

MEDI-CAL
November 2018
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2018-19 *and* 2019-20



The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL
NOVEMBER 2018
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2018-19 and 2019-20**

Fiscal Forecasting Division
State Department of Health Care Services
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November 2018 Medi-Cal Estimate

Current Year (FY 2018-19) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2018-19 Appropriation	Nov 2018 Estimate	Change	
			Amount	Percent
Total Funds	\$99,506.8	\$93,531.6	(\$5,975.2)	-6.0%
Federal Funds	\$63,751.1	\$58,756.1	(\$4,995.0)	-7.8%
General Fund	\$21,622.5	\$19,695.7	(\$1,926.8)	-8.9%
Other Non-Federal Funds	\$14,133.2	\$15,079.8	\$946.6	6.7%

County Administration	FY 2018-19 Appropriation	Nov 2018 Estimate	Change	
			Amount	Percent
Total Funds	\$4,567.3	\$4,606.6	\$39.3	0.9%
Federal Funds	\$3,332.2	\$3,793.3	\$461.1	13.8%
General Fund	\$1,229.7	\$808.4	(\$421.3)	-34.3%
Other Non-Federal Funds	\$5.4	\$4.9	(\$0.5)	-9.3%

Fiscal Intermediary	FY 2018-19 Appropriation	Nov 2018 Estimate	Change	
			Amount	Percent
Total Funds	\$328.3	\$367.7	\$39.4	12.0%
Federal Funds	\$215.6	\$192.4	(\$23.2)	-10.8%
General Fund	\$112.8	\$175.3	\$62.5	55.4%
Other Non-Federal Funds	\$0.0	\$0.0	(\$0.0)	n/a

Total Expenditures	FY 2018-19 Appropriation	Nov 2018 Estimate	Change	
			Amount	Percent
Total Funds	\$104,402.4	\$98,506.0	(\$5,896.5)	-5.6%
Federal Funds	\$67,298.9	\$62,741.8	(\$4,557.1)	-6.8%
General Fund	\$22,965.0	\$20,679.3	(\$2,285.7)	-10.0%
Other Non-Federal Funds	\$14,138.6	\$15,084.7	\$946.1	6.7%

Note: Totals may not add due to rounding.

November 2018 Medi-Cal Estimate

Budget Year (FY 2019-20) Projected Expenditures Compared to Current Year (FY 2018-19)

(Dollars in Millions)

Medical Care Services	FY 2018-19 Estimate	FY 2019-20 Estimate	Change	
			Amount	Percent
Total Funds	\$93,531.6	\$96,027.5	\$2,495.9	2.7%
Federal Funds	\$58,756.1	\$61,717.4	\$2,961.3	5.0%
General Fund	\$19,695.7	\$21,851.2	\$2,155.5	10.9%
Other Non-Federal Funds	\$15,079.8	\$12,458.9	(\$2,620.9)	-17.4%

County Administration	FY 2018-19 Estimate	FY 2019-20 Estimate	Change	
			Amount	Percent
Total Funds	\$4,606.6	\$4,321.5	(\$285.1)	-6.2%
Federal Funds	\$3,793.3	\$3,410.1	(\$383.2)	-10.1%
General Fund	\$808.4	\$906.8	\$98.4	12.2%
Other Non-Federal Funds	\$4.9	\$4.6	(\$0.3)	-6.1%

Fiscal Intermediary	FY 2018-19 Estimate	FY 2019-20 Estimate	Change	
			Amount	Percent
Total Funds	\$367.7	\$350.9	(\$16.8)	-4.6%
Federal Funds	\$192.4	\$231.9	\$39.5	20.5%
General Fund	\$175.3	\$119.0	(\$56.3)	-32.1%
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	n/a

Total Expenditures	FY 2018-19 Estimate	FY 2019-20 Estimate	Change	
			Amount	Percent
Total Funds	\$98,506.0	\$100,699.9	\$2,193.9	2.2%
Federal Funds	\$62,741.8	\$65,359.4	\$2,617.6	4.2%
General Fund	\$20,679.3	\$22,877.0	\$2,197.7	10.6%
Other Non-Federal Funds	\$15,084.7	\$12,463.5	(\$2,621.2)	-17.4%

Note: Totals may not add due to rounding.

November 2018 Medi-Cal Estimate Management Summary

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

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

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

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

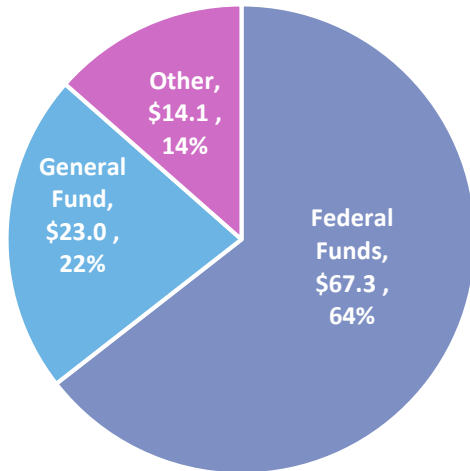
November 2018 Medi-Cal Estimate

Medi-Cal spending is estimated to be \$98.5 billion in FY 2018-19 and \$100.7 billion in FY 2019-20. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.

