29,867,000) | ($29,867,000) | $0 | $0 | $29,867,000 | $29,867,000 |
| 61 | STATE SUPPLEMENTAL DRUG REBATES | ($208,826,000) | ($27,590,660) | ($192,285,000) | ($65,423,790) | $16,541,000 | ($37,833,130) |
| 62 | FEDERAL DRUG REBATE PROGRAM | ($2,201,821,000) | ($711,404,400) | ($2,139,644,000) | ($712,018,900) | $62,177,000 | ($614,500) |
| 204 | DRUG REBATES - RETROACTIVE ACA ADJUSTMENTS | $0 | $487,276,200 | $0 | $0 | $0 | ($487,276,200) |

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# CURRENT YEAR COMPARED TO BUDGET YEAR
# FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **PHARMACY SUBTOTAL** | **($2,472,577,250)** | **($288,491,990)** | **($2,300,959,650)** | **($756,978,530)** | **$171,617,600** | **($468,486,540)** |
| | **DRUG MEDI-CAL** | | | | | | |
| 64 | DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER | $21,503,000 | $4,162,000 | $580,548,000 | $124,364,740 | $559,045,000 | $120,202,740 |
| 67 | DRUG MEDI-CAL PROGRAM COST SETTLEMENT | $2,999,000 | $34,000 | $0 | $0 | ($2,999,000) | ($34,000) |
| 69 | DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT | $0 | $0 | $14,189,000 | $536,900 | $14,189,000 | $536,900 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$24,502,000** | **$4,196,000** | **$594,737,000** | **$124,901,640** | **$570,235,000** | **$120,705,640** |
| | **MENTAL HEALTH** | | | | | | |
| 72 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT | $0 | $0 | $253,505,000 | $0 | $253,505,000 | $0 |
| 73 | MHP COSTS FOR CONTINUUM OF CARE REFORM | $7,539,000 | $4,527,000 | $23,308,000 | $12,423,500 | $15,769,000 | $7,896,500 |
| 74 | PATHWAYS TO WELL-BEING | $5,650,000 | $0 | $17,201,000 | $0 | $11,551,000 | $0 |
| 75 | LATE CLAIMS FOR SMHS | $24,000 | $0 | $4,000 | $4,000 | ($20,000) | $4,000 |
| 76 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT | ($315,000) | $70,000 | $0 | ($200,000) | $315,000 | ($270,000) |
| 78 | CHART REVIEW | ($1,869,000) | $0 | ($1,485,000) | $0 | $384,000 | $0 |
| 79 | INTERIM AND FINAL COST SETTLEMENTS - SMHS | ($59,037,000) | $2,655,000 | $20,758,000 | $21,146,000 | $79,795,000 | $18,491,000 |
| 217 | TRANSITIONAL SMHS CLAIMS | $0 | $0 | $1,472,000 | $1,472,000 | $1,472,000 | $1,472,000 |
| | **MENTAL HEALTH SUBTOTAL** | **($48,008,000)** | **$7,252,000** | **$314,763,000** | **$34,845,500** | **$362,771,000** | **$27,593,500** |
| | **WAIVER--MH/UCD & BTR** | | | | | | |
| 80 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL | $2,622,000,000 | $0 | $1,600,000,000 | $0 | ($1,022,000,000) | $0 |
| 81 | GLOBAL PAYMENT PROGRAM | $2,218,904,000 | $0 | $2,388,446,000 | $0 | $169,542,000 | $0 |

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## CURRENT YEAR COMPARED TO BUDGET YEAR
## FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **WAIVER--MH/UCD & BTR** | | | | | | |
| 82 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS | $480,000,000 | $0 | $720,000,000 | $0 | $240,000,000 | $0 |
| 83 | BTR - LIHP - MCE | $125,692,000 | $0 | $198,363,000 | $0 | $72,671,000 | $0 |
| 84 | LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND | $0 | $0 | $232,500,000 | $0 | $232,500,000 | $0 |
| 85 | BTR - LOW INCOME HEALTH PROGRAM - HCCI | $44,037,000 | $0 | $231,547,000 | $0 | $187,510,000 | $0 |
| 86 | MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE | $46,216,000 | $23,108,000 | $141,905,000 | $70,952,500 | $95,689,000 | $47,844,500 |
| 87 | MH/UCD—HEALTH CARE COVERAGE INITIATIVE | $1,343,000 | $0 | $23,509,000 | $0 | $22,166,000 | $0 |
| 88 | MH/UCD—STABILIZATION FUNDING | $33,686,000 | $33,686,000 | $55,400,000 | $55,400,000 | $21,714,000 | $21,714,000 |
| 89 | MH/UCD—SAFETY NET CARE POOL | $7,844,000 | $0 | ($6,723,000) | $0 | ($14,567,000) | $0 |
| 90 | MH/UCD & BTR—CCS AND GHPP | $6,025,000 | $0 | $0 | $0 | ($6,025,000) | $0 |
| 91 | BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL | $2,913,000 | $0 | $0 | $0 | ($2,913,000) | $0 |
| 92 | UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG | $1,463,000 | $0 | $1,060,000 | $0 | ($403,000) | $0 |
| 93 | BTR—DESIGNATED STATE HEALTH PROGRAMS | $0 | $50,518,000 | $0 | $0 | $0 | ($50,518,000) |
| 94 | MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP | $0 | ($6,205,000) | $0 | $0 | $0 | $6,205,000 |
| 95 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM | $0 | ($75,000,000) | $0 | ($75,000,000) | $0 | $0 |
| 222 | CMS DEFERRED CLAIMS | $0 | $14,926,000 | $0 | $12,378,000 | $0 | ($2,548,000) |
| 223 | CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT | $0 | $226,344,000 | $0 | $0 | $0 | ($226,344,000) |
| | **WAIVER--MH/UCD & BTR SUBTOTAL** | **$5,590,123,000** | **$267,377,000** | **$5,586,007,000** | **$63,730,500** | **($4,116,000)** | **($203,646,500)** |
| | **MANAGED CARE** | | | | | | |
| 98 | CCI-MANAGED CARE PAYMENTS | $10,042,736,000 | $5,021,368,000 | $9,936,539,000 | $4,968,269,500 | ($106,197,000) | ($53,098,500) |
| 100 | MANAGED CARE PUBLIC HOSPITAL IGTS | $247,118,000 | $0 | $2,880,095,000 | $0 | $2,632,977,000 | $0 |

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## CURRENT YEAR COMPARED TO BUDGET YEAR
## FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **MANAGED CARE** | | | | | | |
| 101 | MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES | $1,849,578,000 | $521,681,640 | $2,131,736,000 | $612,223,010 | $282,158,000 | $90,541,370 |
| 103 | MANAGED CARE RATE RANGE IGTS | $870,681,000 | $0 | $3,143,888,000 | $0 | $2,273,207,000 | $0 |
| 105 | HQAF RATE RANGE INCREASES | $125,000,000 | $0 | $232,000,000 | $0 | $107,000,000 | $0 |
| 111 | PALLIATIVE CARE SERVICES IMPLEMENTATION | $10,000 | $5,000 | $2,977,000 | $1,334,530 | $2,967,000 | $1,329,530 |
| 112 | CAPITATED RATE ADJUSTMENT FOR FY 2017-18 | $0 | $0 | $0 | $0 | $0 | $0 |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. | $0 | ($521,682,000) | $0 | ($612,223,000) | $0 | ($90,541,000) |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS | $0 | ($1,190,766,000) | $0 | ($1,780,284,000) | $0 | ($589,518,000) |
| 116 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT | $0 | ($128,145,000) | $0 | ($13,631,000) | $0 | $114,514,000 |
| 117 | MCO TAX MANAGED CARE PLANS | $0 | ($184,621,000) | $0 | ($414,386,000) | $0 | ($229,765,000) |
| 118 | MANAGED CARE IGT ADMIN. & PROCESSING FEE | $0 | ($69,204,000) | $0 | ($275,965,000) | $0 | ($206,761,000) |
| 119 | GENERAL FUND REIMBURSEMENTS FROM DPHS | $0 | ($48,535,000) | $0 | ($253,242,000) | $0 | ($204,707,000) |
| 120 | CENCAL HEALTH PLAN-ADDITION OF CHDP | ($2,574,000) | ($1,287,000) | ($3,329,000) | ($1,664,500) | ($755,000) | ($377,500) |
| 121 | FORMER AGNEWS' BENEFICIARIES RECOUPMENT | ($6,477,000) | ($3,238,500) | $0 | $0 | $6,477,000 | $3,238,500 |
| 122 | MCO TAX MGD. CARE PLANS - INCR. CAP. RATES | $25,332,000 | $12,666,000 | $21,304,000 | $10,464,000 | ($4,028,000) | ($2,202,000) |
| 123 | MANAGED CARE DRUG REBATES | ($2,146,160,000) | ($606,546,680) | ($1,066,751,000) | ($345,951,190) | $1,079,409,000 | $260,595,490 |
| 124 | RETRO MC RATE ADJUSTMENTS | $331,083,000 | ($208,912,100) | ($4,048,269,000) | $191,374,000 | ($4,379,352,000) | $400,286,100 |
| 220 | CCI-QUALITY WITHHOLD REPAYMENTS | $1,353,000 | $676,500 | $9,000,000 | $4,500,000 | $7,647,000 | $3,823,500 |
| 225 | MEDI-CAL NONMEDICAL TRANSPORTATION | $0 | $0 | $6,000,000 | $1,725,530 | $6,000,000 | $1,725,530 |
| | **MANAGED CARE SUBTOTAL** | **$11,337,680,000** | **$2,593,459,860** | **$13,245,190,000** | **$2,092,543,880** | **$1,907,510,000** | **($500,915,980)** |
| | **PROVIDER RATES** | | | | | | |
| 125 | MEDICARE PART B ADJUSTMENT | $23,423,000 | $11,711,500 | ($160,682,000) | ($88,557,500) | ($184,105,000) | ($100,269,000) |

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## CURRENT YEAR COMPARED TO BUDGET YEAR
## FISCAL YEARS 2016-17 AND 2017-18

| NO. | POLICY CHANGE TITLE | MAY 2017 EST. FOR 2016-17 TOTAL FUNDS | MAY 2017 EST. FOR 2016-17 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|
| | **PROVIDER RATES** | | | | | | |
| 126 | DENTAL RETROACTIVE RATE CHANGES | $131,542,000 | $42,416,380 | $23,693,000 | $9,095,270 | ($107,849,000) | ($33,321,110) |
| 127 | FQHC/RHC/CBRC RECONCILIATION PROCESS | $196,942,330 | $73,176,560 | $199,430,150 | $75,718,460 | $2,487,820 | $2,541,890 |
| 128 | AB 1629 ANNUAL RATE ADJUSTMENTS | $93,156,430 | $46,578,210 | $174,846,170 | $87,423,090 | $81,689,740 | $40,844,870 |
| 130 | DPH INTERIM & FINAL RECONS | $81,174,000 | $0 | $137,004,000 | $0 | $55,830,000 | $0 |
| 131 | DPH INTERIM RATE GROWTH | $0 | $0 | $37,920,420 | $18,960,210 | $37,920,420 | $18,960,210 |
| 132 | LTC RATE ADJUSTMENT | $13,434,200 | $6,717,100 | $31,718,000 | $15,859,000 | $18,283,800 | $9,141,900 |
| 133 | ANNUAL MEI INCREASE FOR FQHCS/RHCS | $38,778,220 | $14,408,150 | $51,405,790 | $19,517,480 | $12,627,560 | $5,109,330 |
| 134 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT | $11,188,000 | ($2,522,000) | $11,000,000 | ($2,390,000) | ($188,000) | $132,000 |
| 135 | HOSPICE RATE INCREASES | $2,102,750 | $1,051,370 | $21,480,520 | $10,740,260 | $19,377,770 | $9,688,890 |
| 136 | DISCONTINUE PHARMACY RATE REDUCTIONS | $4,532,130 | $2,266,070 | $22,531,850 | $11,265,920 | $17,999,710 | $8,999,860 |
| 137 | GDSP NEWBORN SCREENING PROGRAM FEE INCREASE | $650,460 | $325,230 | $19,464,620 | $9,732,310 | $18,814,160 | $9,407,080 |
| 138 | GDSP PRENATAL SCREENING FEE INCREASE | $0 | $0 | $4,088,310 | $2,044,150 | $4,088,310 | $2,044,150 |
| 139 | ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE | $32,060 | ($24,600) | $1,551,580 | ($1,247,260) | $1,519,510 | ($1,222,670) |
| 140 | ALTERNATIVE BIRTHING CENTER REIMBURSEMENT | $0 | $0 | $44,390 | $22,190 | $44,390 | $22,190 |
| 141 | DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS | $0 | $104,415,000 | $0 | $0 | $0 | ($104,415,000) |
| 142 | DPH INTERIM RATE | $0 | ($350,932,550) | $0 | ($391,438,740) | $0 | ($40,506,190) |
| 143 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES | $0 | ($481,448,000) | $0 | ($482,975,000) | $0 | ($1,527,000) |
| 144 | LABORATORY RATE METHODOLOGY CHANGE | ($2,312,560) | ($1,156,280) | ($23,980,830) | ($11,990,410) | ($21,668,270) | ($10,834,140) |
| 145 | REDUCTION TO RADIOLOGY RATES | ($16,013,000) | ($8,006,500) | ($22,711,270) | ($11,355,630) | ($6,698,270) | ($3,349,130) |
| 146 | 10% PROVIDER PAYMENT REDUCTION | ($197,626,000) | ($98,813,000) | ($205,136,000) | ($102,568,000) | ($7,510,000) | ($3,755,000) |
| 216 | BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP | $2,734,000 | $1,005,000 | $0 | $0 | ($2,734,000) | ($1,005,000) |

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 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **PROVIDER RATES SUBTOTAL** | **$383,738,040** | **($638,832,350)** | **$323,668,690** | **($832,144,210)** | **($60,069,350)** | **($193,311,860)** |
| | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 129 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS | $82,670,000 | $47,165,000 | $86,243,000 | $48,928,000 | $3,573,000 | $1,763,000 |
| 147 | EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS | $7,022,721,000 | $0 | $15,569,513,000 | $0 | $8,546,792,000 | $0 |
| 148 | PRIVATE HOSPITAL DSH REPLACEMENT | $618,284,000 | $309,142,000 | $573,382,000 | $286,691,000 | ($44,902,000) | ($22,451,000) |
| 149 | DSH PAYMENT | $531,697,000 | $14,744,000 | $444,414,000 | $17,000,000 | ($87,283,000) | $2,256,000 |
| 150 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT | $364,229,000 | $118,400,000 | $300,261,000 | $118,400,000 | ($63,968,000) | $0 |
| 151 | NDPH IGT SUPPLEMENTAL PAYMENTS | $182,290,000 | $0 | $184,924,000 | ($2,441,000) | $2,634,000 | ($2,441,000) |
| 152 | MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS | $192,175,000 | $0 | $125,117,000 | $2,520,000 | ($67,058,000) | $2,520,000 |
| 153 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS | $141,358,000 | $0 | $415,351,000 | $0 | $273,993,000 | $0 |
| 154 | CAPITAL PROJECT DEBT REIMBURSEMENT | $100,295,000 | $39,472,500 | $186,120,000 | $82,810,000 | $85,825,000 | $43,337,500 |
| 155 | FFP FOR LOCAL TRAUMA CENTERS | $140,582,000 | $0 | $106,601,000 | $0 | ($33,981,000) | $0 |
| 156 | DPH PHYSICIAN & NON-PHYS. COST | $59,450,000 | $0 | $154,861,000 | $0 | $95,411,000 | $0 |
| 157 | HOSPITAL QAF - HOSPITAL PAYMENTS | $0 | $0 | $100,398,000 | $0 | $100,398,000 | $0 |
| 158 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS | $89,940,000 | $0 | $73,762,000 | $0 | ($16,178,000) | $0 |
| 159 | GEMT SUPPLEMENTAL PAYMENT PROGRAM | $43,716,000 | $0 | $76,800,000 | $0 | $33,084,000 | $0 |
| 160 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH | $10,037,000 | $5,018,500 | $10,000,000 | $5,000,000 | ($37,000) | ($18,500) |
| 161 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH | $8,009,000 | $4,004,500 | $8,000,000 | $4,000,000 | ($9,000) | ($4,500) |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS | $4,204,000 | $0 | $4,631,000 | $0 | $427,000 | $0 |
| 163 | IGT PAYMENTS FOR HOSPITAL SERVICES | $4,000,000 | $0 | $5,613,000 | $0 | $1,613,000 | $0 |
| 164 | NDPH SUPPLEMENTAL PAYMENT | $3,800,000 | $1,900,000 | $4,950,000 | $1,900,000 | $1,150,000 | $0 |

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

# COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
# CURRENT YEAR COMPARED TO BUDGET YEAR
# FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **SUPPLEMENTAL PMNTS.** | | | | | | |
| 165 | FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS | $0 | $0 | $465,948,000 | $0 | $465,948,000 | $0 |
| 214 | DP-NF CAPITAL PROJECT DEBT REPAYMENT | $0 | $0 | $0 | $57,224,000 | $0 | $57,224,000 |
| 215 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS | $0 | $0 | $1,187,500,000 | $0 | $1,187,500,000 | $0 |
| 232 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS | $0 | $0 | $167,000,000 | $0 | $167,000,000 | $0 |
| 233 | ICF/DD SUPPLEMENTAL PAYMENTS | $0 | $0 | $54,000,000 | $0 | $54,000,000 | $0 |
| 236 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS | $0 | $0 | $650,000,000 | $0 | $650,000,000 | $0 |
| 237 | SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES | $0 | $0 | $280,000,000 | $0 | $280,000,000 | $0 |
| 238 | AIDS WAIVER SUPPLEMENTAL PAYMENTS | $0 | $0 | $8,000,000 | $0 | $8,000,000 | $0 |
| | **SUPPLEMENTAL PMNTS. SUBTOTAL** | **$9,599,457,000** | **$539,846,500** | **$21,243,389,000** | **$622,032,000** | **$11,643,932,000** | **$82,185,500** |
| | **OTHER** | | | | | | |
| 77 | IMD ANCILLARY SERVICES | $0 | $26,632,000 | $0 | $29,565,000 | $0 | $2,933,000 |
| 166 | INFANT DEVELOPMENT PROGRAM | $31,899,000 | $0 | $26,305,000 | $0 | ($5,594,000) | $0 |
| 172 | CCI IHSS RECONCILIATION | $339,270,000 | $0 | $0 | $0 | ($339,270,000) | $0 |
| 174 | ARRA HITECH - PROVIDER PAYMENTS | $198,460,000 | $0 | $175,130,000 | $0 | ($23,330,000) | $0 |
| 176 | ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS | $77,067,000 | $0 | $110,533,000 | $0 | $33,466,000 | $0 |
| 180 | ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS | $12,711,000 | $5,817,000 | $19,921,000 | $8,339,000 | $7,210,000 | $2,522,000 |
| 181 | OVERTIME FOR WPCS PROVIDERS | $11,190,820 | $5,595,410 | $14,686,000 | $7,343,000 | $3,495,180 | $1,747,590 |
| 182 | MEDI-CAL ESTATE RECOVERIES | $12,587,000 | $6,293,500 | $64,707,000 | $32,353,500 | $52,120,000 | $26,060,000 |
| 183 | MINIMUM WAGE INCREASE FOR HCBS WAIVERS | $5,406,130 | $2,703,060 | $15,297,260 | $7,648,630 | $9,891,140 | $4,945,570 |
| 184 | WPCS WORKERS' COMPENSATION | $7,511,000 | $3,755,500 | $3,019,000 | $1,509,500 | ($4,492,000) | ($2,246,000) |
| 185 | INDIAN HEALTH SERVICES | $3,208,000 | ($20,795,000) | $6,239,000 | ($20,795,000) | $3,031,000 | $0 |
| 189 | CDDS DENTAL SERVICES | $984,000 | $0 | $984,000 | $0 | $0 | $0 |

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 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **OTHER** | | | | | | |
| 190 | NURSING FACILITY/ACUTE HOSPITAL WAIVER RENEWAL | $0 | $0 | $6,749,700 | $3,374,850 | $6,749,700 | $3,374,850 |
| 191 | MANAGED CARE ADMIN FINES AND PENALTIES REVENUE | $0 | ($3,404,000) | $0 | $0 | $0 | $3,404,000 |
| 192 | COUNTY SHARE OF OTLICP-CCS COSTS | $0 | ($7,793,000) | $0 | ($8,217,000) | $0 | ($424,000) |
| 193 | FUNDING ADJUST.—ACA OPT. EXPANSION | $0 | ($1,736,550,000) | $0 | ($1,764,846,210) | $0 | ($28,296,210) |
| 194 | FUNDING ADJUST.—OTLICP | $74,000 | ($171,665,760) | $154,000 | ($176,826,160) | $80,000 | ($5,160,400) |
| 195 | FFP REPAYMENT FOR CDDS COSTS | $0 | $0 | $0 | $0 | $0 | $0 |
| 196 | CLPP FUND | $0 | ($725,000) | $0 | ($725,000) | $0 | $0 |
| 197 | CCI-TRANSFER OF IHSS COSTS TO DHCS | $0 | ($1,871,911,000) | $0 | ($1,247,758,000) | $0 | $624,153,000 |
| 198 | EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE | $0 | ($675,175,000) | $0 | ($1,020,525,000) | $0 | ($345,350,000) |
| 199 | CIGARETTE AND TOBACCO SURTAX FUNDS | $0 | ($198,560,000) | $0 | ($208,524,000) | $0 | ($9,964,000) |
| 200 | MEDI-CAL RECOVERIES FIFTY PERCENT RULE | $0 | $0 | ($12,160,000) | ($12,160,000) | ($12,160,000) | ($12,160,000) |
| 201 | MEDICARE BUY-IN QUALITY REVIEW PROJECT RECOVERIES | $0 | $0 | ($2,000,000) | ($1,000,000) | ($2,000,000) | ($1,000,000) |
| 202 | NONCONTRACT HOSP INPATIENT COST SETTLEMENTS | ($6,096,000) | ($3,048,000) | $0 | $0 | $6,096,000 | $3,048,000 |
| 205 | AUDIT SETTLEMENTS | $548,000 | $548,000 | $13,928,000 | $13,928,000 | $13,380,000 | $13,380,000 |
| 206 | INTEGRATION OF THE SF CLSB INTO THE ALW | $0 | $0 | ($746,330) | ($373,170) | ($746,330) | ($373,170) |
| 210 | CCI-FFS SAVINGS FOR ADDITIONAL ENROLLMENT | ($94,594,000) | ($47,297,000) | ($332,853,000) | ($166,426,500) | ($238,259,000) | ($119,129,500) |
| 212 | HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND | $0 | $0 | $0 | ($46,633,000) | $0 | ($46,633,000) |
| 224 | MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS | $0 | $0 | ($1,730,000) | ($865,000) | ($1,730,000) | ($865,000) |
| 227 | NOD - SETTLEMENT PAYMENT TO DMC PLANS | $19,999,000 | $9,999,500 | $0 | $0 | ($19,999,000) | ($9,999,500) |
| 228 | FY 2015-16 ACCRUAL ADJUSTMENT | $65,357,000 | $65,357,000 | $0 | $0 | ($65,357,000) | ($65,357,000) |

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 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | OTHER SUBTOTAL | $685,581,940 | ($4,610,222,790) | $108,163,630 | ($4,571,612,560) | ($577,418,310) | $38,610,230 |
| | GRAND TOTAL | $28,819,860,450 | ($832,094,210) | $43,309,930,040 | ($1,459,624,490) | $14,490,069,590 | ($627,530,280) |

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

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

| SERVICE CATEGORY | PA-OAS | NEWLY | PA-ATD | PA-AFDC | LT-OAS | H-PE |
|---|---|---|---|---|---|---|
| PHYSICIANS | $10,681,650 | $146,055,400 | $88,782,000 | $39,139,710 | $3,012,840 | $41,926,150 |
| OTHER MEDICAL | $58,391,490 | $980,436,460 | $351,851,550 | $259,256,820 | $5,288,120 | $43,068,960 |
| CO. & COMM. OUTPATIENT | $5,725,680 | $126,539,320 | $109,582,590 | $28,044,100 | $737,910 | $44,087,690 |
| PHARMACY | $4,372,970 | $457,628,860 | $511,244,170 | $53,112,750 | $1,919,040 | $23,000,230 |
| COUNTY INPATIENT | $5,988,750 | $543,415,320 | $50,446,600 | $27,526,690 | $3,635,920 | $84,193,400 |
| COMMUNITY INPATIENT | $67,566,940 | $1,195,066,690 | $640,002,010 | $267,414,600 | $20,771,300 | $226,633,370 |
| NURSING FACILITIES | $217,866,640 | $127,585,900 | $489,473,220 | $3,810,190 | $1,264,004,350 | $1,217,000 |
| ICF-DD | $1,056,930 | $4,467,490 | $180,466,410 | $426,580 | $40,836,050 | $0 |
| MEDICAL TRANSPORTATION | $4,978,910 | $14,327,930 | $14,780,450 | $2,712,660 | $2,588,970 | $2,265,950 |
| OTHER SERVICES | $76,408,770 | $24,561,110 | $410,165,540 | $38,226,240 | $63,665,390 | $1,340,290 |
| HOME HEALTH | $1,028,460 | $1,233,450 | $125,587,910 | $5,360,030 | $55,200 | $184,250 |
| **FFS SUBTOTAL** | **$454,067,190** | **$3,621,317,940** | **$2,972,382,470** | **$725,030,360** | **$1,406,515,090** | **$467,917,300** |
| DENTAL | $47,318,000 | $411,403,140 | $126,181,320 | $158,231,980 | $15,716,320 | $0 |
| MENTAL HEALTH | $8,834,490 | $190,312,950 | $991,611,910 | $714,896,230 | $1,108,390 | $0 |
| TWO PLAN MODEL | $2,113,639,470 | $9,232,164,230 | $6,853,774,680 | $1,481,694,550 | $0 | $0 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $293,746,370 | $3,442,835,700 | $1,421,635,380 | $289,571,510 | $756,305,980 | $0 |
| GEOGRAPHIC MANAGED CARE | $199,929,410 | $1,681,356,990 | $1,083,139,110 | $199,361,150 | $0 | $0 |
| PHP & OTHER MANAG. CARE | $212,712,580 | $39,010,880 | $134,771,850 | $24,816,240 | $7,536,460 | $0 |
| EPSDT SCREENS | $0 | $0 | $0 | $7,128,640 | $0 | $0 |
| MEDICARE PAYMENTS | $1,675,781,530 | $60,570,480 | $1,584,517,690 | $2,975,390 | $161,645,620 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $11,967,550 | $0 | $26,995,430 | $35,374,070 | $1,160,160 | $0 |
| MISC. SERVICES | $553,556,870 | $0 | $4,499,349,140 | $4,516,380 | $0 | $0 |
| DRUG MEDI-CAL | $24,638,620 | $227,535,720 | $57,122,330 | $73,671,900 | $2,372,940 | $0 |
| REGIONAL MODEL | $9,465,710 | $541,089,470 | $278,890,020 | $61,034,100 | $0 | $0 |
| **NON-FFS SUBTOTAL** | **$5,151,590,590** | **$15,826,279,560** | **$17,057,988,870** | **$3,053,272,140** | **$945,845,870** | **$0** |
| **TOTAL DOLLARS (1)** | **$5,605,657,780** | **$19,447,597,500** | **$20,030,371,340** | **$3,778,302,500** | **$2,352,360,960** | **$467,917,300** |
| **ELIGIBLES ***** | **441,500** | **3,919,600** | **995,900** | **1,305,000** | **42,800** | **30,400** |
| **ANNUAL $/ELIGIBLE** | **$12,697** | **$4,962** | **$20,113** | **$2,895** | **$54,962** | **$15,392** |
| **AVG. MO. $/ELIGIBLE** | **$1,058** | **$413** | **$1,676** | **$241** | **$4,580** | **$1,283** |

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
**Refer to page following for listing of excluded policy changes.**

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

| SERVICE CATEGORY | LT-ATD | POV 250 | MN-OAS | MN-ATD | MN-AFDC | MI-C |
|---|---|---|---|---|---|---|
| PHYSICIANS | $2,254,920 | $17,598,160 | $21,848,890 | $10,808,200 | $147,349,210 | $21,344,640 |
| OTHER MEDICAL | $3,200,620 | $128,415,920 | $109,186,280 | $68,597,300 | $761,281,180 | $84,506,100 |
| CO. & COMM. OUTPATIENT | $655,270 | $24,660,540 | $16,642,050 | $12,137,300 | $107,422,640 | $12,319,430 |
| PHARMACY | $4,096,620 | $38,071,910 | $12,820,520 | $31,711,480 | $133,825,310 | $33,113,600 |
| COUNTY INPATIENT | $6,416,670 | $3,987,490 | $68,289,400 | $27,111,460 | $142,777,030 | $9,563,430 |
| COMMUNITY INPATIENT | $17,667,320 | $99,690,060 | $164,224,750 | $70,018,750 | $843,585,590 | $84,239,770 |
| NURSING FACILITIES | $282,037,500 | $2,034,310 | $246,681,830 | $49,096,080 | $17,172,500 | $3,696,250 |
| ICF-DD | $165,240,180 | $139,080 | $1,164,640 | $9,434,990 | $1,103,220 | $1,861,750 |
| MEDICAL TRANSPORTATION | $819,080 | $580,770 | $7,347,350 | $5,525,840 | $5,889,560 | $1,009,650 |
| OTHER SERVICES | $9,933,080 | $15,578,130 | $72,188,630 | $64,129,920 | $99,876,180 | $16,922,140 |
| HOME HEALTH | $8,090 | $9,149,870 | $936,080 | $47,444,700 | $9,877,530 | $11,485,460 |
| **FFS SUBTOTAL** | **$492,329,340** | **$339,906,240** | **$721,330,420** | **$396,016,020** | **$2,270,159,950** | **$280,062,210** |
| DENTAL | $15,716,320 | $105,620,890 | $47,318,000 | $15,772,660 | $458,872,730 | $30,177,400 |
| MENTAL HEALTH | $3,585,960 | $18,452,280 | $9,584,280 | $102,963,680 | $470,809,230 | $72,088,410 |
| TWO PLAN MODEL | $0 | $856,127,140 | $1,796,349,830 | $649,804,150 | $3,226,833,020 | $43,367,420 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $221,830,560 | $367,655,880 | $396,596,750 | $309,457,000 | $1,014,146,710 | $31,114,380 |
| GEOGRAPHIC MANAGED CARE | $0 | $154,067,450 | $164,428,230 | $111,942,590 | $460,063,990 | $4,609,350 |
| PHP & OTHER MANAG. CARE | $276,030 | $10,033,270 | $186,744,870 | $21,718,030 | $41,079,050 | $2,874,920 |
| EPSDT SCREENS | $0 | $5,085,230 | $0 | $0 | $19,999,880 | $1,091,050 |
| MEDICARE PAYMENTS | $41,414,850 | $0 | $1,098,245,520 | $508,725,150 | $95,454,780 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $322,570 | $0 | $12,425,650 | $4,328,920 | $99,220,880 | $5,426,740 |
| MISC. SERVICES | $0 | ($55,255,930) | $587,687,070 | $734,563,010 | $12,929,190 | $727,190 |
| DRUG MEDI-CAL | $681,940 | $55,786,170 | $26,157,740 | $9,741,230 | $214,190,730 | $11,941,290 |
| REGIONAL MODEL | $0 | $45,276,120 | $31,116,290 | $24,348,530 | $162,274,040 | $808,440 |
| **NON-FFS SUBTOTAL** | **$283,828,220** | **$1,562,848,500** | **$4,356,654,210** | **$2,493,364,970** | **$6,275,874,210** | **$204,226,590** |
| **TOTAL DOLLARS (1)** | **$776,157,560** | **$1,902,754,740** | **$5,077,984,630** | **$2,889,380,980** | **$8,546,034,160** | **$484,288,810** |
| **ELIGIBLES ***** | **11,900** | **930,900** | **468,000** | **166,100** | **3,660,400** | **199,700** |
| **ANNUAL $/ELIGIBLE** | **$65,223** | **$2,044** | **$10,850** | **$17,395** | **$2,335** | **$2,425** |
| **AVG. MO. $/ELIGIBLE** | **$5,435** | **$170** | **$904** | **$1,450** | **$195** | **$202** |

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
**Refer to page following for listing of excluded policy changes.**

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

| SERVICE CATEGORY | MI-A | REFUGEE | OBRA | POV 185 | POV 133 | POV 100 |
|---|---|---|---|---|---|---|
| PHYSICIANS | $286,540 | $294,070 | $807,240 | $118,422,100 | $12,392,660 | $5,559,620 |
| OTHER MEDICAL | $424,570 | $1,377,360 | $914,020 | $203,434,740 | $122,898,150 | $70,222,670 |
| CO. & COMM. OUTPATIENT | $76,090 | $140,540 | $562,930 | $26,426,270 | $11,590,740 | $6,741,930 |
| PHARMACY | $729,970 | $202,890 | $843,160 | $13,468,580 | $10,748,430 | $18,443,770 |
| COUNTY INPATIENT | $20,450 | $12,070 | $931,130 | $75,966,880 | $3,467,840 | $2,434,410 |
| COMMUNITY INPATIENT | $491,010 | $394,450 | $11,020,150 | $888,061,840 | $82,788,540 | $37,160,550 |
| NURSING FACILITIES | $22,016,750 | $350 | $4,116,680 | $2,010,930 | $4,577,310 | $29,710 |
| ICF-DD | $960,170 | $0 | $383,330 | $0 | $0 | $250 |
| MEDICAL TRANSPORTATION | $68,080 | $7,430 | $110,150 | $1,915,960 | $492,730 | $180,910 |
| OTHER SERVICES | $444,200 | $14,230 | $46,270 | $11,991,310 | $17,438,350 | $11,221,710 |
| HOME HEALTH | $40 | $0 | $770 | $3,128,690 | $2,981,460 | $893,850 |
| **FFS SUBTOTAL** | **$25,517,870** | **$2,443,390** | **$19,735,840** | **$1,344,827,310** | **$269,376,210** | **$152,889,390** |
| DENTAL | $15,823,200 | $15,088,700 | $16,424,200 | $49,272,590 | $78,448,500 | $47,069,100 |
| MENTAL HEALTH | $32,600 | $114,170 | $231,050 | $1,155,240 | $6,142,310 | $20,548,830 |
| TWO PLAN MODEL | $52,380 | $1,395,760 | $0 | $198,031,110 | $754,540,950 | $383,836,740 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $106,350 | $216,230 | $89,120 | $75,318,140 | $259,385,450 | $139,232,420 |
| GEOGRAPHIC MANAGED CARE | $6,410 | $438,840 | $0 | $27,595,890 | $105,151,090 | $58,206,900 |
| PHP & OTHER MANAG. CARE | $1,444,550 | $0 | $0 | $4,334,540 | $7,166,620 | $4,299,970 |
| EPSDT SCREENS | $0 | $0 | $0 | $0 | $4,147,370 | $2,006,560 |
| MEDICARE PAYMENTS | $0 | $0 | $0 | $0 | $0 | $0 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $43,370 | $0 | $67,770 | $40,660 | $0 | $9,956,240 |
| MISC. SERVICES | $100 | $0 | $0 | $66,920 | $2,066,990 | $1,130,690 |
| DRUG MEDI-CAL | $33,270 | $99,800 | $0 | $22,531,800 | $41,570,730 | $20,524,790 |
| REGIONAL MODEL | $0 | $19,850 | $0 | $9,889,490 | $36,931,310 | $17,412,860 |
| **NON-FFS SUBTOTAL** | **$17,542,220** | **$17,373,340** | **$16,812,140** | **$388,236,390** | **$1,295,551,320** | **$704,225,090** |
| **TOTAL DOLLARS (1)** | **$43,060,090** | **$19,816,730** | **$36,547,970** | **$1,733,063,700** | **$1,564,927,530** | **$857,114,480** |
| **ELIGIBLES ***** | **1,600** | **2,500** | **1,500** | **378,700** | **759,200** | **367,300** |
| **ANNUAL $/ELIGIBLE** | **$26,913** | **$7,927** | **$24,365** | **$4,576** | **$2,061** | **$2,334** |
| **AVG. MO. $/ELIGIBLE** | **$2,243** | **$661** | **$2,030** | **$381** | **$172** | **$194** |

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
**Refer to page following for listing of excluded policy changes.**

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

| SERVICE CATEGORY | TOTAL |
|---|---|
| PHYSICIANS | $688,564,000 |
| OTHER MEDICAL | $3,252,752,300 |
| CO. & COMM. OUTPATIENT | $534,093,030 |
| PHARMACY | $1,349,354,280 |
| COUNTY INPATIENT | $1,056,184,930 |
| COMMUNITY INPATIENT | $4,716,797,700 |
| NURSING FACILITIES | $2,737,427,490 |
| ICF-DD | $407,541,070 |
| MEDICAL TRANSPORTATION | $65,602,380 |
| OTHER SERVICES | $934,151,490 |
| HOME HEALTH | $219,355,860 |
| **FFS SUBTOTAL** | $15,961,824,530 |
| DENTAL | $1,654,455,040 |
| MENTAL HEALTH | $2,612,472,000 |
| TWO PLAN MODEL | $27,591,611,420 |
| COUNTY ORGANIZED HEALTH SYSTEMS | $9,019,243,940 |
| GEOGRAPHIC MANAGED CARE | $4,250,297,380 |
| PHP & OTHER MANAG. CARE | $698,819,860 |
| EPSDT SCREENS | $39,458,730 |
| MEDICARE PAYMENTS | $5,229,331,000 |
| STATE HOSP./DEVELOPMENTAL CNTRS. | $207,330,000 |
| MISC. SERVICES | $6,341,337,630 |
| DRUG MEDI-CAL | $788,601,000 |
| REGIONAL MODEL | $1,218,556,230 |
| **NON-FFS SUBTOTAL** | $59,651,514,220 |
| **TOTAL DOLLARS (1)** | $75,613,338,750 |
| **ELIGIBLES** *** | 13,683,000 |
| **ANNUAL $/ELIGIBLE** | $5,526 |
| **AVG. MO. $/ELIGIBLE** | $461 |

(1) Does not include Audits & Lawsuits and Recoveries.
*** Eligibles include the estimated impact of eligibility policy changes.
**Refer to page following for listing of excluded policy changes.**

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 83

| | |
|---|---|
| 1 | FAMILY PACT PROGRAM |
| 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL |
| 5 | BREAST AND CERVICAL CANCER TREATMENT |
| 7 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) |
| 8 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL |
| 10 | NON-OTLICP CHIP |
| 13 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN |
| 23 | 1% FMAP INCREASE FOR PREVENTIVE SERVICES |
| 26 | ACA MAGI SAVINGS |
| 28 | ACA DSH REDUCTION |
| 58 | FAMILY PACT DRUG REBATES |
| 67 | DRUG MEDI-CAL PROGRAM COST SETTLEMENT |
| 72 | SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT |
| 76 | SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT |
| 80 | PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL |
| 81 | GLOBAL PAYMENT PROGRAM |
| 82 | MEDI-CAL 2020 WHOLE PERSON CARE PILOTS |
| 83 | BTR - LIHP - MCE |
| 84 | LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND |
| 85 | BTR - LOW INCOME HEALTH PROGRAM - HCCI |
| 87 | MH/UCD—HEALTH CARE COVERAGE INITIATIVE |
| 88 | MH/UCD—STABILIZATION FUNDING |
| 89 | MH/UCD—SAFETY NET CARE POOL |
| 90 | MH/UCD & BTR—CCS AND GHPP |
| 91 | BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL |
| 92 | UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG |
| 93 | BTR—DESIGNATED STATE HEALTH PROGRAMS |
| 94 | MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP |
| 95 | MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM |
| 110 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) |
| 111 | PALLIATIVE CARE SERVICES IMPLEMENTATION |
| 114 | MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ. |
| 115 | MCO ENROLLMENT TAX MANAGED CARE PLANS |
| 116 | MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT |

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 83

| | |
|---|---|
| 117 | MCO TAX MANAGED CARE PLANS |
| 118 | MANAGED CARE IGT ADMIN. & PROCESSING FEE |
| 119 | GENERAL FUND REIMBURSEMENTS FROM DPHS |
| 126 | DENTAL RETROACTIVE RATE CHANGES |
| 129 | QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS |
| 134 | EMERGENCY MEDICAL AIR TRANSPORTATION ACT |
| 141 | DP/NF-B RETROACTIVE RECOUPMENT FORGIVENESS |
| 143 | LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES |
| 147 | EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS |
| 148 | PRIVATE HOSPITAL DSH REPLACEMENT |
| 149 | DSH PAYMENT |
| 150 | PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT |
| 151 | NDPH IGT SUPPLEMENTAL PAYMENTS |
| 153 | HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS |
| 154 | CAPITAL PROJECT DEBT REIMBURSEMENT |
| 155 | FFP FOR LOCAL TRAUMA CENTERS |
| 156 | DPH PHYSICIAN & NON-PHYS. COST |
| 157 | HOSPITAL QAF - HOSPITAL PAYMENTS |
| 158 | CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS |
| 159 | GEMT SUPPLEMENTAL PAYMENT PROGRAM |
| 160 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH |
| 161 | MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH |
| 162 | STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS |
| 163 | IGT PAYMENTS FOR HOSPITAL SERVICES |
| 164 | NDPH SUPPLEMENTAL PAYMENT |
| 165 | FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS |
| 174 | ARRA HITECH - PROVIDER PAYMENTS |
| 178 | MEDI-CAL TCM PROGRAM |
| 189 | CDDS DENTAL SERVICES |
| 191 | MANAGED CARE ADMIN FINES AND PENALTIES REVENUE |
| 196 | CLPP FUND |
| 197 | CCI-TRANSFER OF IHSS COSTS TO DHCS |
| 198 | EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE |
| 199 | CIGARETTE AND TOBACCO SURTAX FUNDS |

# FISCAL YEAR 2017-18 COST PER ELIGIBLE BASED ON MAY 2017 ESTIMATE

EXCLUDED POLICY CHANGES: 83

| | |
|---|---|
| 205 | AUDIT SETTLEMENTS |
| 212 | HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND |
| 214 | DP-NF CAPITAL PROJECT DEBT REPAYMENT |
| 215 | GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS |
| 216 | BORDER OUT-OF-STATE DIAGNOSIS RELATED GROUP |
| 217 | TRANSITIONAL SMHS CLAIMS |
| 221 | MEC OPTIONAL EXPANSION ADJUSTMENT |
| 222 | CMS DEFERRED CLAIMS |
| 223 | CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT |
| 227 | NOD - SETTLEMENT PAYMENT TO DMC PLANS |
| 228 | FY 2015-16 ACCRUAL ADJUSTMENT |
| 232 | WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS |
| 233 | ICF/DD SUPPLEMENTAL PAYMENTS |
| 236 | PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS |
| 238 | AIDS WAIVER SUPPLEMENTAL PAYMENTS |

# 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 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **ELIGIBILITY** | | | | |
| 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL | $29,170,000 | $22,977,000 | $0 | $6,193,000 |
| 7 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $7,144,000 | $6,286,720 | $857,280 | $0 |
| 8 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $2,755,000 | $2,424,400 | $330,600 | $0 |
| | **ELIGIBILITY SUBTOTAL** | **$39,069,000** | **$31,688,120** | **$1,187,880** | **$6,193,000** |
| | **DRUG MEDI-CAL** | | | | |
| 63 | NARCOTIC TREATMENT PROGRAM | $158,571,000 | $153,244,850 | $5,326,150 | $0 |
| 65 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $24,330,000 | $23,557,490 | $772,510 | $0 |
| 66 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $9,458,000 | $8,038,630 | $1,419,370 | $0 |
| 68 | RESIDENTIAL TREATMENT SERVICES | $1,505,000 | $1,456,000 | $49,000 | $0 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$193,864,000** | **$186,296,970** | **$7,567,030** | **$0** |
| | **MENTAL HEALTH** | | | | |
| 70 | SMHS FOR ADULTS | $1,425,027,000 | $1,315,370,000 | $41,156,000 | $68,501,000 |
| 71 | SMHS FOR CHILDREN | $1,127,659,000 | $1,090,024,340 | $2,266,660 | $35,368,000 |
| | **MENTAL HEALTH SUBTOTAL** | **$2,552,686,000** | **$2,405,394,340** | **$43,422,660** | **$103,869,000** |
| | **MANAGED CARE** | | | | |
| 96 | TWO PLAN MODEL | $20,478,370,000 | $14,361,860,360 | $5,606,509,640 | $510,000,000 |
| 97 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,985,671,000 | $5,600,517,200 | $2,275,153,800 | $110,000,000 |
| 99 | GEOGRAPHIC MANAGED CARE | $3,798,337,000 | $2,743,082,570 | $995,254,430 | $60,000,000 |
| 102 | REGIONAL MODEL | $1,219,782,000 | $878,492,050 | $338,889,950 | $2,400,000 |
| 104 | PACE (Other M/C) | $421,796,000 | $210,898,000 | $182,132,000 | $28,766,000 |
| 106 | DENTAL MANAGED CARE (Other M/C) | $133,170,000 | $86,210,830 | $46,959,170 | $0 |
| 107 | SENIOR CARE ACTION NETWORK (Other M/C) | $65,050,000 | $32,525,000 | $32,525,000 | $0 |
| 108 | AIDS HEALTHCARE CENTERS (Other M/C) | $19,750,000 | $9,875,000 | $9,875,000 | $0 |
| 110 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $3,117,000 | $1,558,500 | $1,558,500 | $0 |
| | **MANAGED CARE SUBTOTAL** | **$34,125,043,000** | **$23,925,019,510** | **$9,488,857,490** | **$711,166,000** |
| | **OTHER** | | | | |
| 167 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,270,379,000 | $1,518,742,500 | $1,751,636,500 | $0 |
| 168 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,125,280,000 | $0 | $2,125,280,000 | $0 |
| 169 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,736,805,000 | $1,736,805,000 | $0 | $0 |
| 170 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,464,250,000 | $1,464,250,000 | $0 | $0 |
| 171 | DENTAL SERVICES | $1,171,505,000 | $769,683,660 | $401,821,340 | $0 |
| 173 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $207,330,000 | $0 | $0 |