FY 2018-19

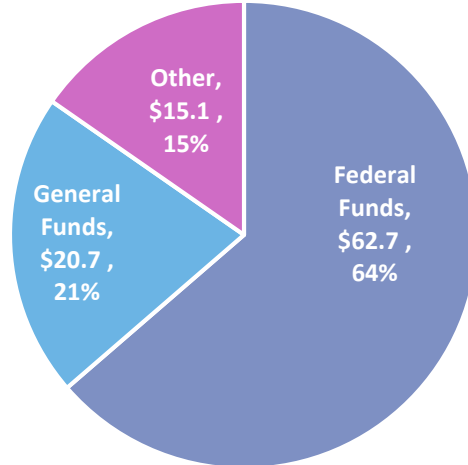
Appropriation

Dollars in Billions, Rounded
\$104.4 Total Funds



Nov 2018

Dollars in Billions, Rounded
\$98.5 Total Funds



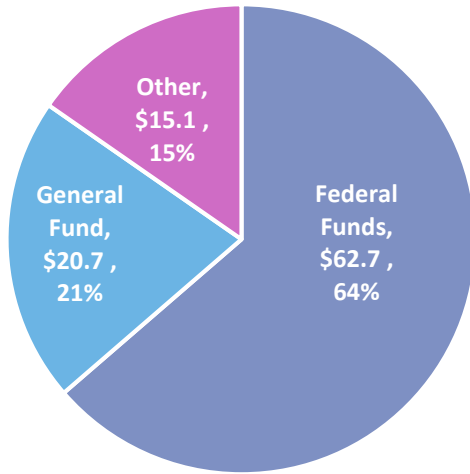
The November 2018 Estimate for FY 2018-19 projects savings of \$2.3 billion General Fund compared to the FY 2018-19 Budget Appropriation.

	FY 2018-19, General Fund		
	Appropriation	Nov 2018	Change
Medical Care Services	\$ 21,622.5	\$ 19,695.7	\$ -1,926.8
County Administration	\$ 1,229.7	\$ 808.4	\$ -421.3
Fiscal Intermediary	<u>\$ 112.8</u>	<u>\$ 175.3</u>	<u>\$ 62.5</u>
Total	\$ 22,965.0	\$ 20,679.3	\$ -2,285.7

(Dollars in Millions, Rounded)

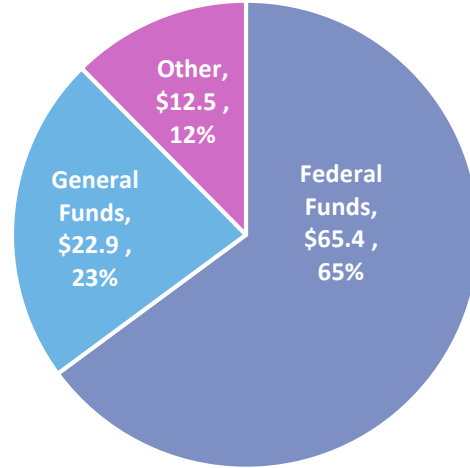
FY 2018-19

Dollars in Billions, Rounded
\$98.5 Total Funds



FY 2019-20

Dollars in Billions, Rounded
\$100.7 Total Funds



The Medi-Cal General Fund costs are estimated to increase by \$2.2 billion between FY 2018-19 and FY 2019-20.

Nov 2018, General Fund

	<u>FY 2018-19</u>	<u>FY 2019-20</u>	<u>Change</u>
Medical Care Services	\$ 19,695.7	\$ 21,851.2	\$ 2,155.5
County Administration	\$ 808.4	\$ 906.8	\$ 98.4
Fiscal Intermediary	\$ 175.3	\$ 119.0	\$ -56.3
Total	\$ 20,679.3	\$ 22,877.0	\$ 2,197.7

(Dollars in Millions, Rounded)

The following pages briefly describe the significant changes in both FY 2018-19 and FY 2019-20.

Caseload

The Medi-Cal Caseload continues a gradual decline experienced since 2016 of -1.2% from FY 2017-18 to FY 2018-19. The lower caseload correlates with California's lower unemployment and a recovering economy, as the decline is mainly within Medi-Cal's Families and Children caseload. After incorporating the impact of the minimum wage increase, the decline in the Families and Children caseload continues into FY 2019-20, although at a slower pace.

Medi-Cal's second largest eligibility group continues to be the Affordable Care Act (ACA) Optional Expansion aid category (adults ages 19 to 64) and is expected to also experience some decline with the minimum wage increase.

The Seniors and Persons with Disabilities caseload has experienced increased growth, mainly with the senior population continuing along historic growth. Both the Seniors and Persons with Disabilities categories have experienced slower growth or declines in the eligibles receiving public assistance, mainly SSI/SSP.

<i>Dollars in Millions</i>		Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
Name	PC	TF	GF	TF	GF
County Health Initiative Matching (CHIM)	5, 200	\$15.8	\$1.9	(\$12.2)	(\$0.5)
This PC estimates the costs for the County Health Initiative Matching (CHIM) fund for the County Children's Health Initiative Program (CCHIP). For CY, the increase is due to shifting funds from prior year to the CY. Additionally, Santa Clara will begin submitting claims from April 2016 forward. For BY, the decrease is due to the prior year funds that are being paid in CY. Also, in July 1, 2019, these beneficiaries will be integrated into the Medi-Cal managed care delivery system.					
Non-OTLICP CHIP	7	\$0.0	(\$30.5)	\$0.0	(\$330.9)
This PC estimates the technical adjustment in funding for the Non-OTLICP population of CHIP. Expenditures are adjusted from Title XIX funding to the various enhanced CHIP FMAPs. For CY, the decrease is due to changes made to the FY 2018-19 proxy adjustments. For BY, the decrease is due to the prior payments being made in FY 2018-19.					
Minimum Wage Increase – Caseload Savings	15	\$207.0	\$48.5	(\$61.6)	(\$15.4)
In CY, there is an overall reduced savings based on a revised estimating methodology. The increase in BY savings is a result of an increase in caseload reduction, updated PMPM costs, and an increase in incremental savings as a result of the minimum wage increasing to \$13 per hour.					
Undocumented Young Adults Full Scope Expansion	204	\$0	\$0	\$257.1	\$194.0
This is a new policy change that reflects the provision of full scope benefits to individuals age 19-25 regardless of immigration status. This change will be effective no sooner than July 1, 2019.					
ACA DSH Reduction	22	\$0.0	\$0.0	(\$603.2)	(\$75.4)
The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of the federal Disproportionate Share Hospital (DSH) allotments beginning October 1, 2019. Scheduled reductions for each fiscal year are expected to continue through Federal Fiscal Year 2025. This policy change estimates the DSH allotment reductions that offset the DSH Payment, Private DSH Replacement, and Global Payment Program policy changes in FY 2019-20.					
Behavioral Health Treatment	25	\$38.3	\$15.3	\$112.6	\$56.9
Medi-Cal covers Behavioral Health Treatment (BHT) services for children under age 21. Beginning February 1, 2016, the Department, in collaboration with the Department of Developmental Services (DDS), transitioned responsibility for BHT services provided to existing Medi-Cal-eligible DDS Regional Center clients to Medi-Cal. In the current BHT estimate, managed care supplemental capitation payments are estimated to increase in FY 2018-19 based on updated payment data. The change from FY 2018-19 to FY 2019-20 is due to the increased FY 2019-20 capitation rate.					