# SUMMARY OF BASE POLICY CHANGES
## FISCAL YEAR 2017-18

| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | FEDERAL FUNDS | GENERAL FUNDS | OTHER STATE FUNDS |
|---|---|---|---|---|---|
| | **OTHER** | | | | |
| 175 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $194,996,000 | $194,996,000 | $0 | $0 |
| 177 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $46,068,000 | $23,034,000 | $23,034,000 | $0 |
| 178 | MEDI-CAL TCM PROGRAM | $30,063,000 | $30,063,000 | $0 | $0 |
| 179 | EPSDT SCREENS | $34,832,000 | $18,157,000 | $16,675,000 | $0 |
| 186 | LAWSUITS/CLAIMS | $2,013,000 | $932,500 | $1,080,500 | $0 |
| 187 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,307,000 | $653,500 | $653,500 | $0 |
| 188 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,028,000 | $1,028,000 | $0 | $0 |
| 203 | BASE RECOVERIES | ($352,303,000) | ($182,998,000) | ($169,305,000) | $0 |
| | **OTHER SUBTOTAL** | **$9,933,553,000** | **$5,782,677,160** | **$4,150,875,840** | **$0** |
| | **GRAND TOTAL** | **$46,844,215,000** | **$32,331,076,100** | **$13,691,910,900** | **$821,228,000** |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
## MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
## FISCAL YEAR 2016-17

| NOV. | MAY | | 2016-17 APPROPRIATION | | NOV. 2016 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2016-17 | | DIFF. MAY TO APPROPRIATION | | DIFFERENCE MAY TO NOVEMBER | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NO. | NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **ELIGIBILITY** | | | | | | | | | | |
| 4 | 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL | $65,561,000 | $0 | $91,732,000 | $0 | $65,767,000 | $0 | $206,000 | $0 | ($25,965,000) | $0 |
| -- | 7 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $0 | $0 | $0 | $0 | $7,058,000 | $846,960 | $7,058,000 | $846,960 | $7,058,000 | $846,960 |
| 8 | 8 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $4,785,000 | $574,200 | $1,746,000 | $209,520 | $2,752,000 | $330,240 | ($2,033,000) | ($243,960) | $1,006,000 | $120,720 |
| | | **ELIGIBILITY SUBTOTAL** | **$70,346,000** | **$574,200** | **$93,478,000** | **$209,520** | **$75,577,000** | **$1,177,200** | **$5,231,000** | **$603,000** | **($17,901,000)** | **$967,680** |
| | | **DRUG MEDI-CAL** | | | | | | | | | | |
| 63 | 63 | NARCOTIC TREATMENT PROGRAM | $116,267,000 | $1,204,400 | $131,983,000 | $1,522,200 | $148,543,000 | $1,979,600 | $32,276,000 | $775,200 | $16,560,000 | $457,400 |
| 65 | 65 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $16,710,000 | $131,550 | $17,264,000 | $149,750 | $22,516,000 | $287,800 | $5,806,000 | $156,250 | $5,252,000 | $138,050 |
| 66 | 66 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $4,952,000 | $979,100 | $6,217,000 | $1,349,920 | $8,377,000 | $1,218,750 | $3,425,000 | $239,650 | $2,160,000 | ($131,170) |
| 68 | 68 | RESIDENTIAL TREATMENT SERVICES | $868,000 | $4,450 | $1,120,000 | $6,900 | $1,481,000 | $18,150 | $613,000 | $13,700 | $361,000 | $11,250 |
| | | **DRUG MEDI-CAL SUBTOTAL** | **$138,797,000** | **$2,319,500** | **$156,584,000** | **$3,028,770** | **$180,917,000** | **$3,504,300** | **$42,120,000** | **$1,184,800** | **$24,333,000** | **$475,530** |
| | | **MENTAL HEALTH** | | | | | | | | | | |
| 70 | 70 | SMHS FOR ADULTS | $1,410,630,000 | $17,359,300 | $1,287,426,000 | $16,110,050 | $1,285,401,000 | $16,006,150 | ($125,229,000) | ($1,353,150) | ($2,025,000) | ($103,900) |
| 71 | 71 | SMHS FOR CHILDREN | $1,091,389,000 | $0 | $1,059,399,000 | $873,850 | $1,058,354,000 | $887,950 | ($33,035,000) | $887,950 | ($1,045,000) | $14,100 |
| | | **MENTAL HEALTH SUBTOTAL** | **$2,502,019,000** | **$17,359,300** | **$2,346,825,000** | **$16,983,900** | **$2,343,755,000** | **$16,894,100** | **($158,264,000)** | **($465,200)** | **($3,070,000)** | **($89,800)** |
| | | **MANAGED CARE** | | | | | | | | | | |
| 96 | 96 | TWO PLAN MODEL | $19,024,105,000 | $5,582,634,920 | $19,859,742,000 | $5,572,405,790 | $19,603,938,000 | $5,440,445,630 | $579,833,000 | ($142,189,290) | ($255,804,000) | ($131,960,160) |
| 97 | 97 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,839,965,000 | $2,261,244,470 | $8,038,535,000 | $2,251,455,440 | $7,891,527,000 | $2,175,773,670 | $51,562,000 | ($85,470,800) | ($147,008,000) | ($75,681,770) |
| 99 | 99 | GEOGRAPHIC MANAGED CARE | $3,590,254,000 | $985,126,420 | $3,671,239,000 | $968,419,600 | $3,677,114,000 | $957,185,730 | $86,860,000 | ($27,940,690) | $5,875,000 | ($11,233,870) |
| 102 | 102 | REGIONAL MODEL | $1,152,969,000 | $338,890,040 | $1,242,284,000 | $333,419,090 | $1,201,454,000 | $314,024,710 | $48,485,000 | ($24,865,330) | ($40,830,000) | ($19,394,380) |
| 104 | 104 | PACE (Other M/C) | $354,239,000 | $177,119,500 | $414,524,000 | $207,262,000 | $418,255,000 | $209,127,500 | $64,016,000 | $32,008,000 | $3,731,000 | $1,865,500 |
| 106 | 106 | DENTAL MANAGED CARE (Other M/C) | $166,851,000 | $65,765,570 | $132,519,000 | $49,754,390 | $126,718,000 | $42,667,050 | ($40,133,000) | ($23,098,520) | ($5,801,000) | ($7,087,340) |
| 107 | 107 | SENIOR CARE ACTION NETWORK (Other M/C) | $68,065,000 | $34,032,500 | $70,604,000 | $35,412,000 | $70,571,000 | $35,285,500 | $2,506,000 | $1,253,000 | ($33,000) | ($126,500) |
| 108 | 108 | AIDS HEALTHCARE CENTERS (Other M/C) | $10,980,000 | $5,490,000 | $10,980,000 | $5,490,000 | $9,628,000 | $4,814,000 | ($1,352,000) | ($676,000) | ($1,352,000) | ($676,000) |
| 110 | -- | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $1,826,000 | $913,000 | $1,826,000 | $913,000 | $0 | $0 | ($1,826,000) | ($913,000) | ($1,826,000) | ($913,000) |

## COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
## MAY 2017 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2016 ESTIMATE
## FISCAL YEAR 2016-17

| NOV. | MAY | | 2016-17 APPROPRIATION | | NOV. 2016 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2016-17 | | DIFF. MAY TO APPROPRIATION | | DIFFERENCE MAY TO NOVEMBER | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NO. | NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | | **MANAGED CARE SUBTOTAL** | **$32,209,254,000** | **$9,451,216,420** | **$33,442,253,000** | **$9,424,531,310** | **$32,999,205,000** | **$9,179,323,790** | **$789,951,000** | **($271,892,630)** | **($443,048,000)** | **($245,207,520)** |
| | | **OTHER** | | | | | | | | | | |
| 167 | 167 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $2,994,034,000 | $1,617,825,500 | $3,002,163,000 | $1,619,150,500 | $3,080,719,000 | $1,649,153,500 | $86,685,000 | $31,328,000 | $78,556,000 | $30,003,000 |
| 168 | 168 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $1,917,313,000 | $1,917,313,000 | $1,921,599,000 | $1,921,599,000 | $1,915,760,000 | $1,915,760,000 | ($1,553,000) | ($1,553,000) | ($5,839,000) | ($5,839,000) |
| 169 | 169 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,535,667,000 | $0 | $1,948,185,000 | $0 | $1,603,877,000 | $0 | $68,210,000 | $0 | ($344,308,000) | $0 |
| 170 | 170 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,518,950,000 | $0 | $1,299,545,000 | $0 | $1,119,545,000 | $0 | ($399,405,000) | $0 | ($180,000,000) | $0 |
| 171 | 171 | DENTAL SERVICES | $1,057,219,000 | $357,650,190 | $992,234,000 | $310,636,300 | $975,699,000 | $302,772,320 | ($81,520,000) | ($54,877,870) | ($16,535,000) | ($7,863,980) |
| 173 | 173 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $0 | $207,330,000 | $0 | $207,330,000 | $0 | $0 | $0 | $0 | $0 |
| 175 | 175 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $161,949,000 | $0 | $226,117,000 | $0 | $215,538,000 | $0 | $53,589,000 | $0 | ($10,579,000) | $0 |
| 177 | 177 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $43,975,000 | $21,987,500 | $41,563,000 | $20,781,500 | $44,055,000 | $22,027,500 | $80,000 | $40,000 | $2,492,000 | $1,246,000 |
| 178 | 178 | MEDI-CAL TCM PROGRAM | $51,147,000 | $0 | $37,245,000 | $0 | $35,392,000 | $0 | ($15,755,000) | $0 | ($1,853,000) | $0 |
| 179 | 179 | EPSDT SCREENS | $42,193,000 | $19,952,700 | $36,894,000 | $17,540,320 | $35,413,000 | $16,952,960 | ($6,780,000) | ($2,999,740) | ($1,481,000) | ($587,360) |
| 186 | 186 | LAWSUITS/CLAIMS | $1,913,000 | $956,500 | $3,537,000 | $1,292,500 | $5,358,000 | $2,203,500 | $3,445,000 | $1,247,000 | $1,821,000 | $911,000 |
| 187 | 187 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,626,000 | $813,000 | $1,476,000 | $738,000 | $1,313,000 | $656,500 | ($313,000) | ($156,500) | ($163,000) | ($81,500) |
| 188 | 188 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,028,000 | $0 | $1,291,000 | $0 | $1,291,000 | $0 | $263,000 | $0 | $0 | $0 |
| 203 | 203 | BASE RECOVERIES | ($294,693,000) | ($154,158,000) | ($333,599,000) | ($160,316,000) | ($321,820,000) | ($154,655,000) | ($27,127,000) | ($497,000) | $11,779,000 | $5,661,000 |
| | | **OTHER SUBTOTAL** | **$9,239,651,000** | **$3,782,340,390** | **$9,385,580,000** | **$3,731,422,120** | **$8,919,470,000** | **$3,754,871,280** | **($320,181,000)** | **($27,469,110)** | **($466,110,000)** | **$23,449,160** |
| | | **GRAND TOTAL** | **$44,160,067,000** | **$13,253,809,810** | **$45,424,720,000** | **$13,176,175,620** | **$44,518,924,000** | **$12,955,770,670** | **$358,857,000** | **($298,039,140)** | **($905,796,000)** | **($220,404,950)** |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **ELIGIBILITY** | | | | | | |
| 4 | 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL | $36,471,000 | $0 | $29,170,000 | $0 | ($7,301,000) | $0 |
| -- | 7 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $0 | $0 | $7,144,000 | $857,280 | $7,144,000 | $857,280 |
| 8 | 8 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $1,362,000 | $163,440 | $2,755,000 | $330,600 | $1,393,000 | $167,160 |
| | | **ELIGIBILITY SUBTOTAL** | **$37,833,000** | **$163,440** | **$39,069,000** | **$1,187,880** | **$1,236,000** | **$1,024,440** |
| | | **DRUG MEDI-CAL** | | | | | | |
| 63 | 63 | NARCOTIC TREATMENT PROGRAM | $135,724,000 | $3,916,520 | $158,571,000 | $5,326,150 | $22,847,000 | $1,409,630 |
| 65 | 65 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $17,377,000 | $379,290 | $24,330,000 | $772,510 | $6,953,000 | $393,220 |
| 66 | 66 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $6,282,000 | $1,388,580 | $9,458,000 | $1,419,370 | $3,176,000 | $30,790 |
| 68 | 68 | RESIDENTIAL TREATMENT SERVICES | $1,057,000 | $17,420 | $1,505,000 | $49,000 | $448,000 | $31,580 |
| | | **DRUG MEDI-CAL SUBTOTAL** | **$160,440,000** | **$5,701,810** | **$193,864,000** | **$7,567,030** | **$33,424,000** | **$1,865,220** |
| | | **MENTAL HEALTH** | | | | | | |
| 70 | 70 | SMHS FOR ADULTS | $1,430,236,000 | $41,444,700 | $1,425,027,000 | $41,156,000 | ($5,209,000) | ($288,700) |
| 71 | 71 | SMHS FOR CHILDREN | $1,131,616,000 | $2,241,690 | $1,127,659,000 | $2,266,660 | ($3,957,000) | $24,970 |
| | | **MENTAL HEALTH SUBTOTAL** | **$2,561,852,000** | **$43,686,390** | **$2,552,686,000** | **$43,422,660** | **($9,166,000)** | **($263,730)** |
| | | **MANAGED CARE** | | | | | | |
| 96 | 96 | TWO PLAN MODEL | $20,194,590,000 | $5,582,634,910 | $20,478,370,000 | $5,606,509,640 | $283,780,000 | $23,874,730 |
| 97 | 97 | COUNTY ORGANIZED HEALTH SYSTEMS | $8,135,638,000 | $2,261,244,540 | $7,985,671,000 | $2,275,153,800 | ($149,967,000) | $13,909,260 |
| 99 | 99 | GEOGRAPHIC MANAGED CARE | $3,759,068,000 | $985,126,590 | $3,798,337,000 | $995,254,430 | $39,269,000 | $10,127,840 |
| 102 | 102 | REGIONAL MODEL | $1,249,041,000 | $338,889,560 | $1,219,782,000 | $338,889,950 | ($29,259,000) | $390 |
| 104 | 104 | PACE (Other M/C) | $425,845,000 | $177,119,500 | $421,796,000 | $182,132,000 | ($4,049,000) | $5,012,500 |
| 106 | 106 | DENTAL MANAGED CARE (Other M/C) | $147,598,000 | $56,443,760 | $133,170,000 | $46,959,170 | ($14,428,000) | ($9,484,590) |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
## MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
## FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **MANAGED CARE** | | | | | | |
| 107 | 107 | SENIOR CARE ACTION NETWORK (Other M/C) | $67,060,000 | $33,530,000 | $65,050,000 | $32,525,000 | ($2,010,000) | ($1,005,000) |
| 108 | 108 | AIDS HEALTHCARE CENTERS (Other M/C) | $10,980,000 | $5,490,000 | $19,750,000 | $9,875,000 | $8,770,000 | $4,385,000 |
| 110 | 110 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $913,000 | $456,500 | $3,117,000 | $1,558,500 | $2,204,000 | $1,102,000 |
| | | **MANAGED CARE SUBTOTAL** | **$33,990,733,000** | **$9,440,935,360** | **$34,125,043,000** | **$9,488,857,490** | **$134,310,000** | **$47,922,130** |
| | | **OTHER** | | | | | | |
| 167 | 167 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,088,491,000 | $1,626,768,500 | $3,270,379,000 | $1,751,636,500 | $181,888,000 | $124,868,000 |
| 168 | 168 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $2,202,798,000 | $1,917,313,000 | $2,125,280,000 | $2,125,280,000 | ($77,518,000) | $207,967,000 |
| 169 | 169 | HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.) | $1,741,214,000 | $0 | $1,736,805,000 | $0 | ($4,409,000) | $0 |
| 170 | 170 | PERSONAL CARE SERVICES (Misc. Svcs.) | $2,120,950,000 | $0 | $1,464,250,000 | $0 | ($656,700,000) | $0 |
| 171 | 171 | DENTAL SERVICES | $1,247,550,000 | $430,696,140 | $1,171,505,000 | $401,821,340 | ($76,045,000) | ($28,874,800) |
| 173 | 173 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $0 | $207,330,000 | $0 | $0 | $0 |
| 175 | 175 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $192,287,000 | $0 | $194,996,000 | $0 | $2,709,000 | $0 |
| 177 | 177 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $43,686,000 | $21,843,000 | $46,068,000 | $23,034,000 | $2,382,000 | $1,191,000 |
| 178 | 178 | MEDI-CAL TCM PROGRAM | $32,676,000 | $0 | $30,063,000 | $0 | ($2,613,000) | $0 |
| 179 | 179 | EPSDT SCREENS | $36,835,000 | $17,512,340 | $34,832,000 | $16,675,000 | ($2,003,000) | ($837,340) |
| 186 | 186 | LAWSUITS/CLAIMS | $1,865,000 | $932,500 | $2,013,000 | $1,080,500 | $148,000 | $148,000 |
| 187 | 187 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,469,000 | $734,500 | $1,307,000 | $653,500 | ($162,000) | ($81,000) |
| 188 | 188 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,028,000 | $0 | $1,028,000 | $0 | $0 | $0 |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
# MAY 2017 ESTIMATE COMPARED TO NOVEMBER 2016 ESTIMATE
# FISCAL YEAR 2017-18

| NOV. NO. | MAY NO. | POLICY CHANGE TITLE | NOV. 2016 EST. FOR 2017-18 TOTAL FUNDS | NOV. 2016 EST. FOR 2017-18 GENERAL FUNDS | MAY 2017 EST. FOR 2017-18 TOTAL FUNDS | MAY 2017 EST. FOR 2017-18 GENERAL FUNDS | DIFFERENCE TOTAL FUNDS | DIFFERENCE GENERAL FUNDS |
|---|---|---|---|---|---|---|---|---|
| | | **OTHER** | | | | | | |
| 203 | 203 | BASE RECOVERIES | ($337,345,000) | ($162,116,000) | ($352,303,000) | ($169,305,000) | ($14,958,000) | ($7,189,000) |
| | | **OTHER SUBTOTAL** | **$10,580,834,000** | **$3,853,683,980** | **$9,933,553,000** | **$4,150,875,840** | **($647,281,000)** | **$297,191,860** |
| | | **GRAND TOTAL** | **$47,331,692,000** | **$13,344,170,980** | **$46,844,215,000** | **$13,691,910,900** | **($487,477,000)** | **$347,739,920** |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
## CURRENT YEAR COMPARED TO BUDGET YEAR
## FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **ELIGIBILITY** | | | | | | |
| 4 | MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL | $65,767,000 | $0 | $29,170,000 | $0 | ($36,597,000) | $0 |
| 7 | COUNTY HEALTH INITIATIVE MATCHING (CHIM) | $7,058,000 | $846,960 | $7,144,000 | $857,280 | $86,000 | $10,320 |
| 8 | MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL | $2,752,000 | $330,240 | $2,755,000 | $330,600 | $3,000 | $360 |
| | **ELIGIBILITY SUBTOTAL** | **$75,577,000** | **$1,177,200** | **$39,069,000** | **$1,187,880** | **($36,508,000)** | **$10,680** |
| | **DRUG MEDI-CAL** | | | | | | |
| 63 | NARCOTIC TREATMENT PROGRAM | $148,543,000 | $1,979,600 | $158,571,000 | $5,326,150 | $10,028,000 | $3,346,550 |
| 65 | OUTPATIENT DRUG FREE TREATMENT SERVICES | $22,516,000 | $287,800 | $24,330,000 | $772,510 | $1,814,000 | $484,710 |
| 66 | INTENSIVE OUTPATIENT TREATMENT SERVICES | $8,377,000 | $1,218,750 | $9,458,000 | $1,419,370 | $1,081,000 | $200,620 |
| 68 | RESIDENTIAL TREATMENT SERVICES | $1,481,000 | $18,150 | $1,505,000 | $49,000 | $24,000 | $30,850 |
| | **DRUG MEDI-CAL SUBTOTAL** | **$180,917,000** | **$3,504,300** | **$193,864,000** | **$7,567,030** | **$12,947,000** | **$4,062,730** |
| | **MENTAL HEALTH** | | | | | | |
| 70 | SMHS FOR ADULTS | $1,285,401,000 | $16,006,150 | $1,425,027,000 | $41,156,000 | $139,626,000 | $25,149,850 |
| 71 | SMHS FOR CHILDREN | $1,058,354,000 | $887,950 | $1,127,659,000 | $2,266,660 | $69,305,000 | $1,378,710 |
| | **MENTAL HEALTH SUBTOTAL** | **$2,343,755,000** | **$16,894,100** | **$2,552,686,000** | **$43,422,660** | **$208,931,000** | **$26,528,560** |
| | **MANAGED CARE** | | | | | | |
| 96 | TWO PLAN MODEL | $19,603,938,000 | $5,440,445,630 | $20,478,370,000 | $5,606,509,640 | $874,432,000 | $166,064,010 |
| 97 | COUNTY ORGANIZED HEALTH SYSTEMS | $7,891,527,000 | $2,175,773,670 | $7,985,671,000 | $2,275,153,800 | $94,144,000 | $99,380,130 |
| 99 | GEOGRAPHIC MANAGED CARE | $3,677,114,000 | $957,185,730 | $3,798,337,000 | $995,254,430 | $121,223,000 | $38,068,700 |
| 102 | REGIONAL MODEL | $1,201,454,000 | $314,024,710 | $1,219,782,000 | $338,889,950 | $18,328,000 | $24,865,240 |
| 104 | PACE (Other M/C) | $418,255,000 | $209,127,500 | $421,796,000 | $182,132,000 | $3,541,000 | ($26,995,500) |
| 106 | DENTAL MANAGED CARE (Other M/C) | $126,718,000 | $42,667,050 | $133,170,000 | $46,959,170 | $6,452,000 | $4,292,120 |
| 107 | SENIOR CARE ACTION NETWORK (Other M/C) | $70,571,000 | $35,285,500 | $65,050,000 | $32,525,000 | ($5,521,000) | ($2,760,500) |

# COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
# CURRENT YEAR COMPARED TO BUDGET YEAR
# FISCAL YEARS 2016-17 AND 2017-18

| | | MAY 2017 EST. FOR 2016-17 | | MAY 2017 EST. FOR 2017-18 | | DIFFERENCE | |
|---|---|---|---|---|---|---|---|
| NO. | POLICY CHANGE TITLE | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS | TOTAL FUNDS | GENERAL FUNDS |
| | **MANAGED CARE** | | | | | | |
| 108 | AIDS HEALTHCARE CENTERS (Other M/C) | $9,628,000 | $4,814,000 | $19,750,000 | $9,875,000 | $10,122,000 | $5,061,000 |
| 110 | FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C) | $0 | $0 | $3,117,000 | $1,558,500 | $3,117,000 | $1,558,500 |
| | **MANAGED CARE SUBTOTAL** | **$32,999,205,000** | **$9,179,323,790** | **$34,125,043,000** | **$9,488,857,490** | **$1,125,838,000** | **$309,533,700** |
| | **OTHER** | | | | | | |
| 167 | MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS | $3,080,719,000 | $1,649,153,500 | $3,270,379,000 | $1,751,636,500 | $189,660,000 | $102,483,000 |
| 168 | MEDICARE PAYMENTS - PART D PHASED-DOWN | $1,915,760,000 | $1,915,760,000 | $2,125,280,000 | $2,125,280,000 | $209,520,000 | $209,520,000 |
| 169 | HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.) | $1,603,877,000 | $0 | $1,736,805,000 | $0 | $132,928,000 | $0 |
| 170 | PERSONAL CARE SERVICES (Misc. Svcs.) | $1,119,545,000 | $0 | $1,464,250,000 | $0 | $344,705,000 | $0 |
| 171 | DENTAL SERVICES | $975,699,000 | $302,772,320 | $1,171,505,000 | $401,821,340 | $195,806,000 | $99,049,020 |
| 173 | DEVELOPMENTAL CENTERS/STATE OP SMALL FAC | $207,330,000 | $0 | $207,330,000 | $0 | $0 | $0 |
| 175 | TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.) | $215,538,000 | $0 | $194,996,000 | $0 | ($20,542,000) | $0 |
| 177 | WAIVER PERSONAL CARE SERVICES (Misc. Svcs.) | $44,055,000 | $22,027,500 | $46,068,000 | $23,034,000 | $2,013,000 | $1,006,500 |
| 178 | MEDI-CAL TCM PROGRAM | $35,392,000 | $0 | $30,063,000 | $0 | ($5,329,000) | $0 |
| 179 | EPSDT SCREENS | $35,413,000 | $16,952,960 | $34,832,000 | $16,675,000 | ($581,000) | ($277,960) |
| 186 | LAWSUITS/CLAIMS | $5,358,000 | $2,203,500 | $2,013,000 | $1,080,500 | ($3,345,000) | ($1,123,000) |
| 187 | HIPP PREMIUM PAYOUTS (Misc. Svcs.) | $1,313,000 | $656,500 | $1,307,000 | $653,500 | ($6,000) | ($3,000) |
| 188 | CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.) | $1,291,000 | $0 | $1,028,000 | $0 | ($263,000) | $0 |
| 203 | BASE RECOVERIES | ($321,820,000) | ($154,655,000) | ($352,303,000) | ($169,305,000) | ($30,483,000) | ($14,650,000) |
| | **OTHER SUBTOTAL** | **$8,919,470,000** | **$3,754,871,280** | **$9,933,553,000** | **$4,150,875,840** | **$1,014,083,000** | **$396,004,560** |
| | **GRAND TOTAL** | **$44,518,924,000** | **$12,955,770,670** | **$46,844,215,000** | **$13,691,910,900** | **$2,325,291,000** | **$736,140,230** |

# MEDI-CAL PROGRAM BASE
# POLICY CHANGE INDEX

| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
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| 177 | WAIVER PERSONAL CARE SERVICES (MISC. SVCS.) |
| 178 | MEDI-CAL TCM PROGRAM |
| 179 | EPSDT SCREENS |
| 186 | LAWSUITS/CLAIMS |
| 187 | HIPP PREMIUM PAYOUTS (MISC. SVCS.) |

# MEDI-CAL PROGRAM BASE
# POLICY CHANGE INDEX


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **OTHER** |
| 188 | CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.) |
| 203 | BASE RECOVERIES |

# SMHS FOR ADULTS

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

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,285,401,000 | $1,425,027,000 |
| - STATE FUNDS | $81,965,150 | $109,657,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,285,401,000 | $1,425,027,000 |
| STATE FUNDS | $81,965,150 | $109,657,000 |
| FEDERAL FUNDS | $1,203,435,850 | $1,315,370,000 |

## DESCRIPTION

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

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

**Interdependent Policy Changes:**
Not Applicable

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

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

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

The responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have 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.