<i>Dollars in Millions</i>		Change from May 2018		Change from FY 2018-19		
		FY 2018-19		FY 2019-20		
		Name	PC	TF	GF	TF
Behavioral Health Treatment – BIS DDS Transition	30	(\$7.5)	(\$3.7)	\$48.6	\$23.1	
<p>This policy change estimates costs for additional DDS Regional Center (RC) clients with a diagnosis other than Autism Spectrum Disorder (ASD) transitioning to Medi-Cal. The FFS transition occurred in March 2018. The managed care transition was phased-in beginning July 2018. In the current estimate, the FY 2018-19 estimate decreased due to the extension of the managed care phase-in schedule to December 2018 and a decrease in the BHT BIS transition population. The increase from FY 2018-19 to FY 2019-20 is due to an increase in the FY 2019-20 capitation rate and the full phase-in by FY 2019-20.</p>						
Drug Rebates	49, 50, 53, 54, 113, 202	(\$492.0)	(\$389.9)	\$1,159.9	\$134.8	
<p>The Department proposes to establish the Medi-Cal Drug Rebates Fund, effective July 1, 2019. The non-federal share of the Medi-Cal drug rebate collections will be deposited into the Medi-Cal Drug Rebates Fund. The newly established Medi-Cal Drug Rebates Fund will fund health care services for Medi-Cal beneficiaries. The current estimate budgets the transfers in the Medi-Cal Drug Rebates Fund policy change beginning in FY 2019-20.</p> <p>Rebate estimates were updated based on actual pharmacy drug rebate collections data through June 2018. In addition, the current estimate includes the funding adjustment for the quarter ending March 2018 that was completed in August 2018, resulting in \$239.2 million GF savings in FY 2018-19. The increase from FY 2018-19 to FY 2019-20 is due to no prior year funding adjustment in FY 2019-20.</p>						
Pharmacy Reimbursement & Dispensing Fee	52	\$18.0	\$7.6	(\$150.0)	(\$54.5)	
<p>This policy change estimates the savings from reimbursing pharmacy drugs based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology, effective April 1, 2017. In the current estimate, FY 2018-19 savings have decreased due to the delay of the implementation date to April 1, 2019. The Erroneous Payment Correction (EPC) for the retroactive period is assumed to be implemented beginning July 2019. The increased savings from FY 2018-19 to FY 2019-20 results from including 12 months of the EPC and a full year of the prospective implementation in FY 2019-20.</p>						
Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver	55	(\$529.7)	(\$97.7)	\$107.9	\$10.2	
<p>This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program for opt-in counties to provide Substance Use Disorder (SUD) services. A total of 39 opt-in counties are estimated to provide DMC-ODS waiver services in FY 2018-19. In the current estimate, the estimated FY 2018-19 DMC-ODS waiver costs have decreased based on actual paid claims data, an updated county implementation schedule, updated county interim rates, and updated assumptions for the cash-basis payments. The increase from FY 2018-19 to FY 2019-20 is due to including the costs for all opt-in counties in FY 2019-20.</p>						

<i>Dollars in Millions</i>		Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
Name	PC	TF	GF	TF	GF
Drug Medi-Cal Base		(\$57.9)	(\$2.4)	\$0.9	\$2.1
Narcotic Treatment Program	56	(\$48.0)	(\$2.8)	\$0.4	\$1.7
Outpatient Drug Free Treatment	57	(\$7.8)	(\$0.2)	\$0.3	\$0.2
Intensive Outpatient Treatment	58	(\$1.7)	\$0.6	\$0.2	\$0.1
Residential Treatment	59	(\$0.5)	(\$0.0)	\$0.0	\$0.0
The four Drug Medi-Cal (DMC) base modalities estimates now use 36 months of cash-basis data. The primary reason for the decrease is the shifting of costs to the DMC-ODS Wavier.					
SMHS Base	61, 62	\$34.9	\$37.2	\$230.7	\$26.7
The Specialty Mental Health Services (SMHS) Base policy changes have been updated for the estimated ACA and regular utilization based on paid claims data as of June 2018. In addition, the current estimate for the SMHS for Children policy change includes the estimated General Fund costs for SMHS services provided to full-scope undocumented children.					
Global Payment Program (GPP)	71	(\$64.2)	\$0.0	\$11.8	\$0.0
GPP payments are authorized under the California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). In the current estimate, the decrease in FY 2018-19 is due to updated payment data for Program Year (PY) 2017-18 and PY 2018-19 payments. The increase from FY 2018-19 to FY 2019-20 is due to the updated Disproportionate Share Hospital (DSH) allotments for the different PYs.					
Public Hospital Redesign & Incentives in Medi-Cal	72	\$163.0	\$0.0	(\$355.8)	\$0.0
Public Hospital Redesign and Incentives in Medi-Cal (PRIME) payments are authorized under the California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). Remaining payments from Demonstration Year (DY) 2016-17 and additional high performance pool payments for DY 2017-18 are estimated to be paid in FY 2018-19. From FY 2018-19 to FY 2019-20, the phase down of the annual allocations for DY 2018-19 and DY 2019-20 result in decreased payments in FY 2019-20.					
Medi-Cal 2020 Dental Transformation Initiative	74	(\$39.8)	(\$19.9)	\$33.9	\$16.9
The Dental Transformation Initiative (DTI) is part of the Medi-Cal 2020 Waiver. These costs include the estimated incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care, and funding for the Local Dental Pilot Projects (LDPPs). The change from the prior estimate, for FY 2018-19, is a net decrease due to lower than estimated usage in Domain 2, a change in methodology in calculating Domain 3 incentive payments, and some LDPPs not executing their contracts. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to anticipated increased participation in the DTI for the remaining program years.					

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
Medi-Cal 2020 Designated State Health Program (DSHP)	81	\$0.0	\$37.3	\$0.0	\$37.7
<p>This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI). The annual limit the State-Only programs may claim for Medi-Cal 2020 DSHP is \$75 million in FFP each Demonstration Year (DY) for a five year total of \$375 million FFP. In the current estimate, only \$37.727 million FFP will be claimed in FY 2018-19. Medi-Cal 2020 DSHP claiming is not estimated to occur in FY 2019-20.</p>					
MH/UCD – Stabilization Funding	75	\$55.4	\$55.4	(\$110.9)	(\$110.9)
<p>This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD). In the current estimate, FY 2018-19 stabilization funding costs have increased due to the delay of the Demonstration Year (DY) 2008-09 final reconciliation to FY 2018-19. No further costs are estimated in FY 2019-20.</p>					
Whole Person Care Housing Services	208	\$0.0	\$0.0	\$100.0	\$100.0
<p>Medi-Cal’s current Whole Person Care pilots provide funding to integrate sustainable services for high-risk, high-utilizing beneficiaries. The new Whole Person Care Housing Services policy change would provide supportive housing services for individuals who are homeless or at risk of becoming homeless, with a focus on people with mental illness. The funds will be available for expenditure until June 30, 2025.</p>					
CCI Managed Care Payments	88	(\$129.9)	(\$65.0)	\$276.5	\$138.3
<p>This policy change estimates the capitation payments for dual eligible and Medi-Cal only beneficiaries transitioned from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal LTC institutional and community-based services and supports benefits. There is an overall net decrease from the prior estimate for FY 2018-19 due to lower eligibles in the Full Dual Opt-In, Non-Full Dual Non Institutional, and Home and Community Based Services (HCBS) categories. FY 2019-20 costs increased from FY 2018-19 in the current estimate due to slightly higher projected eligibles in the Opt-Out/Excluded and Non-Full Dual Non Institutional categories and the addition of two new health care plans, Aetna and United, in San Diego County. Additionally, there is an expected increase in FY 2019-20 budget rates.</p>					
MCO Enrollment Tax Mgd. Care Plans	112	\$0.0	(\$16.2)	\$0.0	\$1,283.2
<p>This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2016. The change for FY 2018-19 is a result of revised funding estimates. The change from FY 2018-19 to FY 2019-20 is due to MCO Enrollment tax ending as of June 30, 2019.</p>					
CCI IHSS Reconciliation	170	(\$197.0)	\$0.0	\$57.7	\$0.0
<p>This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans. The change from the prior estimate, for FY 2018-19, is due to updated reconciliation payment data for CY 2015 and CY 2016 that will be paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to updated reconciliation payment data for CY 2017 that will be paid in FY 2019-20.</p>					

<i>Dollars in Millions</i>		Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		PC	TF	GF	TF
ACA Optional Expansion MLR Risk Corridor	24	(\$400.0)	\$0.0	\$2,400.0	\$0.0
<p>This policy change budgets additional federally funded payments to and recoveries from managed care health plans (MCPs) related to the Medical Loss Ratio (MLR) risk corridor calculations for ACA Optional Expansion (ACA OE) members. The change from the prior estimate for FY 2018-19 is due to finalizing recoupment calculations. The change from FY 2018-19 to FY 2019-20 is due to anticipation of completing all recoupments for the 30-month MLR period in FY 2018-19.</p>					
Retro MC Rate Adjustments	92	\$391.0	\$247.4	(\$620.2)	(\$291.6)
<p>This policy change estimates retroactive managed care capitation rate adjustments. The change from the prior estimate for FY 2018-19 is due to a cost shift from FY 2017-18 to FY 2018-19. Calendar year 2017 full dual rates were updated. The change from FY 2018-19 to FY 2019-20 is due to updated payments and recoupment timeframes.</p>					
Managed Care Public Hospital EPP	93	\$835.0	\$249.0	\$678.2	\$208.5
<p>This policy change is new to this Estimate. The Managed Care Enhanced Payment Program (EPP) provides directed payments for Designated Public Hospitals (DPHs) including University of California Health Systems (UCs). The change from FY 2018-19 to FY 2019-20 is due to payment timing. Capitated sub-pool amounts are budgeted in both current and budget year, while fee-for-service amounts are only budgeted in budget year.</p>					
Managed Care Reimbursements to the General Fund	110	\$0.0	\$499.7	\$0.0	(\$1,066.5)
<p>This policy change budgets reimbursements to the GF by Intergovernmental Transfers (IGTs) from allowable public entities for Medi-Cal payment contributions and administration and processing fees. The change from the prior estimate for FY 2018-19, and the change from FY 2018-19 to FY 2019-20, is due to a shift in reimbursements (and costs) from FY 2018-19 to FY 2019-20 in the current estimate.</p>					
Managed Care Health Care Financing Program	104	(\$1,461.7)	(\$443.5)	\$1,754.6	\$556.2
<p>This policy change estimates increased payments to managed care plans (MCPs) designed to provide additional support for counties and/or public entities serving Medi-Cal beneficiaries. The change from the prior estimate for FY 2018-19, and the change from FY 2018-19 to FY 2019-20, is due to an updated expected CMS approval date of February 2020 for the FY 2018-19 rating period.</p>					
Mgd. Care Public Hospital Quality Incentive Pool	105	(\$640.0)	(\$191.4)	\$640.0	\$190.8
<p>This policy change estimates managed care directed payments from the Quality Incentive Pool (QIP) to Designated Public Hospitals (DPHs) including the University of California Health Systems (UCs), based on their performance on designated metrics. The change from the prior estimate for FY 2018-19, and the change from FY 2018-19 to FY 2019-20, is due to an implementation delay pending CMS approval. Approval is expected September 2019.</p>					