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, for Short-Doyle Medi-Cal (SD/MC) and Fee-For-Service (FFS) Inpatient, is a net decrease due to updated estimated utilization and costs, based on additional claims data through September 2016 for SD/MC and claims through July 2016 for FFS Inpatient.

The change from the prior estimate, for FY 2017-18, for SD/MC, is a net decrease based on updated estimated utilization. The change from the prior estimate, for FY 2017-18, for FFS Inpatient, is a decrease due to updated utilization and cost projections.

The change between FY 2016-17 and FY 2017-18, in the current estimate, is due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2017-18, based on projections.

**Methodology:**
1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2016, with dates of service from December 2010 through September 2016. The FFS data is current as of December 31, 2016, with dates of service from October 2010 through July 2016.

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. Therefore, the most recent 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.

# SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

4. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

| Adult | FY 2016-17 Utilization | FY 2017-18 Utilization |
|---|---|---|
| SD/MC | 232,869 | 233,810 |
| SD/MC ACA | 155,115 | 181,101 |
| FFS | 13,501 | 13,529 |
| FFS ACA | 14,866 | 16,770 |
| Total | 416,351 | 445,210 |

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

(Dollars in Thousands)

| Fiscal Year | TF | SD/MC | FFS Inpatient |
|---|---|---|---|
| FY 2014-15 | $1,629,308 | $1,427,633 | $201,675 |
| FY 2015-16 | $1,740,890 | $1,513,122 | $227,768 |
| FY 2016-17 | $1,905,499 | $1,657,479 | $248,020 |
| FY 2017-18 | $2,075,331 | $1,809,099 | $266,232 |

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 62% of FY 2015-16 claims, and 37% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient adult claims, the Department will be paying 1% of FY 2014-15 claims, 69% of FY 2015-16 claims, and 30% of FY 2016-17 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

| Fiscal Year | TF | SD/MC | FFS Inpatient |
|---|---|---|---|
| FY 2014-15 | $16,293 | $14,276 | $2,017 |
| FY 2015-16 | $1,101,827 | $944,749 | $157,078 |
| FY 2016-17 | $680,518 | $606,023 | $74,495 |
| Total FY 2016-17 | $1,798,638 | $1,565,048 | $233,590 |

7. On a cash basis for FY 2017-18, the Department will be paying 1% of FY 2015-16 claims, 62% of FY 2016-17 claims, and 37% of FY 2017-18 claims for SD/MC claims. For FFS Inpatient adult claims, the Department will be paying 1% of FY 2015-16 claims, 69% of FY 2016-17 claims, and 30% of FY 2017-18 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

| Fiscal Year | TF | SD/MC | FFS Inpatient |
|---|---|---|---|
| FY 2015-16 | $17,409 | $15,131 | $2,278 |
| FY 2016-17 | $1,205,925 | $1,034,881 | $171,044 |
| FY 2017-18 | $741,427 | $661,462 | $79,965 |
| Total FY 2017-18 | $1,964,761 | $1,711,474 | $253,287 |

# SMHS FOR ADULTS

## BASE POLICY CHANGE NUMBER: 70

8. The chart below shows the FY 2016-17 and FY 2017-18 estimate with the following funding adjustments:
   - Medi-Cal claims are eligible for 50% federal reimbursement,
   - ACA is funded by 100% federal funds (FF) until December 31, 2016, 95% FF and 5% GF until December 31, 2017, and 94% FF and 6% GF until December 31, 2018, and
   - GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

| FY | TF | FF | ACA FF | ACA GF | County | GF Reimbursement |
|---|---|---|---|---|---|---|
| **2016-17** | $1,798,638 | **$579,197** | **$624,239** | **$16,006** | $513,237 | **$65,959** |
| **2017-18** | $1,964,761 | **$608,235** | **$707,135** | **$41,156** | $539,734 | **$68,501** |

**Funding:**
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
100% Reimbursement (4260-601-0995)
95% Title XIX FF / 5% GF (4260-101-0001/0890)
94% Title XIX FF / 6% GF (4260-101-0001/0890)

# TWO PLAN MODEL

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 96 |
| IMPLEMENTATION DATE: | 7/2000 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 56 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $19,603,938,000 | $20,478,370,000 |
| - STATE FUNDS | $5,440,445,630 | $6,116,509,640 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $19,603,938,000 | $20,478,370,000 |
| STATE FUNDS | $5,440,445,630 | $6,116,509,640 |
| FEDERAL FUNDS | $14,163,492,370 | $14,361,860,360 |

## DESCRIPTION

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

**Authority:**
Welfare & Institutions Code 14087.3
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
PC 112 Capitated Rate Adjustment for FY 2017-18

**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:**
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously expected average monthly utilizers, and
- Lower POV 250 costs due to lower rates and eligible months.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used in the prior estimate, and
- Higher than previously expected ACA eligible months.

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 96

The change from FY 2016-17 to FY 2017-18, is an increase in the current estimate due to:

- Higher eligible months,
- Higher Hepatitis C costs due to higher utilization in FY 2017-18, and
- Higher ACA costs due to higher ACA eligible months in FY 2017-18.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change.
Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increases by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

**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. 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 the Managed Care Rate Range IGTs policy change. The base IGT capitation payments for Alameda County are budgeted in this policy change.

3. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $433,796,000 for FY 2016-17 and $438,675,000 for FY 2017-18 were included in the rates.

5. The savings from AB 97 are included in the rates. Savings of $260,899,000 for FY 2016-17 and $265,306,000 for FY 2017-18 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 FY 2016-17 rates, but have been removed for FY 2017-18.

7. Acupuncture services are included in the rates as of July 1, 2016.

8. Capitation rate increases due to the MCO Enrollment 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 Enrollment Tax Mgd. Care Plans - Funding Adjustment policy changes.

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

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 96

10. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP of 88/12 was budgeted for OTLICP.

11. Of the nonfederal share for this policy change in 2017-18, $510.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

12. Two Plan Model costs on an accrual basis are:

(Dollars in Thousands)

| FY 2016-17 | Eligible Months | Total |
|---|---|---|
| Alameda | 3,877,235 | $994,359 |
| Contra Costa | 2,551,696 | $650,957 |
| Kern | 3,835,666 | $828,645 |
| Los Angeles | 35,699,652 | $8,405,584 |
| Riverside | 8,331,783 | $1,785,818 |
| San Bernardino | 8,432,229 | $1,802,194 |
| San Francisco | 1,884,288 | $569,432 |
| San Joaquin | 2,930,069 | $565,583 |
| Santa Clara | 4,152,757 | $924,855 |
| Stanislaus | 2,384,166 | $585,029 |
| Tulare | 2,498,729 | $476,941 |
| Fresno | 4,946,332 | $1,158,962 |
| Kings | 552,610 | $107,447 |
| Madera | 659,754 | $134,458 |
| Total | 82,736,969 | $18,990,264 |
| Hepatitis C Adjustment | | $491,684 |
| **Total FY 2016-17** | | **$19,481,948** |

(Dollars in Thousands)

| Included in the Above Dollars | FY 2016-17 |
|---|---|
| Mental Health | $433,795 |
| AB 97 | ($260,898) |

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 96

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| Alameda | 3,924,681 | $1,026,649 |
| Contra Costa | 2,571,771 | $673,204 |
| Kern | 3,889,005 | $840,873 |
| Los Angeles | 36,002,436 | $8,904,418 |
| Riverside | 8,463,785 | $1,898,861 |
| San Bernardino | 8,583,903 | $1,929,615 |
| San Francisco | 1,925,863 | $586,747 |
| San Joaquin | 2,960,640 | $596,955 |
| Santa Clara | 4,163,461 | $945,538 |
| Stanislaus | 2,420,523 | $607,958 |
| Tulare | 2,523,866 | $475,818 |
| Fresno | 5,001,637 | $1,174,303 |
| Kings | 559,926 | $112,469 |
| Madera | 666,396 | $138,787 |
| Total | 83,657,894 | $19,912,195 |
| Hepatitis C Adjustment | | $572,377 |
| **Total FY 2017-18** | | **$20,484,572** |

(Dollars in Thousands)

| Included in the Above Dollars | FY 2017-18 |
|---|---|
| Mental Health | $438,674 |
| AB 97 | ($265,306) |

**Funding:** The dollars below account for a one month payment deferral:

(Dollars in Thousands)

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $10,287,422 | $5,143,711 | $5,143,711 |
| State GF | $31,692 | $31,692 | $0 |
| ACA 100% FFP | $5,025,468 | $0 | $5,025,468 |
| ACA 95/5 GF | $3,474,327 | $173,716 | $3,300,611 |
| Family Planning 90/10 GF | $143,860 | $14,385 | $129,475 |
| Title XXI 88/12 GF | $641,169 | $76,940 | $564,229 |
| **Total** | **$19,603,938** | **$5,440,444** | **$14,163,494** |

# TWO PLAN MODEL

## BASE POLICY CHANGE NUMBER: 96

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $10,031,697 | $5,015,849 | $5,015,848 | $0 |
| State GF | $32,061 | $32,061 | $0 | $0 |
| ACA 95/5 GF | $5,003,502 | $250,175 | $4,753,327 | $0 |
| ACA 94/6 GF | $3,590,531 | $215,432 | $3,375,099 | $0 |
| Family Planning 90/10 GF | $153,815 | $15,382 | $138,433 | $0 |
| Title XXI 88/12 GF | $646,764 | $77,612 | $569,152 | $0 |
| Healthcare Treatment Fund | $510,000 | $0 | $0 | $510,000 |
| Title XIX 100% | $510,000 | $0 | $510,000 | $0 |
| **Total** | **$20,478,370** | **$5,606,510** | **$14,361,860** | **$510,000** |

# COUNTY ORGANIZED HEALTH SYSTEMS

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 97 |
| IMPLEMENTATION DATE: | 12/1987 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 57 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $7,891,527,000 | $7,985,671,000 |
| - STATE FUNDS | $2,175,773,670 | $2,385,153,800 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $7,891,527,000 | $7,985,671,000 |
| STATE FUNDS | $2,175,773,670 | $2,385,153,800 |
| FEDERAL FUNDS | $5,715,753,330 | $5,600,517,200 |

## 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
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
PC 112 Capitated Rate Adjustment for FY 2017-18

**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:**
The change from the prior estimate, for FY 2016-17, is a decrease due to the following:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers, and
- Higher AB 97 savings due to updated enrollments (included in base rates).

The change from the prior estimate, for FY 2017-18, is a decrease due to the following:

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used for FY 2017-18 in the prior estimate,
- Lower Hepatitis C costs due to lower than previously estimated average monthly utilizers, and
- Higher AB 97 savings due to updated enrollments (included in base rates).

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 97

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- Higher eligible months,
- Higher Hepatitis C costs due to higher utilization in FY 2017-18 than in FY 2016-17, and
- Inclusion of Medi-Cal Access Program (MCAP) service costs into the base rate as of July 1, 2017.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change.
Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increases by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

**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. 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 the Managed Care Rate Range IGTs PC. 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 updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

5. Capitation rate increases due to the MCO Enrollment 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 Enrollment 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 $155,724,000 for FY 2016-17 and $157,546,000 for FY 2017-18 were included in the rates.

7. The savings from AB 97 are included in the rates. Savings of $91,939,000 for FY 2016-17 and $93,921,000 for FY 2017-18 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.

8. Acupuncture services are included in the base rates as of July 1, 2016.

9. The MCAP services are included in the base rates as of July 1, 2017.

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 97

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

11. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP.

12. Of the nonfederal share for this policy change in 2017-18, $110.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

13. COHS dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2016-17 | Eligible Months | Total |
|---|---|---|
| 501- San Luis Obispo | 669,306 | $191,984 |
| 502- Santa Barbara | 1,478,442 | $431,046 |
| 503- San Mateo | 1,360,178 | $400,909 |
| 504- Solano | 1,362,710 | $446,616 |
| 505- Santa Cruz | 839,567 | $235,518 |
| 506-Orange | 9,353,192 | $2,654,974 |
| 507- Napa | 349,391 | $123,777 |
| 508-Monterey | 1,865,307 | $468,306 |
| 509- Yolo | 644,434 | $202,566 |
| 513- Sonoma | 1,356,620 | $429,383 |
| 514- Merced | 1,525,367 | $337,978 |
| 510 - Marin | 458,729 | $174,353 |
| 512 - Mendocino | 446,703 | $139,107 |
| 515 - Ventura | 2,497,108 | $649,566 |
| 523 - Del Norte | 136,799 | $42,645 |
| 517 - Humboldt | 630,145 | $199,913 |
| 511 - Lake | 359,957 | $110,845 |
| 518 - Lassen | 87,746 | $27,440 |
| 519 - Modoc | 36,435 | $13,025 |
| 520 - Shasta | 727,280 | $243,307 |
| 521 - Siskiyou | 211,990 | $62,374 |
| 522 - Trinity | 55,007 | $17,824 |
| Total FY 2016-17 | 26,452,416 | $7,603,456 |
| Hepatitis C Adjustment | | $199,017 |
| **Total with Adjustments** | | **$7,802,473** |

(Dollars in Thousands)

| Included in Above Dollars | FY 2016-17 |
|---|---|
| Mental Health | $155,724 |
| AB 97 | ($91,939) |

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 97

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| 501- San Luis Obispo | 668,966 | $195,104 |
| 502- Santa Barbara | 1,484,539 | $432,934 |
| 503- San Mateo | 1,360,696 | $383,306 |
| 504- Solano | 1,361,608 | $449,774 |
| 505- Santa Cruz | 835,376 | $239,739 |
| 506-Orange | 9,505,685 | $2,679,266 |
| 507- Napa | 357,128 | $127,845 |
| 508-Monterey | 1,886,948 | $483,355 |
| 509- Yolo | 644,769 | $210,439 |
| 513- Sonoma | 1,372,745 | $444,441 |
| 514- Merced | 1,547,620 | $351,284 |
| 510 - Marin | 471,859 | $180,843 |
| 512 - Mendocino | 456,038 | $141,092 |
| 515 - Ventura | 2,493,743 | $667,089 |
| 523 - Del Norte | 138,299 | $44,570 |
| 517 - Humboldt | 643,567 | $210,576 |
| 511 - Lake | 366,918 | $117,160 |
| 518 - Lassen | 89,385 | $28,974 |
| 519 - Modoc | 36,835 | $13,622 |
| 520 - Shasta | 733,489 | $254,174 |
| 521 - Siskiyou | 216,573 | $66,134 |
| 522 - Trinity | 55,770 | $18,725 |
| Total FY 2017-18 | 26,728,555 | $7,740,446 |
| Hepatitis C Adjustment | | $231,678 |
| **Total with Adjustments** | | **$7,972,124** |

(Dollars in Thousands)

| Included in Above Dollars | FY 2017-18 |
|---|---|
| Mental Health | $157,546 |
| AB 97 | ($93,921) |

# COUNTY ORGANIZED HEALTH SYSTEMS

## BASE POLICY CHANGE NUMBER: 97

**Funding:**
The dollars below account for a one month payment deferral:

(Dollars in Thousands)

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $4,094,573 | $2,047,286 | $2,047,287 |
| State GF | $12,885 | $12,885 | $0 |
| Family Planning 90/10 GF | $48,803 | $4,880 | $43,923 |
| Title XXI 88/12 GF | $347,596 | $41,712 | $305,884 |
| ACA Optional Expansion 100% FFP | $2,007,463 | $0 | $2,007,463 |
| ACA Optional Expansion 95/5 GF | $1,380,207 | $69,011 | $1,311,196 |
| **Total** | **$7,891,527** | **$2,175,774** | **$5,715,753** |

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $4,077,656 | $2,038,828 | $2,038,828 | $0 |
| State GF | $12,818 | $12,818 | $0 | $0 |
| Family Planning 90/10 GF | $48,643 | $4,865 | $43,778 | $0 |
| Title XXI 88/12 GF | $337,428 | $40,492 | $296,936 | $0 |
| ACA Optional Expansion 95/5 | $1,919,542 | $95,977 | $1,823,565 | $0 |
| ACA Optional Expansion 94/6 | $1,369,584 | $82,175 | $1,287,409 | $0 |
| Healthcare Treatment Fund | $110,000 | $0 | $0 | $110,000 |
| Title XIX 100% FFP | $110,000 | $0 | $110,000 | $0 |
| **Total** | **$7,985,671** | **$2,275,155** | **$5,600,516** | **$110,000** |

# GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,677,114,000 | $3,798,337,000 |
| - STATE FUNDS | $957,185,730 | $1,055,254,430 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,677,114,000 | $3,798,337,000 |
| STATE FUNDS | $957,185,730 | $1,055,254,430 |
| FEDERAL FUNDS | $2,719,928,270 | $2,743,082,570 |

## 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
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
PC 112 Capitated Rate Adjustment for FY 2017-18

**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.

The Department is implementing two new health plans in Sacramento and San Diego, United Healthcare Community Plan of California and Aetna Better Health of California. The Department anticipates United Healthcare Community Plan of California to begin providing services no sooner than July 1, 2017 and Aetna Better Health of California to begin providing services no sooner than January 1, 2018.

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, is an increase due to:

- Final rates for FY 2016-17 replaces draft rates used in the prior estimate,
- Higher than previously estimated eligible months, and
- Mental Health costs based on higher enrollments (included in base rates).

The change from the prior estimate, for FY 2017-18, is an increase due to:

- FY 2017-18 draft rates replaces FY 2016-17 draft rates used for FY 2017-18 in the prior estimate, and
- Mental Health costs based on higher enrollments (included in base rates).

# GEOGRAPHIC MANAGED CARE

## BASE POLICY CHANGE NUMBER: 99

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Higher eligible months in FY 2017-18, and
- Higher Hepatitis C costs due to higher utilization in FY 2017-18.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change.
Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increases by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

**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 FFP. 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. 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 the Managed Care Rate Range IGTs policy change.

3. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

4. Capitation rate increases due to MCO Enrollment Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment 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 $74,009,000 for FY 2016-17 and $75,006,000 for FY 2017-18 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $46,415,000 for FY 2016-17 and $47,405,000 for FY 2017-18 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.

7. Acupuncture services are included in the base rates as of July 1, 2016.

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

9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP.

10. Of the nonfederal share for this policy change in 2017-18, $60.0 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

# GEOGRAPHIC MANAGED CARE

## BASE POLICY CHANGE NUMBER: 99

11. GMC dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2016-17 | Eligible Months | Total |
|---|---|---|
| Sacramento | 5,346,953 | $1,276,855 |
| San Diego | 8,656,838 | $2,309,538 |
| Total | 14,003,791 | $3,586,393 |
| Hepatitis C Adjustment | | $90,892 |
| **Total FY 2016-17** | | **$3,677,285** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2016-17 |
|---|---|
| Mental Health | $74,009 |
| AB 97 | ($46,415) |

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| Sacramento | 5,396,708 | $1,317,790 |
| San Diego | 8,792,493 | $2,370,989 |
| Total | 14,189,201 | $3,688,779 |
| Hepatitis C Adjustment | | $105,809 |
| **Total FY 2017-18** | | **$3,794,588** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2017-18 |
|---|---|
| Mental Health | $75,006 |
| AB 97 | ($47,405) |

# GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 99

**Funding:**
The dollars below account for a one month payment deferral:

(Dollars in Thousands)

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $1,790,328 | $895,164 | $895,164 |
| State GF | $5,695 | $5,695 | $0 |
| Family Planning 90/10 GF | $27,190 | $2,719 | $24,471 |
| Title XXI 88/12 GF | $152,719 | $18,326 | $134,393 |
| ACA Optional Expansion 100% FF | $995,553 | $0 | $995,553 |
| ACA Optional Expansion 95/5 GF | $705,629 | $35,282 | $670,347 |
| **Total** | **$3,677,114** | **$957,186** | **$2,719,928** |

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF | SF |
|---|---|---|---|---|
| Title XIX 50/50 | $1,748,430 | $874,215 | $874,215 | $0 |
| State GF | $5,794 | $5,794 | $0 | $0 |
| Family Planning 90/10 GF | $27,805 | $2,781 | $25,024 | $0 |
| Title XXI 88/12 GF | $147,758 | $17,731 | $130,026 | $0 |
| ACA Optional Expansion 95/5 GF | $1,017,903 | $50,895 | $967,008 | $0 |
| ACA Optional Expansion 94/6 GF | $730,647 | $43,839 | $686,808 | $0 |
| Healthcare Treatment Fund | $60,000 | $0 | $0 | $60,000 |
| Title XIX 100% FFP | $60,000 | $0 | $60,000 | $0 |
| **Total** | **$3,798,337** | **$995,254** | **$2,743,081** | **$60,000** |

# REGIONAL MODEL

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 102 |
| IMPLEMENTATION DATE: | 11/2013 |
| ANALYST: | Andrew Yoo |
| FISCAL REFERENCE NUMBER: | 1842 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,201,454,000 | $1,219,782,000 |
| - STATE FUNDS | $314,024,710 | $341,289,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,201,454,000 | $1,219,782,000 |
| STATE FUNDS | $314,024,710 | $341,289,950 |
| FEDERAL FUNDS | $887,429,290 | $878,492,050 |

## DESCRIPTION

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

**Authority:**
AB 1467 (Chapter 23, Statutes of 2012)
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
PC 112 Capitated Rate Adjustment for FY 2017-18

**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:**
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- Lower than previously expected Hepatitis C average monthly utilizers, and
- Updated FY 2016-17 rates from draft rates to final rates.

The change from the prior estimate, for FY 2017-18, is a decrease due to:

- Updated FY 2017-18 rates from draft FY 2016-17 rates to draft FY 2017-18 rates, and
- Lower Hepatitis C rates and lower than previously expected average monthly utilizers.