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
Name	PC	TF	GF	TF	GF
Capitated Rate Adjustment for FY 2019-20	106	\$0.0	\$0.0	\$384.0	\$183.4
The policy change estimates the 2.86% average increase for the Managed Care capitation rates for FY 2019-20, excluding optional expansion rates. FY 2018-19 base rates are kept constant for FY 2019-20 in the Managed Care Base PCs.					
Managed Care IGT Admin & Processing Fee	109	\$0	\$13.9	\$0.0	\$102.6
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities. The change from the prior estimate for FY 2018-19 is due to updated GME IGT payment methodology calculations. The change from FY 2018-19 to FY 2019-20 is due to the discontinuation of the managed care IGT administration and processing fee program. Fees associated with graduate medical education (GME) IGTs will continue to be budgeted in this PC.					
Managed Care Private Hospital Directed Payments	160	\$0.0	\$0.0	\$2,100.0	\$0.0
This policy change estimates the managed care Private Hospital Directed Payments (PHDP) to private hospitals through enhanced capitation payments to managed care plans (MCPs). Payments for the FY 2017-18 rating period are estimated to begin in FY 2019-20. The state share of these payments are funded by the Hospital Quality Assurance Revenue Fund.					
Two Plan Model	85	(\$489.9)	(\$202.7)	\$411.5	\$284.1
This policy change estimates the managed care capitation costs for the Two-Plan model. The change from the prior estimate for FY 2018-19, is due to lower than previously projected eligibles and rates. The change from FY 2018-19 to FY 2019-20 is due to expected eligible growth while the GF increases due to the change in federal matching rates for Title 21 and Optional Expansion. Also, there are no Healthcare Treatment Fund expenditures in FY 2019-20.					
County Organized Health Systems	86	(\$73.0)	(\$15.9)	\$21.0	\$82.1
This policy change estimates the managed care capitation costs for the County Organized Health Systems model. The change from the prior estimate for FY 2018-19 is due to lower than previously expected eligibles and rates. The change from FY 2018-19 to FY 2019-20 is due to expected eligible growth while the GF increases due to the change in federal matching rates for Title 21 and Optional Expansion,					
Geographic Managed Care	87	(\$48.3)	(\$22.3)	\$14.1	\$38.7
This policy change estimates the managed care capitation costs for the Geographic Managed Care model plans. The change from the prior estimate for FY 2018-19, is due to lower than previously projected eligibles, rates and mental health costs. The change from FY 2018-19 to FY 2019-20 is due to higher expected eligible growth while the GF increases due to the change in federal matching rates for Title 21 and Optional Expansion.					

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
Regional Model	91	(\$17.3)	(\$6.9)	\$11.3	\$16.3
<p>This policy change estimates the managed care capitation costs for the Regional model plans. The change from the prior estimate for FY 2018-19, is due to lower than previously projected eligibles, rates, and decreased Hep C costs due to lower than previously expected average monthly users. The change from FY 2018-19 to FY 2019-20 is due to higher expected eligible growth while the GF increases due to the change in federal matching rates for Title 21 and Optional Expansion.</p>					
AB 1629 Annual Rate Adjustment	118	\$52.9	\$26.4	\$66.2	\$33.1
<p>This policy change estimates the cost of the AB 1629 rate increases and add-ons for Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B). In the current estimate, the increase in FY 2018-19 is due to an updated methodology used to estimate the costs for FSSA/NF-Bs, which are facilities that have higher reimbursement rates compared to FS/NF-Bs. The change from FY 2018-19 to FY 2019-20 is due to the full year implementation of the rate year (RY) 2018-19 rate adjustments and slightly higher add-on costs in FY 2019-20.</p>					
Long Term Care Quality Assurance Fund Expenditures	129	\$0.0	(\$439.7)	\$0.0	\$396.5
<p>Effective August 1, 2013, the revenue generated by the Long Term Care (LTC) Quality Assurance (QA) fees are collected and deposited into the Long Term Care Quality Assurance Fund (LTCQAF). This policy change budgets the funding adjustment from the LTCQAF to the General Fund (GF). In the current estimate, fund transfers from the LTCQAF to the GF are estimated to increase based on the LTC QAF withhold amounts from previous years being transferred into the LTCQAF in FY 2018-19. The fund transfers from FY 2018-19 to FY 2019-20 are estimated to decrease due to the reduction in prior year withhold transfers in FY 2019-20.</p>					
Graduate Medical Education Payments to DPHs	136	(\$559.3)	\$0.0	(\$517.1)	\$0.0
<p>This policy change estimates direct and indirect GME payments to the Designated Public Hospitals (DPHs). The non-federal share of the payments will be funded with intergovernmental transfers (IGTs). In the current estimate, the GME payment methodology was revised which decreased the annual total computable estimate from \$950 million TF to \$345.1 million TF. In addition, from the prior estimate, four additional quarters (for a total of ten quarters) are estimated to be paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20 is due to fewer quarters of GME payments estimated in FY 2019-20.</p>					