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 102

The change from FY 2016-17 to FY 2017-18, is an increase in the current estimate due to:

- Higher expected eligible months,
- Higher ACA dollars due to higher ACA eligible months, and
- Higher Hepatitis C utilization in FY 2017-18.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change.
Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increases by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

**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 Enrollment Tax are initially paid from the GF. The GF is then reimbursed in arrears through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment 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 the Managed Care Rate Range IGTs policy change.

4. Rates have been updated for FY 2016-17 from draft FY 2016-17 rates in the prior estimate to final FY 2016-17 rates in the current estimate. FY 2017-18 rates have been updated from draft FY 2016-17 rates in the previous estimate, to draft FY 2017-18 rates in the current estimate.

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $27,215,000 for FY 2016-17 and $27,324,000 for FY 2017-18 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $11,493,000 for FY 2016-17 and $11,564,000 for FY 2017-18 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.

7. Acupuncture services are included in the base rates as of July 1, 2016.

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

9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 was budgeted for OTLICP.

10. Of the nonfederal share for this policy change in 2017-18, $2.4 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 102

11. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

| FY 2016-17 | Eligible Months | Total |
|---|---|---|
| Alpine | 2,816 | $816 |
| Amador | 78,909 | $20,290 |
| Butte | 789,521 | $224,264 |
| Calaveras | 117,525 | $31,174 |
| Colusa | 85,840 | $17,050 |
| El Dorado | 360,478 | $94,173 |
| Glenn | 118,260 | $26,956 |
| Inyo | 47,216 | $11,506 |
| Mariposa | 46,263 | $12,410 |
| Mono | 33,361 | $7,760 |
| Nevada | 245,009 | $63,422 |
| Placer | 567,852 | $139,692 |
| Plumas | 58,074 | $16,208 |
| Sierra | 6,808 | $1,953 |
| Sutter | 396,290 | $91,994 |
| Tehama | 246,889 | $63,316 |
| Tuolumne | 133,501 | $36,101 |
| Yuba | 302,599 | $75,980 |
| Imperial | 907,345 | $206,255 |
| San Benito | 97,649 | $16,873 |
| Total FY 2016-17 | 4,642,205 | $1,158,193 |
| Hepatitis C Adjustment | | $30,756 |
| **Total with Adjustments** | | **$1,188,949** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2016-17 |
|---|---|
| Mental Health | $27,215 |
| AB 97 | ($11,493) |

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 102

(Dollars in Thousands)

| FY 2017-18 | Eligible Months | Total |
|---|---|---|
| Alpine | 2,786 | $826 |
| Amador | 79,735 | $20,659 |
| Butte | 789,387 | $227,846 |
| Calaveras | 118,798 | $31,998 |
| Colusa | 86,948 | $17,675 |
| El Dorado | 360,951 | $95,551 |
| Glenn | 119,338 | $27,554 |
| Inyo | 47,249 | $11,551 |
| Mariposa | 46,693 | $12,688 |
| Mono | 34,397 | $8,200 |
| Nevada | 243,348 | $64,014 |
| Placer | 571,496 | $143,107 |
| Plumas | 59,226 | $16,828 |
| Sierra | 6,818 | $1,976 |
| Sutter | 397,485 | $93,799 |
| Tehama | 246,321 | $64,196 |
| Tuolumne | 133,253 | $36,558 |
| Yuba | 302,949 | $77,411 |
| Imperial | 918,263 | $213,913 |
| San Benito | 100,530 | $17,376 |
| Total FY 2017-18 | 4,665,972 | $1,183,726 |
| Hepatitis C Adjustment | | $35,804 |
| **Total with Adjustments** | | **$1,219,530** |

(Dollars in Thousands)

| Included in Dollars Above | FY 2017-18 |
|---|---|
| Mental Health | $27,324 |
| AB 97 | ($11,564) |

# REGIONAL MODEL

## BASE POLICY CHANGE NUMBER: 102

**Funding:**

The dollars below account for a one month payment deferral:

(Dollars in Thousands)

| FY 2016-17 | | TF | GF | FF |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | $589,267 | $294,634 | $294,634 |
| State GF | 4260-101-0001 | $1,933 | $1,933 | $0 |
| ACA 100% FFP | 4260-101-0890 | $329,368 | $0 | $329,368 |
| ACA 95/5 GF | 4260-101-0890 | $229,307 | $11,465 | $217,842 |
| Family Planning 90/10 GF | 4260-101-0001/0890 | $9,831 | $983 | $8,848 |
| OTLICP 88/12 GF | 4260-113-0001/0890 | $41,748 | $5,010 | $36,738 |
| **Total** | | **$1,201,454** | **$314,025** | **$887,430** |

(Dollars in Thousands)

| FY 2017-18 | | TF | GF | FF | SF |
|---|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | $601,639 | $300,819 | $300,820 | $0 |
| State GF | 4260-101-0001 | $1,755 | $1,755 | $0 | $0 |
| ACA 95/5 GF | 4260-101-0890 | $326,397 | $16,320 | $310,077 | $0 |
| ACA 94/6 FFP | 4260-101-0890 | $233,779 | $14,027 | $219,752 | $0 |
| Family Planning 90/10 GF | 4260-101-0001/0890 | $10,029 | $1,002 | $9,026 | $0 |
| OTLICP 88/12 GF | 4260-113-0001/0890 | $41,383 | $4,966 | $36,417 | $0 |
| Healthcare Treatment Fund | 4260-101-3305 | $2,400 | $0 | $0 | $2,400 |
| Title XIX 100% FFP | 4260-101-0890 | $2,400 | $0 | $2,400 | $0 |
| **Total*** | | **$1,219,782** | **$338,890** | **$878,492** | **$2,400** |

*Difference due to rounding.

# PACE (Other M/C)

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 104 |
| IMPLEMENTATION DATE: | 7/1992 |
| ANALYST: | Randolph Alarcio |
| FISCAL REFERENCE NUMBER: | 62 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $418,255,000 | $421,796,000 |
| - STATE FUNDS | $209,127,500 | $210,898,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $418,255,000 | $421,796,000 |
| STATE FUNDS | $209,127,500 | $210,898,000 |
| FEDERAL FUNDS | $209,127,500 | $210,898,000 |

## DESCRIPTION

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

**Authority:**
Welfare & Institutions Code 14591-14594
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. 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 95% of the FFS Upper Payment Limits (UPL), pursuant to SB 870.

The Department worked with PACE Organizations to support passage of the PACE Modernization Act through the FY 2016-17 budget, authorizing changes to current law to transition from a FFS based methodology to a PACE experience based rate methodology. The Department has engaged a rate workgroup with the PACE Organizations, the California PACE Association, and their contracted actuaries to revise the existing UPL methodology and develop the new experience-based rate methodology. The legislation requires that the effective date for implementation of the new rate

# PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 104

methodology will be no sooner than July 1, 2017. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

The Governor's Budget estimate of the Coordinated Care Initiative (CCI) projects that it will no longer be cost-effective. Therefore, pursuant to the provisions of current law, the program will be discontinued in 2017-18. Based on the lessons learned from the CCI demonstration project, the Budget proposes the extension of the Cal MediConnect program and the mandatory enrollment of dual eligible and integrating of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS would be removed from capitation rate payments effective January 1, 2018.

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 |

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, is an overall increase due to the implementation of the 2016 PACE rates for all plans in April 2017 and 2017 PACE rates for all plans in September 2017. The change from the prior estimate, for FY 2017-18, is a decrease due to a slight drop in the projected overall enrollment. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to actual eligible month trending at a 6% increase.

In addition to the changes specified above, another change is the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for new growth in expenditures as compared to the 2016 Budget Act for this policy change. Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increases by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

**Methodology:**

1. Assume the January 2016 through June 2017 rates are calculated using the existing comparable population FFS UPL methodology.

# PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 104

2. FY 2016-17 and FY 2017-18 estimated funding is based on pending CMS approval of calendar year (CY) 2016 rates and projected CY 2017 and CY 2018 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 worked with PACE Organizations to support legislation authorizing changes to current law to transition from an UPL-based methodology to an actuarially sound experienced-based methodology. The legislation requires that the effective date for implementation of the new rate methodology will be no sooner than July 1, 2017.

5. The Department anticipates receiving CMS approval of contract amendments implementing 2016 rates in February 2017, retroactive to January 2016. This results in a repayment of $42,552,000 for the increase of Non-dual and Dual rates that were paid at 2016 PACE rates from January to March 2017. The repayment is expected to occur during the April 2017 capitation cycle.

6. The Department anticipates the submission of CY 2017 rates to CMS in May 2017 with a projected approval date by CMS in August 2017, retroactive to January 2017. This will result in a repayment of approximately $12,806,000 to the PACE plans. The repayment is expected to occur during the September 2017 capitation cycle.

7. Of the non-federal share for this policy change in 2017-18, $30 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

| FY 2016-17 | TF Cost (Rounded) | Eligible Months | Avg. Monthly Enrollment |
|---|---|---|---|
| Centers for Elders' Independence (Alameda and Contra Costa | $43,194,000 | 8,127 | 677 |
| Sutter Senior Care | $14,761,000 | 3,148 | 262 |
| AltaMed Senior BuenaCare | $120,235,000 | 25,217 | 2,101 |
| OnLok (SF, Alameda and Santa Clara) | $96,195,000 | 17,122 | 1,427 |
| St. Paul's PACE | $31,084,000 | 6,736 | 561 |
| Los Angeles Jewish Homes | $9,506,000 | 2,160 | 180 |
| CalOptima PACE | $10,531,000 | 2,148 | 179 |
| InnovAge (San Bernardino and Riverside) | $17,764,000 | 3,595 | 300 |
| Redwood Coast | $4,555,000 | 1,087 | 91 |
| Central Valley Medical Services | $16,123,000 | 3,338 | 278 |
| San Ysidro San Diego | $11,755,000 | 2,198 | 183 |
| **Total Capitation Payments** | $375,703,000 | 74,876 | 6,239 |
| | | | |
| 2016 Rate Repayment | $42,552,000 | | |
| **Total FY 2016-17** | **$418,255,000** | | |

*Totals may differ due to rounding.

# PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 104

| FY 2017-18 | TF Cost (Rounded) | Eligible Months | Avg. Monthly Enrollment |
|---|---|---|---|
| Centers for Elders' Independence (Alameda and Contra Costa) | $44,501,000 | 8,109 | 676 |
| Sutter Senior Care | $15,335,000 | 3,160 | 263 |
| AltaMed Senior BuenaCare | $134,949,000 | 27,383 | 2,282 |
| OnLok (SF, Alameda and Santa Clara) | $99,436,000 | 17,130 | 1,428 |
| St. Paul's PACE | $36,871,000 | 7,715 | 643 |
| Los Angeles Jewish Homes | $9,863,000 | 2,168 | 181 |
| CalOptima PACE | $10,832,000 | 2,153 | 179 |
| InnovAge (San Bernardino and Riverside) | $18,759,000 | 3,660 | 305 |
| Redwood Coast | $4,726,000 | 1,092 | 91 |
| Central Valley Medical Services | $16,921,000 | 3,432 | 286 |
| San Ysidro San Diego | $16,797,000 | 3,072 | 256 |
| **Total Capitation Payments** | $408,990,000 | 79,074 | 6,590 |
| | | | |
| 2017 Rate Repayment | $12,806,000 | | |
| **Total FY 2017-18** | **$421,796,000** | | |

*Totals may differ due to rounding.

**Funding:**

FY 2016-17: 50% Title XIX / 50% GF (4260-101-0001/0890)

FY 2017-18: 50% Title XIX / 50% GF (4260-101-0001/0890) $364,264,000
Healthcare Treatment Fund (4260-101-3305) $ 28,766,000
Title XIX 100% FFP (4260-101-0890) $ 28,766,000

# 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 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,080,719,000 | $3,270,379,000 |
| - STATE FUNDS | $1,649,153,500 | $1,751,636,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,080,719,000 | $3,270,379,000 |
| STATE FUNDS | $1,649,153,500 | $1,751,636,500 |
| FEDERAL FUNDS | $1,431,565,500 | $1,518,742,500 |

## 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 125 Medicare Part B Adjustment

**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:**
The change from the prior estimate for FY 2016-17 is due to:

1. The actual 2017 Medicare Part B premium is higher than estimated in the November 2016 Estimate; the 2017 Part B premium from the Medicare Part B Adjustment policy change is now included in this estimate.
2. The estimated change in both Medicare Part A and Part B eligibles. Since the November 2016 Estimate, both Part A and Part B eligibles exhibited a slower growth for FY 2016-17 than previously estimated.

The change from the prior estimate for FY2017-18 is due to:

1. Higher Part B premium rate estimate: the Part B premium from the Medicare Part B Adjustment policy change is now included in this estimate.
2. Slower growth estimate for both Part A and Part B eligibles.

The change from FY 2016-17 to FY 2017-18 is related to:

1. Projected growth in the premium for both Part A and Part B.
2. Continued moderate growth expected in both Part A and Part B eligible counts.

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

BASE POLICY CHANGE NUMBER: 167

| | 2016 | 2017 | | 2018 | |
|---|---|---|---|---|---|
| | Actual | November 2016 Estimate | May 2017 Actual | November 2016 Estimate | May 2017 Estimate |
| | Premiums | | | | |
| Part A | $411.00 | $413.00 | $413.00 | $425.00 | $425.00 |
| Part B | $121.80 | $121.80 | $134.00 | $124.40 | $134.00 |
| | Average Estimated Monthly Eligibles | | | | |
| Part A | | 178,400 | 176,800 | 182,100 | 179,700 |
| Part B | | 1,382,500 | 1,377,800 | 1,414,000 | 1,411,400 |

**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 following rates for 2016 and 2017:

| Calendar Year | Part A Premium | Part B Premium |
|---|---|---|
| 2016 | $ 411.00 | $ 121.80 |
| 2017 | $ 413.00 | $ 134.00 |

3. For 2018, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, projected at 2.8% growth in the Medicare Part A premiums. Applying this growth to the 2017 Part A Premium ($413 x 1.028) = $425 (rounded)

4. The Medicare Part B premium is budgeted at $134.00 in this policy change and the projected 2018 premium change is budgeted in the Medicare Part B Adjustment policy change.

| **FY 2016-17** | **Part A** | **Part B** |
|---|---|---|
| Average Monthly Eligibles | 176,800 | 1,377,800 |
| Rate 07/2016-12/2016 | $411.00 | $121.80 |
| Rate 01/2017-06/2017 | $413.00 | $134.00 |

| **FY 2017-18** | | |
|---|---|---|
| Average Monthly Eligibles | 179,700 | 1,411,400 |
| Rate 07/2017-12/2017 | $413.00 | $134.00 |
| Rate 01/2018-06/2018 | $425.00 | $134.00 |

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

## BASE POLICY CHANGE NUMBER: 167

(Dollars in Thousands)

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $2,784,929 | $1,392,464 | $1,392,465 |
| State GF 100% | $256,689 | $256,689 | $0 |
| Title XIX 100% FFP | $39,101 | $0 | $39,101 |
| **Total** | **$3,080,719** | **$1,649,153** | **$1,431,566** |

(Dollars in Thousands)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Title XIX 50/50 | $2,953,781 | $1,476,890 | $1,476,891 |
| State GF 100% | $274,746 | $274,746 | $0 |
| Title XIX 100% FFP | $41,852 | $0 | $41,852 |
| **Total** | **$3,270,379** | **$1,751,636** | **$1,518,743** |

# MEDICARE PAYMENTS - PART D PHASED-DOWN

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 168 |
| IMPLEMENTATION DATE: | 1/2006 |
| ANALYST: | Joulia Dib |
| FISCAL REFERENCE NUMBER: | 1019 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,915,760,000 | $2,125,280,000 |
| - STATE FUNDS | $1,915,760,000 | $2,125,280,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,915,760,000 | $2,125,280,000 |
| STATE FUNDS | $1,915,760,000 | $2,125,280,000 |
| 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:**
Medicare's Part D benefit began January 1, 2006. 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 decreased by 1 ⅔% each year until it reached 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:

| Calendar Year | PMPM rate |
|---|---|
| 2014 | $97.40 |
| 2015 | $98.76 |
| 2016 | $110.23 |
| 2017 | $123.38 |
| 2018 | $125.10 (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 2013-14 | $1,479,580,071 | 1,213,682 |
| FY 2014-15 | $1,522,511,847 | 1,296,510 |
| FY 2015-16 | $1,670,974,353 | 1,357,168 |

**Reason for Change:**
The change from the prior estimate for FY 2016-17 is due to a decrease in recent eligible counts of approximately 3,900 average monthly eligibles. The change from the prior estimate for FY 2017-18 is due to a decrease in the estimated 2018 PMPM from $137.92 to $125.10. The change between FY 2016-17 and FY 2017-18 is due to an estimated increase of $1.72 PMPM for 2018 and estimated historical growth in eligibles.

**Methodology:**

1. The 2016 growth increased 11.61% over 2015 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2016 is $110.23.

2. The 2017 growth increased 11.93% over 2016 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2017 is $123.38.

3. The 2018 growth is estimated to increase 1.38% based on the Part D 2017 annual percentage increase from *Centers for Medicare & Medicaid Services.* Medi-Cal's estimated PMPM for 2018 is $125.10.

4. Phase-down payments have a two-month lag (i.e., the invoice for January is received in February and due in March).

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from July 2011 to January 2017.

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 2016-17** | 12 | 1,392,884 | $159,646,700 | **$1,915,760,000** |
| **FY 2017-18** | 12 | 1,428,765 | $177,106,700 | **$2,125,280,000** |

**Funding:**
100% GF (4260-101-0001)

# DENTAL SERVICES

| | |
|---|---|
| BASE POLICY CHANGE NUMBER: | 171 |
| IMPLEMENTATION DATE: | 7/1988 |
| ANALYST: | Nikaela Ratliff |
| FISCAL REFERENCE NUMBER: | 135 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $975,699,000 | $1,171,505,000 |
| - STATE FUNDS | $302,772,320 | $401,821,340 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $975,699,000 | $1,171,505,000 |
| STATE FUNDS | $302,772,320 | $401,821,340 |
| FEDERAL FUNDS | $672,926,680 | $769,683,660 |

## DESCRIPTION

**Purpose:**
The policy change estimates the cost of dental services.

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

**Interdependent Policy Changes:**
PC 40 Dental Children's Outreach Ages 0-3
PC 44 Beneficiary Outreach and Education Program
PC 46 Allied Dental Professionals Enrollment
PC 47 CHDP Program Dental Referral

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

The Department has acquired approval for a one-year extension of the current contract with Delta for the period July 1, 2016 through September 30, 2017. The Department is currently seeking approval on an additional contract extension amendment to extend through Assumption of Operations of the new contractors.

Delta was awarded a multi-year Administrative Services Organization (ASO) contract in 2016. The ASO contractor is responsible for duties including claims processing, provider enrollment, and outreach of the Medi-Cal Dental Program. Hewlett Packard Enterprise (HPE) was awarded a multi-year FI contract in 2016. HPE is responsible for all the FI services of the Medi-Cal Dental Program.

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

# DENTAL SERVICES

## BASE POLICY CHANGE NUMBER: 171

serves Medi-Cal beneficiaries, including Federally Qualified Health Clinics (FQHCs) and Rural Health Centers (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, Federally Required Adult Dental 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.

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, is an overall decrease due to an increase in ACA optional average monthly eligibles, a decrease in regular average monthly eligibles, and a decrease in costs to be paid in FY 2016-17 for the Health Insurance Provider Fee (HIPF). The change from the prior estimate, for FY 2017-18, is an overall decrease due to an increase in ACA optional average monthly eligibles, a decrease in regular average monthly eligibles, a decrease in the rate, and a decrease in costs to be paid in FY 2017-18 for the HIPF. The change from FY 2016-17 to FY 2017-18, in the current estimate, is an overall increase due to the inclusion of the underwriting gain/loss in FY 2016-17, an increase in average monthly eligibles for the ACA optional and regular populations in FY 2017-18, and an increase in costs to be paid in FY 2017-18 for the HIPF.

**Methodology:**

1. The proposed FY 2015-16 capitation rate of $8.32 is used in both FY 2016-17 and FY 2017-18 for regular and refugee eligibles as there is a single rate for both populations. FY 2015-16 rates include the exemption from AB 97.

2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ending June 30, 2015 resulted in an underwriting gain of $179.1 million. According to the contract distribution provisions, the Department will receive $174.5 million and Delta will retain $4.7 million in FY 2016-17.

3. The impact of the HIPF for the first six months of CY 2015 is $3,958,000 in FY 2016-17. The impact of the HIPF for the second six months of CY 2015 is $4,007,000 in FY 2017-18.

4. Of the nonfederal share for this policy change in 2017-18, $44,170,000 in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

(Dollars in Thousands)

| **FY 2016-17** | **Rate** | **Average Monthly Eligibles** | **Total Funds** |
|---|---|---|---|
| Regular 7/15 – 6/16 | $8.32 | 8,243,092 | $822,990 |
| Other FFS | Non-Capitated | | $7,399 |
| | | Subtotal | $830,389 |
| HIPF Add-on | | | $3,265 |
| Underwriting Gain | | | ($174,469) |
| | | Total | $659,185 |
| ACA | | | |
| ACA Optional Dental | $8.32 | 3,163,269 | $315,821 |
| HIPF Add-on | | | $693 |
| ACA Subtotal | | | $316,514 |
| | | **Total FY 2016-17** | **$975,699** |

# DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

(Dollars in Thousands)

| FY 2017-18 | Rate | Average Monthly Eligibles | Total Funds |
|---|---|---|---|
| Regular 7/15 – 6/16 | $8.32 | 8,266,378 | $825,315 |
| Other FFS | Non-Capitated | | $6,840 |
| | | Subtotal | $832,155 |
| HIPF Add-on | | | $2,839 |
| ACA | | | |
| ACA Optional Dental | $8.32 | 3,358,809 | $335,343 |
| HIPF Add-on | | | $1,168 |
| ACA Subtotal | | | $336,511 |
| | | **Total FY 2017-18** | **$1,171,505** |

**Funding (Totals may differ due to rounding):**

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| 88% Title XXI / 12% GF (4260-113-0001/0890) | $80,176,000 | $9,621,120 | $70,554,880 |
| 65% Title XIX / 35% GF (4260-101-0001/0890) | $477,000 | $166,950 | $310,050 |
| 100% GF (4260-101-0001) | $62,000 | $62,000 | $0 |
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $569,574,000 | $284,787,000 | $284,787,000 |
| 100% Title XIX ACA (4260-101-0890) | $162,705,000 | $0 | $162,705,000 |
| 95% Title XIX ACA FF / 5% GF (4260-101-0001/0890) | $162,705,000 | $8,135,250 | $154,569,750 |
| **Total** | **$975,699,000** | **$302,772,320** | **$672,926,680** |

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 88% Title XXI / 12% GF (4260-113-0001/0890) | $80,310,000 | $9,637,200 | $70,672,800 |
| 65% Title XIX / 35% GF (4260-101-0001/0890) | $477,000 | $166,950 | $310,050 |
| 100% GF (4260-101-0001) | $62,000 | $62,000 | $0 |
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $657,658,000 | $328,829,000 | $328,829,000 |
| 95% Title XIX ACA FF / 5% GF (4260-101-0001/0890) | $172,329,000 | $8,616,450 | $163,712,550 |
| 94% Title XIX ACA FF / 6% GF (4260-101-0001/0890) | $172,329,000 | $10,339,740 | $161,989,260 |
| 100% Title XIX FFP (4260-101-0890) | $44,170,000 | | $44,170,000 |
| Healthcare Treatment Fund | $44,170,000 | $44,170,000 | |
| **Total** | **$1,171,505,000** | **$401,821,340** | **$769,683,660** |

# MEDI-CAL PROGRAM REGULAR
# POLICY CHANGE INDEX

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# MEDI-CAL PROGRAM REGULAR
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# MEDI-CAL PROGRAM REGULAR
# POLICY CHANGE INDEX


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# NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10
IMPLEMENTATION DATE: 12/1998
ANALYST: Jason Moody
FISCAL REFERENCE NUMBER: 13

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $401,000,000 |
| - STATE FUNDS | $53,229,010 | -$78,752,490 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $401,000,000 |
| STATE FUNDS | $53,229,010 | -$78,752,490 |
| FEDERAL FUNDS | -$53,229,010 | $479,752,490 |

## DESCRIPTION

**Purpose:**
This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are 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:**
Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate. The other CHIP eligibility categories are budgeted in this policy change.