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
Hospital Quality Assurance Fee (HQAF)	134, 135, 192	(\$416.5)	(\$427.7)	(\$3,665.9)	\$309.9
<p>The HQAF program assesses a fee on applicable general acute care hospitals and matches the fee with federal financial participation providing fee-for-service (FFS) and managed care supplemental payments to hospitals. The HQAF also provides additional funding for children’s health care coverage. In the current estimate:</p> <ul style="list-style-type: none"> • <u>PC 134 FFS payments</u>: HQAF FFS payments are estimated to increase in FY 2018-19 due to the addition of HQAF IV reconciliation payments, HQAF V reconciliation payments, additional UPL repayments to CMS, and subacute payments to be paid in FY 2018-19. The decrease from FY 2018-19 to FY 2019-20 is due to fewer prior year HQAF FFS payments in FY 2019-20. • <u>PC 135 Managed Care payments</u>: HQAF managed care payments are estimated to decrease in the current year due to shifting the HQAF V payments for the FY 2018-19 rating period to FY 2019-20. The decrease from FY 2018-19 to FY 2019-20 is due to fewer prior year payments in FY 2019-20. • <u>PC 192 Children’s Health Care</u>: HQAF Children’s Health Care savings have increased in FY 2018-19 due to the timing of a \$263.7 million technical funding adjustment for HQAF IV in July 2018. In addition, HQAF IV reconciliations were shifted to FY 2019-20 and are estimated to result in \$107.8 million GF savings. The decrease from FY 2018-19 to FY 2019-20 is due to lower estimated Children’s Health Care payments for HQAF VI. 					
QAF Withholds	167	(\$45.9)	(\$22.9)	(\$442.0)	(\$221.0)
<p>This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF) and the AB 1629 Quality Assurance Fee (QAF) assessed on Skilled Nursing Facilities (SNF) and the QAF assessed on Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs). In the current estimate, the net Hospital QAF withhold transfers have decreased based on revised data. This decrease in FY 2018-19 is offset by the addition of the net SNF and ICF/DD QAF withhold transfers estimated to be paid in FY 2018-19. The decrease from FY 2018-19 to FY 2019-20 is due to reduced prior year withhold transfers occurring in FY 2019-20.</p>					
Prop 56 – CBAS	40	\$0.0	\$0.0	(\$2.0)	(\$0.0)
<p>This PC estimates the one-time Prop 56 funds allocated to qualifying CBAS programs. For CY, there is no change from the previous estimate. For BY, the decrease is a result of the one-time funds being used entirely in CY.</p>					
Prop 56 – Home Health Rate Increase	120	(\$0.1)	(\$0.0)	\$8.2	\$0.0
<p>Effective for dates of services on and after July 1, 2018, the Department will increase rates for certain fee-for-service (FFS) home health agency and Private Duty Nursing (PDN) services by 50%. Proposition 56 revenue will be used to fund the non-federal share of these rate increases. In the current estimate, FY 2018-19 costs have decreased due to updated payment lags and funding assumptions. The increase from FY 2018-19 to FY 2019-20 is due to a full year of the rate increase reflected in FY 2019-20.</p>					

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
Prop 56 – Pediatric Day Health Care Rate Increase	124	(\$2.5)	(\$0.0)	\$2.5	\$0.0
Effective for dates of services on and after July 1, 2018, the Department will increase Pediatric Day Health Care (PDHC) services rates by 50%. Proposition 56 revenue will be used to fund the non-federal share of these rate increases. In the current estimate, FY 2018-19 costs have decreased due to updated payment lags and updated utilization assumptions. The increase from FY 2018-19 to FY 2019-20 is due to a full year of the rate increase reflected in FY 2019-20.					
Prop 56 – Physician Services Supplemental Payments	137	\$49.4	(\$0.0)	\$87.7	\$0.0
The Proposition 56 physician supplemental payments pertain to 13 specific Current Procedural Terminology (CPT) codes for FY 2017-18 and 23 CPT codes for FY 2018-19 and FY 2019-20. The change in the FY 2018-19 estimate is due to updated payment lags and updated funding assumptions. The increase from FY 2018-19 to FY 2019-20 is due to higher prior year FFS and managed care costs included in FY 2019-20.					
Prop 56 – Supplemental Payments for Dental Services	140	(\$14.9)	(\$0.0)	\$36.6	\$0.0
This policy change estimates the expenditures related to providing supplemental payments for specific dental services. The change from the prior estimate, for FY 2018-19, is a decrease due to updated procedure and expenditure data used to project future years. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to caseload growth.					
Prop 56 – Women’s Health Supplemental Payments	150	\$19.8	\$0.0	(\$43.4)	\$0.0
For CY, the increase is due to lower utilization; however, there are EPCs occurring that contribute to the overall increase. For BY, the decrease is a result of the EPCs only occurring in CY.					
Prop 56 – ICF/DD Supplemental Payments	152	\$2.9	\$0.0	(\$1.6)	(\$0.0)
In the current estimate, the FY 2018-19 Proposition 56 ICF/DD supplemental payments have increased due to updated fee-for-service (FFS) and managed care costs based on payments lags and managed care payment timing. In addition, the FY 2018-19 total managed care payments have increased to include payments to Coordinated Care Initiative (CCI) plans. The change from FY 2018-19 to FY 2019-20 is due to lower CCI payment amounts in FY 2019-20.					
Prop 56 – FS-PSA Supplemental Payments	157	(\$1.8)	(\$0.0)	(\$4.4)	(\$0.0)
This policy change estimates the cost of providing one-time Proposition 56 supplemental payments to Freestanding Pediatric Subacute facilities for the 2018-19 rate year (RY). These payments were budgeted in the LTC Rate Adjustment policy change in the prior estimate. In the current estimate, the FY 2018-19 costs have decreased due to the application of payment lags and reflecting only 11 months of payments. The change from FY 2018-19 to FY 2019-20 is due to completing the remaining RY 2018-19 payments for one month in FY 2019-20.					

<i>Dollars in Millions</i>		Change from May 2018		Change from FY 2018-19		
		FY 2018-19		FY 2019-20		
		Name	PC	TF	GF	TF
Prop 56 – Value-Based Payment Program	205	\$0.0	\$0.0	\$360.0	\$0.0	
Beginning in FY 2019-20, a Value-Based Payment (VBP) Program will be implemented in managed care through a directed payment program. DHCS will develop specific measures and targets to determine the amount of the incentive payments. This incentive program is targeted at providers that meet specific achievements on certain metrics.						
Prop 56 – Trauma and Developmental Screenings	206	\$0.0	\$0.0	\$105.0	\$0.0	
Beginning in FY 2019-20, the budget includes \$60 million (\$30 million Proposition 56 funds) to increase developmental screenings for children and \$45 million (\$22.5 million Proposition 56 funds) for trauma screenings for children and adults.						
Prop 56 – Medi-Cal Family Planning	207	\$0.0	\$0.0	\$500.0	\$0.0	
The Estimate reflects a supplemental payment starting in FY 2019-20 for any office-based family planning service billed under specific CPT codes. These supplemental payments for Medi-Cal family planning services are intended to help support the larger Medi-Cal population accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program.						
Prop 56 – Physicians & Dentists Loan Repayment Program	--	(\$220)	\$0.0	\$0.0	\$0.0	
This policy change estimated the cost of the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program. The Estimate does not assume expenditures for the loan repayment program as the Department is working to develop cost estimates for the first round of funding. This PC was withdrawn for the November 2018 Estimate and is captured in Information Only.						
Dental Managed Care (Other M/C)	95	(\$42.5)	(\$15.3)	(\$13.7)	(\$4.7)	
The policy change estimates the cost of dental capitation rates for the Dental Managed Care (DMC) program. The change from the prior estimate, for FY 2018-19, is a decrease due to changes in rate payment timing, updated eligibles, and changes in HIPF payment timing. The change from FY 2018-19 to FY 2019-20, results from no HIPF payments scheduled in FY 2019-20.						
Dental Services	166	(\$588.2)	(\$213.3)	\$507.4	\$177.6	
The policy change estimates the cost of dental services. The change from the prior estimate, for FY 2018-19, is a decrease due to a change in methodology to project using actual check write data, a shift of HIPF payments, and an underwriting gain to be returned to the Department. The change from FY 2018-19 to FY 2019-20, is a net increase due to no underwriting gain return in FY 2019-20.						
Periodontal Maintenance Reimb Rate Adj	127	\$6.0	\$3.0	(\$6.0)	(\$3.0)	
This new policy change estimates the adjustment to the Periodontal Maintenance rate for Skilled Nursing Facilities or Intermediate Care Facilities because of a Centers for Medicare & Medicaid Services (CMS) policy. An erroneous payment correction (EPC) will be issued for the period of July 1, 2016, through May 15, 2018. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease as all adjustment payments are expected to be paid in FY 2018-19.						

<i>Dollars in Millions</i>	PC	Change from May 2018		Change from FY 2018-19	
		FY 2018-19		FY 2019-20	
		TF	GF	TF	GF
School-Based Medi-Cal Administrative Activities (SMAA)	OA 1	\$105.2	(\$108.4)	(\$110.7)	(\$28.0)
<p>The SMAA program reimburses Local Educational Agencies (LEAs) or school districts for the federal share of certain costs for administering the Medi-Cal program. Under the 2014 CMS agreement, deferred SMAA claims from FY 2009-10 through FY 2014-15 (Quarters 1 and 2) are subject to backcasting, using a Random Moment Time Study (RMTS) methodology. In the current estimate, the FY 2018-19 repayments have decreased significantly based on actual backcasting invoices. The Department assumes CMS repayments will be completed in FY 2018-19.</p>					
Medical Fiscal Intermediary (FI) PCs	OA 32, 49-56	(\$13.4)	(\$4.8)	(\$69.5)	(\$18.9)
<p>The policy changes for the current Medical FI contract have decreased in FY 2018-19 due to a portion of the FY 2018-19 payments shifting to FY 2019-20. The budget year includes remaining payments through the end of contract period.</p>					
Medical FI BO & IT M&O PCs	OA 57-65	\$0.0	\$0.0	\$104.1	\$26.9
<p>The Assumption of Operations for the new Medical FI Business Operations and Information Technology Maintenance and Operations (IT M&O) FI contracts is October 2019. The current estimate includes payments for the Medical FI BO and IT M&O contracts starting November 2019, the next month.</p>					
Enhanced Federal Funding	CA 6	\$0.0	(\$95.5)	\$0.0	\$77.2
<p>This PC estimates the savings from enhanced federal funding for certain eligibility determination functions. For CY, the decrease is due to the timing of claiming and a change in methodology. In CY, there will be five quarters of payments. For BY, the increase is due to only four quarters of payments.</p>					
CMS Deferrals and Negative Balances	83, 193, CA 7, OA 103	\$0.0	(\$417.7)	\$0.0	(\$165.5)
<p>The Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by Medicaid agencies and may defer payment on claims requiring additional information or claims CMS interprets as not meeting all federal funding requirements. Upon receiving a deferral, the state must promptly return the federal funds to CMS. In the current estimate, CMS deferral estimates are lower than previously estimated based on actual deferrals issued through the September 2017 quarter (Federal Fiscal Year 2018 Quarter 1). In addition, The Department reclaimed \$179.5 million for released deferrals in August 2018.</p> <p>As part of the California Medi-Cal 2020 Demonstration Waiver, the Department must settle all outstanding deferrals and negative balances with CMS. The Department estimates to repay \$108.2 million GF, related to negative balances, to CMS in FY 2018-19.</p>					

Medi-Cal Funding Summary
November 2018 Estimate Compared to Appropriation
Fiscal Year 2018 - 2019