- Resource Disregard Program: Prior to the implementation of the Affordable Care Act (ACA), Medi-Cal had asset limitations where families that exceeded it were eligible through the CHIP Resource Disregard Program. However, the ACA requires that states raise the minimum income level to at least 133 percent of the 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. Until these children transition out of the associated aid codes, the Department continues to budget the adjustment in this policy change. (Aid codes 8N, 8P, 8R, 8T)

- Medicaid Expansion: This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL. (Aid codes M5, M6)

# NON-OTLICP CHIP

## REGULAR POLICY CHANGE NUMBER: 10

- Hospital Presumptive Eligibility (HPE): Effective January 1, 2016, the ACA requires the Department to give hospitals the option to determine 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. CHIP coverage extends to a portion of HPE. (Aid codes H0, H6, H9)

- California was granted a proxy methodology (CS3-Proxy) to claim enhanced FMAP for children formerly eligible for CHIP who are now eligible for Medicaid. Due to the ACA and pursuant to 42 CFR 435.907(e), California may not collect information concerning asset eligibility and, therefore, the State cannot determine which children are only eligible for Medicaid because of the loosening of the asset test rules and would have received CHIP funding. The CS3-Proxy aims to provide the same level of CHIP funding as before this change.

**Reason for Change:**
The change from the prior estimate for FY 2016-17 and FY 2017-18 is a decrease in GF savings due to prior year CS3-Proxy adjustments. The GF savings decrease is slightly offset in both FY's by an increase in Medicaid Expansion expenditures, based on the addition of fee for service data through January 2017 and managed care data through September 2016, which results in additional adjustments to enhanced FFP. The change from FY 2016-17 to FY 2017-18 in the current estimate is an increase in GF savings mostly due to the CS3-Proxy adjustment, but slightly offset by a decrease in estimated expenditures for Resource Disregard, HPE and the Medicaid Expansion populations.

**Methodology:**

1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be $471,388,000 TF in FY 2016-17 and $465,028,000 TF in FY 2017-18.

(Dollars in Thousands)

| FY 2016-17 | TF | GF |
|---|---|---|
| Resource Disregard | $32,015 | ($12,166) |
| HPE | $4,763 | ($1,810) |
| Medicaid Expansion | $434,610 | ($165,152) |
| **Total Cost** | **$471,388** | **($179,127)** |

| FY 2017-18 | TF | GF |
|---|---|---|
| Resource Disregard | $30,067 | ($11,425) |
| HPE | $4,595 | ($1,746) |
| Medicaid Expansion | $430,366 | ($163,539) |
| **Total Cost** | **$465,028** | **($176,710)** |

2. 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 October 1, 2015, estimated costs are eligible for Title XXI 88/12 FMAP.

3. The Department has starting claiming under the CS3-Proxy in March 2016 with a two-year lag. This adjustment shifts funding from Title 19 federal funds with a 50% General Fund match to Title 21 federal funds with a 35% General Fund match. Four quarterly adjustments will occur in FY 2016-17 and FY 2017-18 (Ongoing Adjustment).

# NON-OTLICP CHIP

REGULAR POLICY CHANGE NUMBER: 10

4. The 2014 and the Jan – March 2015 adjustments overdrew CHIP funding. In FY 2017-18, the Department will repay the CHIP Title XXI federal funds and corresponding General Fund (Fund 4260-113-0001) and utilize General Fund (4260-101-0001) and Title XIX federal funds.

**Funding:**
(Dollars in Thousands)

| FY 2016-17 | | TF | GF | FF |
|---|---|---|---|---|
| 50 % Title XIX /50 % GF | 4260-101-0001/0890 | ($1,074,461) | ($537,230) | ($537,230) |
| Title XIX FF | 4260-101-0890 | ($45,522) | $0 | ($45,522) |
| Title XIX GF | 4260-101-0001 | $499,998 | $499,998 | $0 |
| 65% Title XXI / 35% GF | 4260-113-0001/0890 | $148,597 | $52,009 | $96,588 |
| Title XXI FF | 4260-113-0890 | $18,114 | $0 | $18,114 |
| Title XXI GF | 4260-113-0001 | ($18,114) | ($18,114) | $0 |
| 88 % Title XXI /12 % GF | 4260-113-0001/0890 | $471,388 | $56,567 | $414,821 |
| **Net Impact** (rounded) | | **$0** | **$53,229** | **($53,229)** |

| FY 2017-18 | | TF | GF | FF |
|---|---|---|---|---|
| 50 % Title XIX /50 % GF | 4260-101-0001/0890 | ($261,311) | ($130,655) | ($130,655) |
| Title XIX FF | 4260-101-0890 | $14,491 | $0 | $14,491 |
| Title XIX GF | 4260-101-0001 | ($67,967) | ($67,967) | $0 |
| 65% Title XXI / 35% GF | 4260-113-0001/0890 | $250,759 | $87,766 | $162,993 |
| Title XXI FF | 4260-113-0890 | $23,699 | $0 | $23,699 |
| Title XXI GF | 4260-113-0001 | ($23,699) | ($23,699) | $0 |
| 88 % Title XXI /12 % GF | 4260-113-0001/0890 | $465,028 | $55,803 | $409,225 |
| **Net Impact** (rounded) | | **$401,000** | **($78,752)** | **$479,752** |

*Difference in totals is due to rounding

# NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 12/1997
ANALYST: Jason Moody
FISCAL REFERENCE NUMBER: 15

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $985,633,000 | $899,150,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $985,633,000 | $899,150,000 |
| FEDERAL FUNDS | -$985,633,000 | -$899,150,000 |

## DESCRIPTION

**Purpose:**
This policy change is a technical adjustment to shift funds from Title XIX and Title XXI 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), Permanent Residence Under the Color of Law (PRUCOL), and undocumented children.

**Authority:**
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code 14007.5
SB 75 (Chapter 18, Statutes of 2015)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
HR 3734 (1996), PRWORA, specifies that FFP is not available for full-scope Medi-Cal services for qualified, nonexempt immigrants who have resided in the United States for less than five years since their date of entry. 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.

Previously, California provided restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to many low income undocumented children. FFP was available, regardless of immigration status, for emergency and pregnancy related services. Effective May 16, 2016, individuals under age 19 and who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship are eligible for full scope Medi-Cal benefits. 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.

# NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 11

**Reason for Change:**
The increase from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the addition of FFS and managed care expenditure data from July 2016 through December 2016 that includes costs for SB 75 undocumented children (previously identified in PC 2 Undocumented Children Full Scope Expansion), which began transitioning to full-scope Medi-Cal in May, 2016. There was also a technical adjustment to include enhanced funding categories, which had previously not been included. The increase is slightly offset by the exclusion of the Children's Health Insurance Program Reauthorization Act (CHIPRA) population in updated FFS expenditure reports.

The decrease from FY 2016-17 to FY 2017-18 in the current estimate, is due to updated estimated expenditure projections. This is mostly driven by a reduction in estimated costs for the managed care ACA population.

**Methodology:**

1. Based on updated July through December 2016 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be $299,647,000 TF in FY 2016-17 and $291,447,000 TF in FY 2017-18.

2. Based on July 2016 through December 2016 managed care reports of non-emergency services provided to this population, the Department estimates non-emergency managed care capitation costs for the ACA optional expansion population will be $583,241,000 TF in FY 2016-17 and $537,735,000 TF in FY 2017-18. The repayment for this group will be 100% FFP for FY 2016-17 until January, 2017 when FFP changes to 95%. For FY 2017-18, the repayment for this group will be 94% from January 2018 to December 2018.

3. Based on January 2016 through December 2016 managed care reports of non-emergency services provided to this population, the Department estimates non-emergency managed care capitation costs for the non-ACA (All Others) population will be $515,092,000 TF in FY 2016-17 and $473,336,000 in FY 2017-18. The repayment for this group is at 50/50 FMAP and 88/12 FMAP.

4. The implementation date for full-scope coverage for eligible undocumented children under SB 75 was May 16, 2016. As of November 30, 2016, 100% of the 120,614 undocumented children enrolled in restricted-scope Medi-Cal transitioned to full-scope Medi-Cal. As of March 2, 2017, 61,917 eligible but not enrolled undocumented children were determined newly eligible for full-scope Medi-Cal. The total number of undocumented children enrolled in full-scope Medi-Cal is 182,531.

5. 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.

6. 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.

7. Of the nonfederal share for this policy change in 2017-18, $77 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

8. The estimated FFP Repayment in FY 2016-17 and FY 2017-18:

# NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 11

(Dollars in Thousands)

| | FY 2016-17 | | FY 2017-18 | |
|---|---|---|---|---|
| **FFS and MC costs** | **TF** | **FF Repayment** | **TF** | **FF Repayment** |
| All Others (50% FF / 50% GF) | 785,593 | $392,796 | $738,202 | $369,101 |
| All Others (65% FF / 35% GF) | $8,035 | $5,223 | $7,683 | $4,994 |
| All Others (88% FF / 12% GF) | $17,155 | $15,097 | $14,801 | $13,025 |
| ACA | $587,197 | $572,517 | $541,831 | $512,030 |
| **Total** | $1,397,980 | **$985,633** | $1,302,517 | **$899,150** |

**Funding:**
100% Title XIX FFP (4260-101-0890)
100% Title XIX ACA FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
100% GF (4260-101-0001)

# PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 8/2011
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1632

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$11,933,000 | -$25,087,000 |
| - STATE FUNDS | -$5,966,500 | -$17,168,000 |
| PAYMENT LAG | 0.9654 | 0.9711 |
| % REFLECTED IN BASE | 77.64 % | 75.34 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$2,575,900 | -$6,007,700 |
| STATE FUNDS | -$1,287,950 | -$4,111,280 |
| FEDERAL FUNDS | -$1,287,950 | -$1,896,390 |

## DESCRIPTION

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

**Authority:**
Welfare & Institutions Code 14124.11
Military & Veterans Code 972.5

**Interdependent Policy Changes:**
Not Applicable

**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.

As a result of the implementation of the Affordable Care Act, several million new beneficiaries enrolled in Medi-Cal over the last three 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: 14

**Reason for Change:**
The reason for change from prior estimate, for FY 2016-17 and FY 2017-18, is an increase in savings due to updated managed care (MC) rates and fee-for-service (FFS) per member per month (PMPM) costs, as well as updated discontinued eligibles. Discontinuances were increased from 311 to 328 in FY 2016-17 and to 520 in FY 2017-18. The estimated average PMPM savings increased from $187.69 to $248.03 in FY 2016-17 and FY 2017-18. The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to updated payment lag, percent in base, and dollars in base data for FY 2017-18.

**Methodology:**

1. The Department currently operates PARIS-Veterans in 58 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 programs.

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

3. It is estimated program expenditures will be reduced for 328 veterans (220 MC and 108 FFS) in FY 2016-17 and 520 veterans (348 MC and 172 FFS) in FY 2017-18. The Department expects that savings will continue in budget year through discontinuances, share of cost modifications, and cost avoidance by identifying Other Health Coverage.

4. Estimated average PMPM savings is $248.03 in FY 2016-17 and FY 2017-18. These savings are not captured in the base trends.

5. In FY 2016-17, it is estimated that 77.64% of the MC and FFS savings is captured in the base trends. In FY 2017-18, it is estimated that 75.34% of the MC and FFS savings is captured in the base trends.

6. Total estimated savings are $11,933,000 for FY 2016-17 and $25,087,000 for FY 2017-18.

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

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

REGULAR POLICY CHANGE NUMBER: 55
IMPLEMENTATION DATE: 7/2015
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1931

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $28,263,000 | $87,390,000 |
| - STATE FUNDS | $13,050,400 | $39,927,680 |
| PAYMENT LAG | 0.9230 | 0.9650 |
| % REFLECTED IN BASE | 55.26 % | 17.66 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $11,671,200 | $69,438,400 |
| STATE FUNDS | $5,389,170 | $31,725,780 |
| FEDERAL FUNDS | $6,282,050 | $37,712,660 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of new high cost treatments for specific medical conditions.

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

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Medi-Cal program provides needed health care services and treatments for low-income individuals and people with specific diseases who receive case management and care coordination from the California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP). This policy change budgets new high cost services and treatments recently approved by the U.S. Food and Drug Administration (FDA) separately until the costs of these services are fully incorporated into the rates.

Recently approved FDA treatments and services covered under the Medi-Cal Program are:

- Orkambi: A two-drug therapy combining the drugs ivacaftor with lumacaftor in a single pill designed to address chloride channel abnormalities in cystic fibrosis (CF) patients.
- DEFLAZACORT: A once weekly lifetime intravenous infusion for the treatment of Duchenne Muscular Dystrophy (DMD) patients.
- Exondys 51: A once weekly lifetime intravenous infusion for the treatment of DMD in patients who have a confirmed mutation in the DMD gene that is amenable to Exondys 51 skipping.
- SPINRAZA: A continuous, life long, intrathecally administered drug treatment program for spinal muscular atrophy (SMA).

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

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

REGULAR POLICY CHANGE NUMBER: 55

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, is an overall increase due to:

- The addition of three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries, and
- A lower than anticipated number of GHPP beneficiaries receiving Orkambi.

The change from the prior estimate, for FY 2017-18, is an overall increase due to:

- The addition of three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA) for CCS beneficiaries,
- The CCS removal of the Orkambi forced expiratory volume (FEV) threshold and hospitalization authorization criteria for beneficiaries 20 years of age or younger, and
- A lower than anticipated number of GHPP beneficiaries receiving Orkambi.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is an increase due to:

- The continued phase-in of additional CCS beneficiaries receiving the three recently approved treatments and services (DEFLAZACORT, Exondys 51 and SPINRAZA), and
- The CCS removal of the Orkambi FEV threshold and hospitalization authorization criteria for beneficiaries 20 years of age or younger.

**Methodology:**

1. For FY 2016-17 and FY 2017-18, Orkambi cost are estimated as follows:

   - The cost of Orkambi for FY 2015-16 was $224,000 per beneficiary per year.
   - Based on actuals, assume a 5% increase in Orkambi costs per beneficiary per year.

     FY 2016-17: $224,000 + 5% = $235,000 per beneficiary per year
     FY 2017-18: $235,000 + 5% = $247,000 per beneficiary per year

   - Assume a 24-month phase-in of eligibles beginning July 1, 2015.
   - Assume 71 CCS and 37 GHPP beneficiaries will be prescribed Orkambi by the end of FY 2016-17.
   - Due to the CCS removal of the FEV threshold and hospitalization authorization criteria for clients 20 years of age or younger, assume a 30% increase of eligible CCS beneficiaries over a 12 month period starting May 1, 2017.
   - Total estimated costs for Orkambi are:

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| CCS Medi-Cal: | $11,144,000 | $17,488,000 |
| CCS OTLICP: | $1,648,000 | $2,537,000 |
| GHPP: | $6,180,000 | $9,146,000 |
| Total Orkambi: | $18,972,000 | $29,171,000 |

2. For FY 2016-17 and FY 2017-18, DEFLAZACORT cost are estimated as follows:

   - Assume a $7,400 per member per month (PMPM) cost for each beneficiary receiving DEFLAZACORT.
   - Assume a 24-month phase in of 361 beneficiaries beginning February 1, 2017.
   - Total estimated costs DEFLAZACORT are:

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS
REGULAR POLICY CHANGE NUMBER: 55

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| CCS Medi-Cal: | $1,450,000 | $13,378,000 |
| CCS OTLICP: | $215,000 | $1,940,000 |
| Total DEFLAZACORT: | $1,665,000 | $15,318,000 |

3. For FY 2016-17 and FY 2017-18, Exondys 51 cost are estimated as follows:

   - Assume a $25,000 PMPM cost for each beneficiary receiving Exondys 51.
   - Assume a 24-month phase in of 42 beneficiaries beginning September 1, 2016.
   - Total estimated costs for Exondys 51 are:

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| CCS Medi-Cal: | $1,416,000 | $7,074,000 |
| CCS OTLICP: | $210,000 | $1,027,000 |
| Total Exondys 51: | $1,626,000 | $8,101,000 |

4. For FY 2016-17 and FY 2017-18, SPINRAZA cost are estimated as follows:

   - Assume 55 existing beneficiaries are eligible to receive SPINRAZA.
   - Assume a 24-month phase-in of the existing beneficiaries beginning January 1, 2017.
   - Assume each beneficiary will receive loading doses over the first 72 days of treatment for a total one-time cost of $750,000 per beneficiary, and then one dose every four months, for life, at a cost of $350,000 per does.
   - Total estimated costs for SPINRAZA are:

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| CCS Medi-Cal: | $5,228,000 | $30,390,000 |
| CCS OTLICP: | $772,000 | $4,410,000 |
| Total SPINRAZA: | $6,000,000 | $34,800,000 |

5. Of the nonfederal share for this policy change in 2017-18, $12,170,000 in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.

6. County funds will be allocated in the County Share of OTLICP-CCS Costs policy change.

| **FY 2016-17** | **TF** | **GF** | **FF** |
|---|---|---|---|
| CCS-Medi-Cal | $19,238,000 | $9,619,000 | $9,619,000 |
| CCS OTLICP | $2,845,000 | $342,000 | $2,503,000 |
| GHPP-Medi-Cal | $6,180,000 | $3,090,000 | $3,090,000 |
| **Total** | **$28,263,000** | **$13,051,000** | **$15,212,000** |

# NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS

REGULAR POLICY CHANGE NUMBER: 55

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| CCS-Medi-Cal | $68,330,000 | $34,165,000 | $34,165,000 |
| CCS OTLICP | $9,914,000 | $1,190,000 | $8,724,000 |
| GHPP-Medi-Cal | $9,146,000 | $4,573,000 | $4,573,000 |
| **Total** | **$87,390,000** | **$39,928,000** | **$47,462,000** |

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
100% Title XIX FFP (4260-101-0890)

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 4/2017
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 2012

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $21,503,000 | $580,548,000 |
| - STATE FUNDS | $4,162,000 | $124,364,740 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $21,503,000 | $580,548,000 |
| STATE FUNDS | $4,162,000 | $124,364,740 |
| FEDERAL FUNDS | $17,341,000 | $456,183,260 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver pilot program for opt-in counties to provide Substance Use Disorder (SUD) services.

**Authority:**
Drug Medi-Cal Organized Delivery System Waiver

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Under the State Plan, the Drug Medi-Cal program currently covers the following SUD services: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and the Narcotic Treatment Program (NTP).

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the DMC-ODS waiver. The DMC-ODS is a pilot project authorized originally under California's Section 1115 Bridge to Reform Demonstration Waiver and continued in the Medi-Cal 2020 Waiver. The purpose of the pilot program is to test a new paradigm for organized delivery of health care services for Medicaid eligible individuals with a substance use disorder.

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and additional new and expanded county optional services. Counties that opt-in to participate in the DMC-ODS waiver are required to provide a continuum of care to all eligible beneficiaries modeled after the American Society of Addiction Medicine (ASAM) Criteria. Counties will submit implementation plans and proposed interim rates for all county-covered SUD services, except for the NTP rates, which are set by the State.

Counties currently provide many of the required services (e.g. treatments covered by the current four modalities ODF, IOT, NTP, and Perinatal RTS) under the current DMC program and will continue to

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

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provide these when the county opts-in to the DMC-ODS waiver. The interim rate for the existing modalities, except NTP; however, will now be paid at the county-established rate instead of the State rates.

Additionally for counties opting in, the following new/expanded services, not currently separately reimbursable in the four modalities, will be available under the DMC-ODS waiver:

<u>Required</u>

- Non-perinatal Residential Treatment Services
- Withdrawal Management (Levels 1.0, 2.0, and 3.2)
- Recovery Services
- Case Management
- Physician Consultation
- Expanded Medication Assisted Treatment (MAT) (buprenorphine, naloxone, and disulfiram)

<u>Optional</u>

- Additional MAT (non-NTP Providers)
- Partial Hospitalization
- Withdrawal Management (Levels 3.7 and 4.0)

Interim payments of federal financial participation (FFP) will be made to the DMC-ODS counties based on submitted certified public expenditures (CPEs). Claims will be reimbursed based on the approved interim rate for the service subject to the applicable Federal Medical Assistance Percentage (FMAP). The State will complete the final settlement process within three years of the interim settlement. If underpayments are determined, the State will make additional payments to the counties and if overpayments are determined, the State will recoup the FFP from the counties.

The responsibility for Drug Medi-Cal services was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, state requirements enacted after September 30, 2012, that have 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 funding for the cost increase.

Funding for the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS) will remain the same. New services under the waiver, except for non-perinatal IOT and RTS expanded services, will be funded with federal funds (FF) and County Funds (CF). Consistent with prior estimates, expanded IOT and RTS services will be funded with FF and General Fund (GF).

Funding is generally 50% FF and 50% CF or 50% GF. 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, 95% beginning January 2017, and 94% beginning January 2018.

**Reason for Change:**

This change from the prior estimate, for FY 2016-17 and FY 2017-18, is due to the following:

- Updated county implementation schedule – The prior estimate assumed 16 counties to implement the DMC-ODS, six counties in FY 2016-17 and ten counties in FY 2017-18. The current estimate assumes seven counties to implement the waiver in FY 2016-17, and nine counties in FY 2017-18.
- System change delays – Payments to counties were delayed to April 2017.

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

## REGULAR POLICY CHANGE NUMBER: 64

- Updated approved county rates – The current estimate includes approved rates for three additional counties, for a total eight counties with approved rates.
  - FY 2016-17 – Riverside County's rates were revised and are significantly higher than previously estimated. As a result, the total cost for FY 2016-17 is slightly higher than the previous estimate.
  - FY 2017-18 – Los Angeles County's rates were revised and significantly lower than previously estimated. The projected annual cost for the remaining counties have decreased, and as a result, the total cost for FY 2017-18 have decreased significantly from the previous estimate.

The change in the current estimate, from FY 2016-17 to FY 2017-18, is primarily due to additional counties implementing the optional DMC-ODS waiver services in FY 2017-18 on a phase-in basis.

**Methodology:**

1. DMC-ODS waiver services for opt-in counties are assumed to begin in February 2017 on a phase-in basis. County implementation is expected to phase-in as follows:
   - Seven counties (San Mateo, Santa Cruz, Riverside, Santa Clara, Marin, San Francisco and Contra Costa) will begin providing services in FY 2016-17.
   - Nine additional counties (for a total of 16 counties) will begin providing services in FY 2017-18.

2. The cost estimate for waiver services is developed based on county approved rates, projected caseload, and projected total units of services (UOS) to be delivered.

<u>DMC-ODS Waiver Costs</u>

3. Costs for the new DMC-ODS waiver services are estimated to be:

| New Waiver Services | FY 2016-17 | | FY 2017-18 | |
|---|---|---|---|---|
| Required | Accrual | Cash | Accrual | Cash |
| Recovery Services | $3,140,000 | $1,239,000 | $56,551,000 | $47,731,000 |
| Case Mgmt | $4,116,000 | $1,790,000 | $48,019,000 | $41,242,000 |
| Physician Consult. | $342,000 | $185,000 | $8,182,000 | $6,789,000 |
| WM 1.0, 2.0, 3.2 | $1,388,000 | $583,000 | $20,504,000 | $17,421,000 |
| MAT Expansion | $1,277,000 | $494,000 | $11,516,000 | $10,324,000 |
| Subtotal | $10,263,000 | $4,291,000 | $144,772,000 | $123,507,000 |
| Optional | | | | |
| Partial Hospitalization | $269,000 | $91,000 | $1,379,000 | $1,249,000 |
| Additional MAT | $1,089,000 | $443,000 | $3,466,000 | $3,143,000 |
| Subtotal | $1,358,000 | $534,000 | $4,845,000 | $4,392,000 |
| | $11,621,000 | $4,825,000 | $149,617,000 | $127,899,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

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4. Costs for the existing modalities for the DMC-ODS waiver services are estimated to be:

| Services | FY 2016-17 | | FY 2017-18 | |
|---|---|---|---|---|
| Existing Modalities | Accrual | Cash | Accrual | Cash |
| IOT | $15,347,000 | $8,909,000 | $159,947,000 | $136,062,000 |
| RTS 3.1, 3.3, 3.5 | $13,041,000 | $5,807,000 | $333,639,000 | $277,622,000 |
| NTP | $7,026,000 | $2,425,000 | $112,675,000 | $95,317,000 |
| ODF | $11,223,000 | $5,625,000 | $153,395,000 | $129,912,000 |
| Subtotal | $46,637,000 | $22,766,000 | $759,656,000 | $638,913,000 |

Base Adjustments for Existing Modalities

5. Costs for the existing modalities are already budgeted in the related base policy changes. Costs budgeted in this policy change account for rate changes and service expansion. Costs already included in base were adjusted based on county phase-in.

| Services | Cost In Base | |
|---|---|---|
| Existing Modalities | FY 2016-17 | FY 2017-18 |
| IOT | $326,000 | $6,552,000 |
| RTS 3.1, 3.3, 3.5 | $13,000 | $201,000 |
| NTP | $2,264,000 | $91,856,000 |
| ODF | $483,000 | $11,476,000 |
| Total | $3,086,000 | $110,085,000 |

| FY 2016-17 | DMC Waiver - Cash Estimate | Less: Cost in Base | Cash Basis Adjustment |
|---|---|---|---|
| IOT | $8,909,000 | $326,000 | $8,583,000 |
| RTS 3.1, 3.3, 3.5 | $5,807,000 | $13,000 | $5,794,000 |
| NTP | $2,425,000 | $2,264,000 | $161,000 |
| ODF | $5,625,000 | $483,000 | $5,142,000 |
| Total | $22,766,000 | $3,086,000 | $19,680,000 |
| FY 2017-18 | | | |
| IOT | $136,062,000 | $6,552,000 | $129,510,000 |
| RTS 3.1, 3.3, 3.5 | $277,622,000 | $201,000 | $277,421,000 |
| NTP | $95,317,000 | $91,856,000 | $3,461,000 |
| ODF | $129,912,000 | $11,476,000 | $118,436,000 |
| Total | $638,913,000 | $110,085,000 | $528,828,000 |

Net DMC-ODS Waiver Costs

6. Total net cost for the DMC-ODS waiver services are:

| DMC-ODS Waiver Net Cost | FY 2016-17 | FY 2017-18 |
|---|---|---|
| Required Services | $4,291,000 | $123,507,000 |
| Optional Services | $534,000 | $4,392,000 |
| Existing Services | $19,680,000 | $528,828,000 |
| Total | $24,505,000 | $656,727,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64

| FY 2016-17 | TF | GF | FFP Title XIX | FFP Title XXI | CF |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $13,611,000 | $3,949,000 | $6,750,000 | $98,000 | $2,814,000 |
| ACA Optional | $10,545,000 | $211,000 | $10,282,000 | $0 | $52,000 |
| **Perinatal** | | | | | |
| Current | $275,000 | $0 | $135,000 | $4,000 | $136,000 |
| ACA Optional | $74,000 | $2,000 | $72,000 | $0 | $0 |
| **Total** | $24,505,000 | **$4,162,000** | **$17,239,000** | **$102,000** | $3,002,000 |

| FY 2017-18 | TF | GF | FFP Title XIX | FFP Title XXI | CF |
|---|---|---|---|---|---|
| **Regular** | | | | | |
| Current | $364,747,000 | $111,760,000 | $180,891,000 | $2,610,000 | $69,486,000 |
| ACA Optional | $282,617,000 | $12,497,000 | $267,071,000 | $0 | $3,049,000 |
| **Perinatal** | | | | | |
| Current | $7,381,000 | $0 | $3,629,000 | $108,000 | $3,644,000 |
| ACA Optional | $1,982,000 | $108,000 | $1,874,000 | $0 | $0 |
| **Total** | $656,727,000 | **$124,365,000** | **$453,465,000** | **$2,718,000** | $76,179,000 |

**Funding:**

| FY 2016-17 | TF | GF | FFP | CF |
|---|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $7,882,000 | $3,941,000 | $3,941,000 | $0 |
| 100% Title XIX FF (4260-101-0890) | $5,887,000 | $0 | $2,944,000 | $2,943,000 |
| 100% Title XXI FF (4260-113-0890) | $52,000 | $0 | $45,000 | $7,000 |
| 88% Title XXI FF / 12% GF (4260-113-0001/0890) | $65,000 | $8,000 | $57,000 | $0 |
| 100% ACA Title XIX FF (4260-101-0890) | $6,355,000 | $0 | $6,303,000 | $52,000 |
| 95% ACA Title XIX FF / 5% GF (4260-101-0001/0890) | $4,264,000 | $213,000 | $4,051,000 | $0 |
| **Total** | $24,505,000 | **$4,162,000** | **$17,341,000** | $3,002,000 |

# DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 64

| FY 2017-18 | TF | GF | FFP | CF |
|---|---|---|---|---|
| 50% Title XIX / 50% GF (4260-101-0001/0890) | $223,084,000 | $111,542,000 | $111,542,000 | $0 |
| 100% Title XIX FF (4260-101-0890) | $145,956,000 | $0 | $72,978,000 | $72,978,000 |
| 100% Title XXI FF (4260-113-0890) | $1,269,000 | $0 | $1,117,000 | $152,000 |
| 88% Title XXI FF / 12% GF (4260-113-0001/0890) | $1,819,000 | $218,000 | $1,601,000 | $0 |
| 100% ACA Title XIX FF (4260-101-0890) | $55,427,000 | $0 | $52,378,000 | $3,049,000 |
| 95% ACA Title XIX FF / 5% GF (4260-101-0001/0890) | $114,586,000 | $5,730,000 | $108,856,000 | $0 |
| 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890) | $114,586,000 | $6,875,000 | $107,711,000 | $0 |
| **Total** | $656,727,000 | **$124,365,000** | **$456,183,000** | $76,179,000 |

# MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 5/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1588

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $247,118,000 | $2,880,095,000 |
| - STATE FUNDS | $123,559,000 | $471,745,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $247,118,000 | $2,880,095,000 |
| STATE FUNDS | $123,559,000 | $471,745,000 |
| FEDERAL FUNDS | $123,559,000 | $2,408,350,000 |

## 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)
AB 85 (Chapter 24, Statutes of 2013)

**Interdependent Policy Changes:**
PC 119 General Fund Reimbursement from DPHs

**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 methodology to 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 prior FFS SPD members transitioning into managed care called for adjustments to the baseline SPD capitation rates. The historical Public Provider allowable costs for services are also recognized and included in the managed care capitation rates. Through IGTs, Public Providers will provide the non-federal share portion 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.

# MANAGED CARE PUBLIC HOSPITAL IGTS

## REGULAR POLICY CHANGE NUMBER: 100

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.

Effective January 1, 2014, the ACA expanded Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. The expansion of Medicaid coverage to previously ineligible persons is referred to as the Affordable Care Act optional expansion (ACA OE).

State law requires DPHs to be reimbursed at no less than the costs of providing services to the OE population. The payment structure for the OE members in managed care may require adjustments to the baseline OE capitation rates. Through an IGT, Public Providers will provide the non-federal share portion of the adjusted capitation rates related to the costs for this population. This portion is budgeted in the General Fund Reimbursements from DPHs Policy Change.

**Reason for Change:**
The change from the prior estimate, for FY 2016-17, is a decrease due to:

- ACA OE payments for FY 2015-16 and FY 2016-17 are expected to occur in FY 2017-18 and have been updated based on actuarial estimates.

The change from the prior estimate, for FY 2017-18, is an increase due to:

- A shift in ACA OE payments for FY 2015-16 and FY 2016-17 from FY 2016-17, and
- The addition of SPD and ACA OE payments for FY 2017-18.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- Timing of payments for both SPD and ACA OE payments, and
- ACA OE payments are not expected to be paid until FY 2017-18.

**Methodology:**
<u>DPH – SPDs</u>

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. Factor into the estimate the number of participants electing/not electing to enroll.
8. All out-of-network costs were included in the capitation rate increases; therefore, excess costs will not be paid for as part of the rate range IGTs as of July 1, 2014.
9. The SPD FY 2014-15 IGTs occurred in FY 2016-17. The FY 2013-14 DPH unexpended amounts of $665,426 was applied against the FY 2014-15 IGT collection.
10. The FY 2015-16, FY 2016-17, and FY 2017-18 payments are expected to occur in FY 2017-18. The actual IGTs have not yet been determined; therefore placeholders have been budgeted.

# MANAGED CARE PUBLIC HOSPITAL IGTS

## REGULAR POLICY CHANGE NUMBER: 100

DPH – OE

1. FY 2015-16 payments are expected to occur in FY 2017-18. $0 has been budgeted as the IGT amount as this rating period is funded solely by federal funds.
2. FY 2016-17 and FY 2017-18 payments are expected to occur in FY 2017-18. The final reimbursement has not yet been calculated, therefore, actuarial estimates have been budgeted. Estimated IGT amounts have been budgeted for these time periods to account for the cost based and rate range reimbursements.

(Dollars in Thousands)

| FY 2016-17 | TF | IGT | FF | ACA |
|---|---|---|---|---|
| SPD FY 2013-14 | *($665) | ($333) | ($333) | $0 |
| SPD FY 2014-15 | $247,784 | $123,892 | $123,892 | $0 |
| **Total FY 2016-17** | **$247,118** | **$123,559** | **$123,559** | **$0** |

| FY 2017-18 | TF | IGT | FF | ACA |
|---|---|---|---|---|
| SPD FY 2015-16 | $260,173 | $130,086 | $130,086 | $0 |
| SPD FY 2016-17 | $273,182 | $136,591 | $136,591 | $0 |
| SPD FY 2017-18 | *$286,841 | $143,420 | $143,420 | $0 |
| ACA OE FY 2015-16 | $518,700 | $0 | $0 | $518,700 |
| ACA OE FY 2016-17 | $770,600 | $19,265 | $0 | $751,335 |
| ACA OE FY 2017-18 | $770,600 | $42,383 | $0 | $728,217 |
| **Total FY 2017-18** | ***$2,880,095** | **$471,745** | ***$410,098** | **$1,998,252** |

*Difference due to rounding.

**Funding:**

100% Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)
100% Title XIX ACA (4260-101-0890)
95% Title XIX ACA FF / 5% GF (4260-101-0890)
94% Title XIX ACA FF / 6% GF (4260-101-0890)

# HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 135
IMPLEMENTATION DATE: 10/2006
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 96

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $2,638,000 | $24,014,000 |
| - STATE FUNDS | $1,319,000 | $12,007,000 |
| PAYMENT LAG | 0.7971 | 0.8945 |
| % REFLECTED IN BASE | 70.34 % | 7.26 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $623,700 | $19,921,000 |
| STATE FUNDS | $311,840 | $9,960,520 |
| FEDERAL FUNDS | $311,840 | $9,960,520 |

## 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
42 Code of Federal Regulations (CFR) Part 418 – CMS Final Rule

**Interdependent Policy Changes:**
PC 193 Funding Adjust.—ACA Opt. Expansion
PC 194 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 reimburses each hospice facility's room and board rate at 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.

   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

# HOSPICE RATE INCREASES

## REGULAR POLICY CHANGE NUMBER: 135

implement further rate freezes and payment reductions for long-term care (LTC) facilities, effective June 1, 2011. The Department removed the rate freeze for certain LTC facilities.

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:**

The change from the prior estimate, for FY 2016-17, is due to:

- Updated FY 2015-16 retroactive Erroneous Payment Correction (EPC) amount based on actuals provided by CA-MMIS;
- Shifts in rate and retroactive payment implementation dates due to system delays; and
- Revised Routine Home Care (RHC) estimates based on updated utilization through January 2017.

The change from the prior estimate, for FY 2017-18, is due to:

- Shifts in rate and retroactive payment implementation dates due to system delays; and
- Revised Routine Home Care (RHC) estimates based on updated utilization through January 2017.

The change from FY 2016-17 to FY 2017-18, in the current estimate, is due to:

- The impact of the FY 2015-16 RHC rates and FY 2016-17 hospice rate increases being budgeted in FY 2017-18;
- The FY 2016-17 hospice services retroactive EPC being implemented in FY 2017-18; and
- The implementation of the FY 2017-18 hospice rates in FY 2017-18.

**Methodology:**

1. 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.

2. The estimated weighted increase for hospice service rates for FY 2016-17 and FY 2017-18 is 1.97%.

# HOSPICE RATE INCREASES

## REGULAR POLICY CHANGE NUMBER: 135

3. Effective January 1, 2016, the CMS final hospice rule changes the payment methodology for Routine Home Care rates to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced payment rate for days thereafter. Based on utilization trends, it is assumed that 54.1% of beneficiaries have hospice stays of 60 days or less and 45.9% have hospice stays of 61 days or more.

   The CMS final hospice rule also establishes a Service Intensity Add-on (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary's life for a maximum of four hours a day. It is assumed that the maximum SIA payments will be applied to each hospice beneficiary.

4. The 2015-16 RHC rates and SIA are expected to be implemented December 2017, with the retroactive payment for the period of January 2016 through November 2017 expected to be implemented in May 2018.

5. The 2016-17 RHC rates and SIA are expected to be implemented March 2018, with the retroactive payment for the period of October 2016 through February 2018 expected to be implemented in August 2018.

6. The 2017-18 RHC rates and SIA are expected to be implemented September 2018, with the retroactive payment for the period of October 2017 through August 2018 expected to be implemented in FY 2018-19.

7. Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen. The weighted increase for hospice room and board rates for FY 2016-17 and FY 2017-18 is estimated to be 2.53%.

| Cash Basis | FY 2016-17 | FY 2017-18 |
|---|---:|---:|
| FY 2015-16 - RHC Hospice Services | $0 | $3,852,000 |
| FY 2015-16 - Retroactive Payments | $139,000 | $0 |
| FY 2016-17 - Hospice Services | $73,000 | $2,016,000 |
| FY 2016-17 - Room & Board | $2,426,000 | $2,647,000 |
| FY 2016-17 - Retroactive Payments | $0 | $12,801,000 |
| FY 2017-18 - Hospice Services | $0 | $210,000 |
| FY 2017-18 - Room & Board | $0 | $2,488,000 |
| **TOTAL** | **$2,638,000** | **$24,014,000** |

**Funding:**
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion
OTLICP funding identified in PC 194 Funding Adjust.—OTLICP

# ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 140 |
| IMPLEMENTATION DATE: | 10/2017 |
| ANALYST: | Sharisse DeLeon |
| FISCAL REFERENCE NUMBER: | 2000 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $51,000 |
| - STATE FUNDS | $0 | $25,500 |
| PAYMENT LAG | 1.0000 | 0.8703 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $44,400 |
| STATE FUNDS | $0 | $22,190 |
| FEDERAL FUNDS | $0 | $22,190 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of adjusted reimbursement rates that result from the amended rate-setting methodology for Fee-for-Service (FFS) all-inclusive delivery services provided in Alternative Birthing Centers (ABCs).

**Authority:**
AB 102 (Chapter 29, Statutes of 2011)
SB 97 (Chapter 52, Statutes of 2017)

**Interdependent Policy Changes:**
PC 193 Funding Adjust.—ACA Opt. Expansion

**Background:**
Currently, W&I Code Section 14148.8 requires the Department to provide Medi-Cal reimbursement to ABCs for facility and service related costs. These costs reflect a statewide all-inclusive delivery service rate, that does not exceed eighty percent of the average Medi-Cal reimbursement to General Acute Care (GAC) hospitals with Medi-Cal contracts. Under the Selective Provider Contracting Program (SPCP), the California Medical Assistance Commission (CMAC) negotiated GAC hospital inpatient rates.

Pursuant to AB 102, CMAC was dissolved, effective July 1, 2012. Consequently, the rate-setting responsibilities were transferred to the Department. Additionally, AB 102 required the Department to develop and implement a payment methodology based on Diagnosis-Related Groups (DRG). Upon implementation of the DRG methodology, the prior SPCP methodology was discontinued.

The DRG inpatient methodology was implemented for private hospitals beginning July 2013 and for Non-Designated Public Hospitals beginning January 2014.

The Department is currently amending W&I Code Section 14148.8 to reflect a rate-setting methodology for the Medi-Cal FFS ABCs all-inclusive delivery service rate, based on the Medi-Cal Level-1 DRG payment used for GACs, to be effective July 1, 2017.

# ALTERNATIVE BIRTHING CENTER REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 140

**Reason for Change:**
There is no material change for FY 2017-18 from the prior estimate.

**Methodology:**

1. Effective July 2017, the change to the ABC reimbursement methodology for the all-inclusive delivery service rate would result in an increased rate for ABC providers. The rate increase is expected to be implemented October 2017.

2. Retroactive payments for the period of July 1, 2017 through September 30, 2017, are expected to be implemented December 2017.

3. On average, there are approximately 200 all-inclusive FFS deliveries in an ABC each year. The incremental increase for the new Medi-Cal rate is $253 per delivery.

   200 deliveries x $253 increase = $51,000 TF (rounded)

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Rate Increase | $38,000 | $19,000 | $19,000 |
| Retro | $13,000 | $6,500 | $6,500 |
| **Total** | **$51,000** | **$25,500** | **$25,500** |

**Funding:**
50% Title XIX / 50% GF (4260-101-0001/0890)
ACA Optional Expansion funding identified in PC 193 Funding Adjust.—ACA Opt. Expansion

# OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 181
IMPLEMENTATION DATE: 2/2016
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1852

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $11,466,000 | $14,686,000 |
| - STATE FUNDS | $5,733,000 | $7,343,000 |
| PAYMENT LAG | 0.9760 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $11,190,800 | $14,686,000 |
| STATE FUNDS | $5,595,410 | $7,343,000 |
| FEDERAL FUNDS | $5,595,410 | $7,343,000 |

## DESCRIPTION

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

**Authority:**
Welfare & Institutions (W&I) Code, Section 12300.4

**Interdependent Policy Changes:**
Not Applicable

**Background:**
New federal regulations require In-Home Supportive Services (IHSS) and WPCS employees to be paid overtime adding costs to the Department related to the WPCS policy change. The W&I Code, Section 12300.4 identifies two additional costs to the IHSS and WPCS Program. These new areas include overtime and travel time to be paid at time and a half for any hours worked over 40 in a workweek for IHSS/WPCS providers. Based on statute, All-County, and Waiver Policy Letters, an IHSS/WPCS provider who works for one participant only cannot exceed 70 hours and 45 minutes in a workweek: a 40 hour workweek and 30 hours and 45 minutes of overtime. An IHSS/WPCS provider who works for two or more participants 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; with certain exemptions. Beginning February 1, 2016, the Department began paying for overtime. A three month hold harmless period from February 2016 through April 2016 was included to allow a transition period for providers to help understand the requirements.

The California Department of Social Services and the Department are allowing exemptions to promote continuity and quality of care standards. Primarily, the Department will allow overtime between IHSS and WPCS up to 90 hours per week for recipients up to the waiver limit, a 12-hour work day or 360 hours per month, on a case by case basis.

# OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 181

On January 1, 2017, the minimum wage increased from $10.00 to $10.50 per hour for providers living in counties that pay below $10.50 per hour. Beginning January 1, 2018, the minimum wage will increase from $10.50 to $11.00 per hour.

**Reason for Change:**
The decrease from the prior estimate, for FY 2016-17, is due to the 3-month hold harmless being paid in FY 2015-16, which reduced the cost in FY 2016-17 by $3,480,000 TF. Overall, costs did increase for FY 2016-17 and FY 2017-18 due to an increase in the weighted average rate and the number of providers who received an approved exemption. The change from FY 2016-17 to FY 2017-18, in the current estimate, increased due to the minimum wage increase and an estimated higher number of providers to receive an approved exemption.

**Methodology:**
1) Assume overtime and travel time costs began in February 2016.

2) Assume 1,695 WPCS beneficiaries will have providers receiving overtime in FY 2016-17 and 1,785 in FY 2017-18.

3) Assume the annual cost for overtime without exemptions or travel time in FY 2016-17 is $5,612,000 and $5,921,000 in FY 2017-18.

4) Assume 650 WPCS beneficiaries will have providers receiving overtime exemptions in FY 2016-17 and 996 in FY 2017-18.

5) Assume the annual cost for overtime for providers who received exemption in FY 2016-17 is $5,200,000 and $8,093,000 in FY 2017-18.

6) Assume the annual travel time cost for WPCS providers in FY 2016-17 is $653,000 and $671,000 in FY 2017-18.

7) The estimated cost for overtime, including exemptions, and travel time for WPCS providers is **$11,466,000 TF ($5,733,000 GF)** in FY 2016-17 and **$14,686,000 TF ($7,343,000 GF)** in FY 2017-18.

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

# MEDI-CAL RECOVERIES FIFTY PERCENT RULE

REGULAR POLICY CHANGE NUMBER: 200
IMPLEMENTATION DATE: 7/2017
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 2008

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$12,160,000 |
| - STATE FUNDS | $0 | -$12,160,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$12,160,000 |
| STATE FUNDS | $0 | -$12,160,000 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the recoveries and costs associated with the rejected trailer bill language that would have amended the Medi-Cal Recoveries Fifty Percent Rule.

**Authority:**
Welfare & Institutions (W&I) Code 14124.78

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Department recovers Medi-Cal treatment costs from liable third parties, thereby ensuring that Medi-Cal is the payer of last resort. When a Medi-Cal beneficiary seeks treatment for an injury, the federal government pays a percentage of the cost of treating the injury known as Federal Financial Participation (FFP). When the Department makes a recovery, federal law requires the Department to reimburse a portion of the recovery equal to the FFP provided for the services to treat the injury.

The Fifty Percent Rule requires the Department to take no more than half of a settlement after all attorney's fees and legal costs are paid. An audit from Centers for Medicare and Medicaid Services (CMS), found that W&I Code Section 14124.78 ("Fifty Percent Rule") did not comply with the Social Security Act ("the Act"). Specifically, the Act requires the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the Medi-Cal beneficiary receiving funds. The Department had no valid justification under the Fifty Percent Rule for allowing Medi-Cal beneficiaries to obtain settlement funds prior to the Federal Fund (FF) being fully reimbursed and required the Department to reimburse the difference in cases settled under the Fifty Percent Rule. The Department has been reimbursing the FFP share for cases settled under the Fifty Percent Rule from the General Fund (GF).

# MEDI-CAL RECOVERIES FIFTY PERCENT RULE

## REGULAR POLICY CHANGE NUMBER: 200

The Administration proposed amending W&I Code Section 14124.78 to revise the Fifty Percent Rule. The amendment would have resulted in GF savings, as the Department would no longer take funds from the GF to subsidize the federal repayment obligation. The legislature rejected the proposed amendments to the Fifty Percent Rule and incorrectly approved the savings reflected in this policy change.

**Reason for Change:**
There is no change from the prior estimate for FY 2016-17 and FY 2017-18.

**Methodology:**
1. The following amounts are the total estimated recovery of settlements under the rejected Fifty Percent Rule proposal and based on the settlement amounts from actuals in FY 2015-16.

2. Under the rejected proposal, for beneficiaries with a FFP of 50%, the Department would have collected the entire amount, reimbursed 50% of this amount to the FF, and reimbursed the remaining 50% to the GF.

3. Under the rejected proposal, for beneficiaries with a FFP of 100%, the Department would have collected the entire portion and reimbursed 100% of that amount to FF.

| Prior to Amending The Fifty Percent Rule | TF | GF | FF | Beneficiary* |
|---|---|---|---|---|
| Cases with 50% FFP | ($8,210,000) | $0 | ($8,210,000) | ($8,210,000) |
| Cases with 100% FFP | ($3,950,000) | $3,950,000 | ($7,900,000) | ($3,950,000) |
| Total | ($12,160,000) | $3,950,000 | ($16,110,000) | ($12,160,000) |

| After Amending The Fifty Percent Rule | TF | GF | FF | Beneficiary* |
|---|---|---|---|---|
| Cases with 50% FFP | ($16,420,000) | ($8,210,000) | ($8,210,000) | $0 |
| Cases with 100% FFP | ($7,900,000) | ($0) | ($7,900,000) | $0 |
| Total | ($24,320,000) | ($8,210,000) | ($16,110,000) | $0 |
| | | | | |
| **Difference in FY 2017-18** | **($12,160,000)** | **($12,160,000)** | **($0)** | $12,160,000 |

*Not included in the total funds.

**Funding**:
100% GF (4260-101-0001)

# ANNUAL CONTRACEPTIVE COVERAGE

REGULAR POLICY CHANGE NUMBER: 208
IMPLEMENTATION DATE: 5/2017
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 2016

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $6,092,000 | $36,554,000 |
| - STATE FUNDS | $1,374,200 | $8,244,500 |
| PAYMENT LAG | 0.6155 | 0.9950 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,749,600 | $36,371,200 |
| STATE FUNDS | $845,820 | $8,203,280 |
| FEDERAL FUNDS | $2,903,810 | $28,167,950 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost impact of expanding on existing contraceptive coverage for the Medi-Cal and Family Planning, Access, Care and Treatment (Family PACT) programs.

**Authority:**
SB 999 (Chapter 499, Statutes of 2016)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
Title 22, California Code of Regulations (CCR), Section 51313(b) allows for drugs to be furnished as a pharmacy benefit in quantities not to exceed a 100 calendar day supply, including self-administered hormonal contraceptives. Medi-Cal pharmacy providers fall within the restriction of this regulation and therefore dispense three months of this prescription written by Medi-Cal and Family PACT providers.

340B clinics provide onsite dispensing of family planning drugs and supplies.

Effective January 1, 2017, the Department will expand on existing contraceptive coverage policy by covering up to a 12-month supply of Food and Drug Administration (FDA)-approved, self-administered hormonal contraceptives (ring, patch and oral contraceptives) dispensed at one time by a prescriber, pharmacy, or onsite location licensed or authorized to dispense drugs or supplies.

**Reason for Change:**
The increase in FY 2016-17 from the prior estimate is due to the implementation date change from July 1, 2017 to May 1, 2017. There is no change from the prior estimate for FY 2017-18. The increase from FY 2016-17 to FY 2017-18 in the current estimate is due to having two months of implementation in FY 2016-17 versus twelve months of implementation in FY 2017-18.

# ANNUAL CONTRACEPTIVE COVERAGE

## REGULAR POLICY CHANGE NUMBER: 208

**Methodology:**

1. Assume annual contraceptive coverage will be implemented May 1, 2017, retroactive to January 1, 2017.
2. Assume a 10% increase in utilization due to the change in policy. This includes beneficiaries switching from one contraceptive to another.
3. Managed care costs are not included in this policy change.

340B Clinics

4. 340B clinics currently dispense a 12-month supply for oral contraceptives and a 90-day supply for the hormonal patch and ring.
5. For the hormonal patch and ring, assume all clients will opt-in to receive a 12-month supply with providers billing at the maximum allowable rate.
6. Total costs for onsite dispensing at 340B clinics is estimated to be $13,588,000 TF ($3,065,000 GF).

Fee-for-Service Pharmacies

7. Pharmacies currently dispense a 90-day supply for oral contraceptives and hormonal patches and rings. Assume all clients will opt-in for a 12-month supply with providers billing at the maximum allowable rate.
8. Total costs for onsite dispensing at pharmacies is estimated to be $63,777,000 TF ($14,385,000 GF).
9. Pharmacy dispensing fee savings as a result of clients getting annual supply of contraceptives instead of every 90 days is estimated to be $5,096,000 TF ($1,149,000 GF).
10. Pharmacy rebate savings due to utilization increase for oral contraceptives, and hormonal patch and ring are $35,715,000 TF ($8,056,000 GF).

11. The net cost impact due to the contraceptive coverage expansion is:

(Dollars in Thousands)

| Annual Cost | TF | GF | FF |
|---|---|---|---|
| 340B - Onsite Dispensing | $ 13,588 | $ 3,065 | $ 10,523 |
| Pharmacy Costs | $ 63,777 | $ 14,385 | $ 49,392 |
| Dispensing Fee Savings | $ (5,096) | $ (1,149) | $ (3,947) |
| Rebate Savings | $ (35,715) | $ (8,056) | $ (27,659) |
| **Net Cost** | **$ 36,554** | **$ 8,245** | **$ 28,309** |

**Funding:**

(Dollars in Thousands)

| FY 2016-17 | TF | GF | FF |
|---|---|---|---|
| 90% Title XIX / 10% GF (4260-101-0890/0001) | $ 5,242 | $ 1,000 | $ 5,000 |
| 100% GF (4260-101-0001) | $ 850 | $ 850 | $ - |
| **Total** | **$ 6,092** | **$ 1,850** | **$ 5,000** |

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| 90% Title XIX / 10% GF (4260-101-0890/0001) | $ 31,455 | $ 3,146 | $ 28,309 |
| 100% GF (4260-101-0001) | $ 5,099 | $ 5,099 | $ - |
| **Total** | **$ 36,554** | **$ 8,245** | **$ 28,309** |

# GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 215
IMPLEMENTATION DATE: 8/2017
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2024

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $1,187,500,000 |
| - STATE FUNDS | $0 | $593,750,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $1,187,500,000 |
| STATE FUNDS | $0 | $593,750,000 |
| FEDERAL FUNDS | $0 | $593,750,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates direct and indirect graduate medical education (GME) payments to the Designated Public Hospitals (DPHs) participating in the Medi-Cal managed care program and their affiliated public medical/nursing/paramedical schools, in recognition of the Medi-Cal managed care share of graduate medical education costs.

**Authority:**
Title 42, CFR, Section 438.60
SB 97 (Chapter 52, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Medicare enactment of direct and indirect GME identified the importance of paying the extra costs of teaching hospitals to ensure seniors' ability to access the care they require. According to the Balanced Budget Act of 1997, Medicare capped the levels of funding for both direct and indirect GME costs when the number of allopathic and osteopathic medical residents exceeded the expected limit. In accordance with Title 42, CFR, Section 438.60, the Department is authorized to make new GME payments to DPH systems.

GME is the supervised, hands-on training after medical school that all physicians complete to become independent and licensed practitioners. The length of this training varies depending on specialty, but generally lasts three to five years. Residents and supervising physicians at teaching hospitals are available around the clock and are prepared to care for the nation's most critically ill or injured patients, with hospitals often absorbing the cost of training.

The Department will make new Medi-Cal GME payments to DPH systems, pending the Centers for Medicare and Medicaid Services' (CMS) approval of State Plan Amendment (SPA) 17-009. Building from the Medicare program, the GME payments would recognize the Medi-Cal managed care share of the cost for a combination of the following:

# GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 215

- Direct GME payments for Medicaid's share of the cost of training new health care providers,
- Indirect GME payments for the additional training time and resources,
- Incentive payments that recognize the importance of training a new workforce generation to help address access to care in California.

Intergovernmental transfers (IGTs) will fund the nonfederal share of the cost. The Department will assess a 5% administrative fee on IGTs related to the GME payments to reimburse the Department for support costs associated with administering the program, resulting in a savings. The IGT savings will be budgeted in the Managed Care IGT Admin. & Processing Fee policy change.

The Department will submit SPA 17-009 to CMS in March 2017 with a January 1, 2017 effective date.

**Reason for Change:**
This is a new policy change.

**Methodology:**

1. The direct GME payments include costs incurred by DPHs due to salaries, benefits, physician oversight, and allocated overhead costs incurred for interns and residents in medicine, osteopathy, dentistry, podiatry, nursing, and allied health/paramedical programs, at an inflation-adjusted blended average cost per full-time equivalent (FTE).

2. The indirect medical education (IME) payments include costs incurred by DPHs due to teaching activities. Such indirect, inflation-adjusted costs will be determined by measuring the ratio of uncapped interns to available beds, applying the Medicare algorithm for this intern-to-bed ratio, multiplied by Medi-Cal managed care revenues.

3. The sum of GME and IME payments are estimated to provide approximately $950 million total computable payments annually.

4. Payments would be made on a lump-sum quarterly basis throughout the fiscal year and would not be paid as individual increases to current reimbursement rates for specific services.

5. Assume an effective date of January 1, 2017, pending CMS approval of SPA 17-009.

6. Assume two quarters of FY 2016-17 will be paid in FY 2017-18.

7. Assume three quarters of FY 2017-18 will be paid in FY 2017-18, and one quarter will be paid in a subsequent fiscal year.

(Dollars in Thousands)

| FY 2017-18 | TF | IGT | FF |
|---|---|---|---|
| FY 2016-17 | $475,000 | $237,500 | $237,500 |
| FY 2017-18 | $712,500 | $356,250 | $356,250 |
| **Total** | **$1,187,500** | **$593,750** | **$593,750** |

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

# MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 224 |
| IMPLEMENTATION DATE: | 7/2017 |
| ANALYST: | Ila Zapanta |
| FISCAL REFERENCE NUMBER: | 2036 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$1,730,000 |
| - STATE FUNDS | $0 | -$865,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$1,730,000 |
| STATE FUNDS | $0 | -$865,000 |
| FEDERAL FUNDS | $0 | -$865,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings associated with the multiple settlements and litigation costs for Medi-Cal recoveries.

**Authority:**
Welfare and Institutions (W&I) Codes 14124.785, 14124.72 and 14124.74
SB 97 (Chapter 52, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Medi-Cal program complies with Federal and State laws relating to the legal liability of third parties for health care services to beneficiaries. The Department recovers Medi-Cal treatment costs from liable third parties, thereby ensuring that Medi-Cal is the payer of last resort. 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, special needs trusts, provider/beneficiary overpayments, and other health insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Multiple Settlements
The Federal and State laws require Medi-Cal to review expenditures paid for treating a beneficiary's injury and file liens against any settlement, judgment, or award ("settlement") resulting from a beneficiary's claim or action against a liable third party. While most injury claims result in a single settlement, medical malpractice cases and other severe injuries often result in multiple settlements. Currently, W&I Code Section 14124.785 limits the Department's recovery to the amount derived from applying the lowest of the three statutory reductions defined in W&I Code 14124.72, 14124.76, or 14124.78, whichever is less.

Attorneys have found a way to use the provisions in existing law to deny the Department some or all

# MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS

REGULAR POLICY CHANGE NUMBER: 224

recovery when there are multiple settlements. Often, attorneys only provide information on the first settlement and the Department's recovery is limited by the statutory reductions. Later, when multiple settlements are disclosed, the Department is not be able to make additional recoveries, resulting in lost General Fund (GF) savings.

Litigation Costs

When an attorney facilitates a personal injury settlement on a Medi-Cal case, the Department's recovery of personal injury liens are reduced by the cost of attorney fees and the state's portion of litigation costs. Currently, provisions in W&I Code Section 14124.72(d) calculates the attorney fee reduction at 25% of the Department's lien and the proportionate share of litigation costs reduction is determined by the ratio of the Department's lien to the total settlement amount.

In cases where the settlement is smaller than the Department's lien, the formula for the state's proportionate share of the litigation costs creates situations where the Department must reduce its lien by amounts greater than the actual litigation costs. In some cases the litigation cost reductions significantly erode the Department's lien to result in zero recovery.

The Department has proposed Trailer Bill Language to address lost Medi-Cal personal injury recoveries pertaining to multiple settlements and the state's portion of litigation costs.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. The multiple settlements and litigation costs savings are estimated to start July 1, 2017.

2. For multiple settlements, the assumed savings are based on historical data on actual cases where liens were reduced. The total reductions for these cases were estimated to be $5.3 million TF.

3. Assume 10% of the total amount lost due lien reductions have multiple settlements.

4. As a result, the annual savings for multiple settlements are estimated to be -$530,000 TF.

5. For litigation costs, the assumed savings are based on historical data on settled litigation costs.

6. Assume the litigation costs would show a reduction after applying an algorithm of historical data on settlements, liens, and pro rata share of litigation costs.

7. As a result, the annual savings for litigation costs are estimated to be -$1,200,000 TF.

8. The annual estimated savings for multiple settlements and litigation costs are shown below:

| FY 2017-18 | TF | GF | FF |
|---|---|---|---|
| Multiple Settlements | ($530,000) | ($265,000) | ($265,000) |
| Litigation Costs | ($1,200,000) | ($600,000) | ($600,000) |
| **Total** | **($1,730,000)** | **($865,000)** | **($865,000)** |

**Funding:**

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

# FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 231
IMPLEMENTATION DATE: 1/2018
ANALYST: Nikaela Ratliff
FISCAL REFERENCE NUMBER: 2043

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $69,458,000 |
| - STATE FUNDS | $0 | $34,729,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $69,458,000 |
| STATE FUNDS | $0 | $34,729,000 |
| FEDERAL FUNDS | $0 | $34,729,000 |

## DESCRIPTION

**Purpose:**
The policy change estimates the cost of fully restoring adult dental benefits to the Medi-Cal Dental Program. This proposal would increase the benefits covered by the Medi-Cal Dental Program for the adult Medi-Cal population.

**Authority:**
SB 97 (Chapter 52, Statutes of 2017)

**Interdependent Policy Changes:**
N/A

**Background:**
Effective July 1, 2009, Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10) added Section 14131.10 to the Welfare and Institutions Code, which eliminated specific optional benefits from the Medi-Cal program, including most dental services for adults ages 21 and older. Effective May 1, 2014, some adult dental benefits were restored in accordance with Assembly Bill 82. Those services included initial examinations, radiographs, restorations, anterior root canals, complete dentures and complete denture adjustments, repairs and relines.

Effective January 1, 2018, the full restoration of adult dental benefits will include the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals).

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Data regarding the number of incidences, number of users, and total reimbursement rates from January 1, 2008 through December 31, 2008 were pulled and were specific to adult beneficiaries ages 21 and older.

# FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 231

2. A percentage increase was applied to account for population growth and the resultant increased number of users.

3. Assume this policy will be implemented on January 1, 2018. As such only six (6) months are costed for FY 2017-18.

| Fiscal Year | TF | GF | FF |
|---|---|---|---|
| FY 2017-18 | $69,458,000 | $34,729,000 | $34,729,000 |

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

# WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 232
IMPLEMENTATION DATE: 1/2018
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 2044

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $167,000,000 |
| - STATE FUNDS | $0 | $50,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $167,000,000 |
| STATE FUNDS | $0 | $50,000,000 |
| FEDERAL FUNDS | $0 | $117,000,000 |

## DESCRIPTION

**Purpose:**
This policy estimates the expenditures related to providing supplemental payments for specific women's health services.

**Authority:**
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
AB 120 appropriates up to $50 million from Proposition 56 revenues to provide supplemental payments for specific women's health services.

This policy change includes the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for women's health services.

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services shall develop the structure of the supplemental payments and post those parameters on its Internet Web site by July 31, 2017. The supplemental payments shall not be available until all of the following conditions have been satisfied: (1) The director of the Department of Health Care Services seeks all necessary federal approvals; and (2) All necessary federal approvals have been obtained. The supplemental payment shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized. Additionally, the supplemental payment program is available only to the extent federal Medicaid policy does not reduce federal financial participation as projected in the annual budget act as determined by the Department of

# WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 232

Finance.

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Payments will be made via supplemental payments.
2. This policy is effective July 1, 2017; however payments will not begin until January 2018.
3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

| FY 2017-18 | TF | FF | SF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 | **$ 50,000** | **$ -** | **$ 50,000** |
| 100% Title XIX | **$ 117,000** | **$ 117,000** | **$ -** |
| **Total** | **$ 167,000** | **$ 117,000** | **$ 50,000** |

**Funding:**
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)

# ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 233
IMPLEMENTATION DATE: 1/2018
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 2045

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $54,000,000 |
| - STATE FUNDS | $0 | $27,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $54,000,000 |
| STATE FUNDS | $0 | $27,000,000 |
| FEDERAL FUNDS | $0 | $27,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures related to providing supplemental payments to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

**Authority:**
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
This policy change includes the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for supplemental payments to ICF/DDs.

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services shall develop the structure of the supplemental payments and post those parameters on its Internet Web site by July 31, 2017. The supplemental payments shall not be available until all of the following conditions have been satisfied: (1) The director of the Department of Health Care Services seeks all necessary federal approvals; and (2) All necessary federal approvals have been obtained. The supplemental payment shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized. Additionally, the supplemental payment program is available only to the extent federal Medicaid policy does not reduce federal financial participation as projected in the annual budget act as determined by the Department of Finance.

# ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 233

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Payments will be made via supplemental payments.

2. This policy is effective August 1, 2017; however payments will not begin until January 2018.

3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop 56 | $27,000 | $27,000 | $0 |
| 100% Title XIX | $27,000 | $0 | $27,000 |
| **Total** | **$54,000** | **$27,000** | **$27,000** |

**Funding:**
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)

# MEDICALLY TAILORED MEALS PILOT PROGRAM

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 234 |
| IMPLEMENTATION DATE: | 1/2018 |
| ANALYST: | Randolph Alarcio |
| FISCAL REFERENCE NUMBER: | 2046 |

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $2,000,000 |
| - STATE FUNDS | $0 | $2,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $2,000,000 |
| STATE FUNDS | $0 | $2,000,000 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the contract cost to provide the Medically Tailored Meals Pilot Program (Pilot).

**Authority:**
Welfare & Institutions Code (W&IC) 14042.1

**Interdependent Policy Changes:**
Not Applicable

**Background:**
The Department will identify eligible Medi-Cal participants and providers to participate in a three-year Pilot, conducted in Alameda, Los Angeles, Marin, San Diego, San Francisco, San Mateo, Santa Clara, and Sonoma counties. The Pilot will provide medically tailored meal intervention services to Medi-Cal participants with one or more of the following health conditions: congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. The Department may establish additional eligibility requirements based upon acuity and other selection criteria. For 12 to 24 weeks, each participating Medi-Cal beneficiary in the Pilot will receive a standard intervention of up to 21 medically tailored meals, per week, designed to meet the specific nutritional needs of the beneficiary's health condition. At the conclusion of the Pilot, the Department shall evaluate the impact on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization.

The Department will reimburse contractors or entities that provide meal intervention services.

**Reason for Change:**
This is a new policy change.

**Methodology:**

1. Assume the Pilot will begin in January 2018.

2. Assume the cost for FY 2017-18 is $2,000,000 TF.

# MEDICALLY TAILORED MEALS PILOT PROGRAM

## REGULAR POLICY CHANGE NUMBER: 234

**Funding:**
100% GF (4260-101-0001)

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 236
IMPLEMENTATION DATE: 1/2018
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 2048

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $650,000,000 |
| - STATE FUNDS | $0 | $325,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $650,000,000 |
| STATE FUNDS | $0 | $325,000,000 |
| FEDERAL FUNDS | $0 | $325,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures related to providing supplemental payments for physician services.

**Authority:**
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
This policy change includes the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for supplemental payments for physician services.

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services shall develop the structure of the supplemental payments and post those parameters on its Internet Web site by July 31, 2017. The supplemental payments shall not be available until all of the following conditions have been satisfied: (1) The director of the Department of Health Care Services seeks all necessary federal approvals; and (2) All necessary federal approvals have been obtained. The supplemental payment shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized. Additionally, the supplemental payment program is available only to the extent federal Medicaid policy does not reduce federal financial participation as projected in the annual budget act as determined by the Department of Finance.

# PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 236

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017; however payments will not begin until January 2018.

3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 | $325,000 | $325,000 | $0 |
| 100% Title XIX | $325,000 | $0 | $325,000 |
| **Total** | **$650,000** | **$325,000** | **$325,000** |

**Funding:**
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)

# SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 237
IMPLEMENTATION DATE: 1/2018
ANALYST: Ila Zapanta
FISCAL REFERENCE NUMBER: 2049

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $280,000,000 |
| - STATE FUNDS | $0 | $140,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $280,000,000 |
| STATE FUNDS | $0 | $140,000,000 |
| FEDERAL FUNDS | $0 | $140,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures related to providing supplemental payments for specific dental services.

**Authority:**
AB 120 (Chapter 22. Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
AB 120 appropriates up to $280 million from Proposition 56 revenues to provide supplemental payments for specific dental services.

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Payments will be made via supplemental payments.
2. This policy is effective July 1, 2017; however payments will not begin until January 2018.
3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Health Care Treatment Fund Prop 56 | $140,000 | $140,000 | $0 |
| 100% Title XIX | $140,000 | $0 | $140,000 |
| **Total** | **$280,000** | **$140,000** | **$140,000** |

**Funding:**
Healthcare Treatment Fund (42601013305)
100% Title XIX (42601010890)

# AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 238
IMPLEMENTATION DATE: 1/2018
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2050

| | FY 2016-17 | FY 2017-18 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $8,000,000 |
| - STATE FUNDS | $0 | $4,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $8,000,000 |
| STATE FUNDS | $0 | $4,000,000 |
| FEDERAL FUNDS | $0 | $4,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures related to providing supplemental payments for specific AIDS Waiver services.

**Authority:**
AB 120 (Chapter 22, Statutes of 2017)

**Interdependent Policy Changes:**
Not Applicable

**Background:**
AB 120 appropriates up to $4 million from Proposition 56 revenues to provide supplemental payments for specific AIDS waiver services.

This policy change includes the use of California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue as a funding source for the AIDS Waiver Supplemental Payment Program.

Proposition 56, passed by the voters in November 2016, increases the excise tax rate on cigarettes and electronic cigarettes, effective April 1, 2017, and other tobacco products effective July 1, 2017. The excise tax increased by $2 from 87 cents to $2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services shall develop the structure of the supplemental payments and post those parameters on its Internet Web site by July 31, 2017. The supplemental payments shall not be available until all of the following conditions have been satisfied: (1) The director of the Department of Health Care Services seeks all necessary federal approvals; and (2) All necessary federal approvals have been obtained. The supplemental payment shall be implemented only to the extent the department determines federal financial participation is available and is not otherwise jeopardized. Additionally, the supplemental

# AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 238

payment program is available only to the extent federal Medicaid policy does not reduce federal financial participation as projected in the annual budget act as determined by the Department of Finance.

**Reason for Change:**
This is a new policy change.

**Methodology:**
1. Payments will be made via supplemental payments.

2. This policy is effective July 1, 2017; however payments will not begin until January 2018.

3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

| FY 2017-18 | TF | SF | FF |
|---|---|---|---|
| Healthcare Treatment Fund Prop. 56 | $4,000 | $4,000 | $0 |
| 100% Title XIX | $4,000 | $0 | $4,000 |
| **Total** | **$8,000** | **$4,000** | **$4,000** |

**Funding:**
Healthcare Treatment Fund (4260-101-3305)
100% Title XIX (4260-101-0890)