TOTAL FUNDS

Benefits:	Total Appropriation	Nov 2018 Estimate	Difference Incr./(Decr.)
4260-101-0001/0890(3)	\$75,311,757,000	\$70,039,273,000	(\$5,272,484,000)
4260-101-0080 CLPP Funds	\$725,000	\$725,000	\$0
4260-101-0232 Prop 99 Hospital Svc. Acct.	\$73,335,000	\$73,335,000	\$0
4260-101-0233 Prop 99 Physician Svc. Acct	\$22,496,000	\$22,496,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,609,000	\$31,609,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$8,525,000	\$7,576,000	(\$949,000)
4260-101-3305 Healthcare Treatment Fund	\$1,039,038,000	\$935,138,000	(\$103,900,000)
4260-102-0001/0890 Capital Debt	\$102,780,000	\$105,845,000	\$3,065,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$220,000,000	\$0	(\$220,000,000)
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,900,000	\$2,425,000	\$525,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$137,900,000	\$137,900,000	\$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	\$10,173,000	\$10,152,000	(\$21,000)
4260-111-0001(3) CHDP State Only *	\$0	\$0	\$0
4260-113-0001/0890 Healthy Families	\$2,752,220,000	\$2,736,472,000	(\$15,748,000)
4260-601-0942142 Local Trauma Centers	\$64,207,000	\$53,752,000	(\$10,455,000)
4260-601-0942 Home Health Program Account	\$347,000	\$265,000	(\$82,000)
4260-601-0995 Reimbursements	\$1,547,072,000	\$1,155,497,000	(\$391,575,000)
4260-601-3156 MCO Tax Fund	\$21,286,000	\$286,000	(\$21,000,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$762,447,000	\$843,924,000	\$81,477,000
4260-601-3213 LTC QA Fund	\$460,098,000	\$899,759,000	\$439,661,000
4260-601-3293 MCO Tax Fund 2016	\$2,520,163,000	\$2,526,905,000	\$6,742,000
4260-601-3323 Medi-Cal Emergency Transport Fund	\$60,884,000	\$62,118,000	\$1,234,000
4260-601-7502 Demonstration DSH Fund	\$179,295,000	\$166,777,000	(\$12,518,000)
4260-601-7503 Health Care Support Fund	\$337,306,000	\$105,284,000	(\$232,022,000)
4260-601-8107 Whole Person Care Pilot Fund	\$437,421,000	\$419,861,000	(\$17,560,000)
4260-601-8108 Global Payment Program Fund	\$1,246,043,000	\$1,213,940,000	(\$32,103,000)
4260-601-8113 DPH GME Special Fund	\$568,422,000	\$359,406,000	(\$209,016,000)
4260-602-0309 Perinatal Insurance Fund	\$11,734,000	\$16,019,000	\$4,285,000
4260-605-0001 SNF Quality & Accountability *	\$48,310,000	\$50,252,000	\$1,942,000
4260-605-3167 SNF Quality & Accountability	\$43,004,000	\$44,663,000	\$1,659,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,310,000)	(\$50,252,000)	(\$1,942,000)
4260-606-0834 SB 1100 DSH	\$151,893,000	\$166,365,000	\$14,472,000
4260-611-3158/0890 Hospital Quality Assurance	\$11,382,710,000	\$11,393,874,000	\$11,164,000
Total Benefits	\$99,506,790,000	\$93,531,641,000	(\$5,975,149,000)
County Administration:			
4260-101-0001/0890(1)	\$4,489,000,000	\$4,525,840,000	\$36,840,000
4260-106-0890(1) Money Follow Person Fed. Grant	\$682,000	\$744,000	\$62,000
4260-113-0001/0890 Healthy Families	\$62,661,000	\$65,707,000	\$3,046,000
4260-117-0001/0890 HIPPA	\$9,612,000	\$9,350,000	(\$262,000)
4260-601-0942 Home Health Program Account	\$317,000	\$317,000	\$0
4260-601-0995 Reimbursements	\$568,000	\$222,000	(\$346,000)
4260-602-3311 Healthcare Svc. Plans Fines and Penalties Fund	\$1,063,000	\$1,063,000	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$3,407,000	\$3,395,000	(\$12,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$0	\$0	\$0
Total County Administration	\$4,567,310,000	\$4,606,638,000	\$39,328,000
Fiscal Intermediary:			
4260-101-0001/0890(2)	\$309,524,000	\$351,733,000	\$42,209,000
4260-111-0001(2) CHDP State Only *	\$0	\$0	\$0
4260-113-0001/0890 Healthy Families	\$4,871,000	\$4,871,000	\$0
4260-117-0001/0890 HIPAA	\$13,945,000	\$11,102,000	(\$2,843,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$328,340,000	\$367,706,000	\$39,366,000
Grand Total - Total Funds	\$104,402,440,000	\$98,505,985,000	(\$5,896,455,000)

Medi-Cal Funding Summary
November 2018 Estimate Compared to Appropriation
Fiscal Year 2018 - 2019

STATE FUNDS

Benefits:	State Funds Appropriation	Nov 2018 Estimate	Difference Incr./(Decr.)
4260-101-0001(3) *	\$21,308,884,000	\$19,468,531,000	(\$1,840,353,000)
4260-101-0080 CLPP Funds	\$725,000	\$725,000	\$0
4260-101-0232 Prop 99 Hospital Svc. Acct.	\$73,335,000	\$73,335,000	\$0
4260-101-0233 Prop 99 Physician Svc. Acct	\$22,496,000	\$22,496,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$31,609,000	\$31,609,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$8,525,000	\$7,576,000	(\$949,000)
4260-101-3305 Healthcare Treatment Fund	\$1,039,038,000	\$935,138,000	(\$103,900,000)
4260-102-0001 Capital Debt *	\$36,635,000	\$34,914,000	(\$1,721,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$220,000,000	\$0	(\$220,000,000)
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,900,000	\$2,425,000	\$525,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$137,900,000	\$137,900,000	\$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-111-0001(3) CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Healthy Families *	\$108,415,000	\$21,656,000	(\$86,759,000)
4260-601-0942142 Local Trauma Centers	\$64,207,000	\$53,752,000	(\$10,455,000)
4260-601-0942 Home Health Program Account	\$347,000	\$265,000	(\$82,000)
4260-601-0995 Reimbursements	\$1,547,072,000	\$1,155,497,000	(\$391,575,000)
4260-601-3156 MCO Tax Fund	\$21,286,000	\$286,000	(\$21,000,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$762,447,000	\$843,924,000	\$81,477,000
4260-601-3213 LTC QA Fund	\$460,098,000	\$899,759,000	\$439,661,000
4260-601-3293 MCO Tax Fund 2016	\$2,520,163,000	\$2,526,905,000	\$6,742,000
4260-601-3323 Medi-Cal Emergency Transport Fund	\$60,884,000	\$62,118,000	\$1,234,000
4260-601-8107 Whole Person Care Pilot Fund	\$437,421,000	\$419,861,000	(\$17,560,000)
4260-601-8108 Global Payment Program Fund	\$1,246,043,000	\$1,213,940,000	(\$32,103,000)
4260-601-8113 DPH GME Special Fund	\$568,422,000	\$359,406,000	(\$209,016,000)
4260-602-0309 Perinatal Insurance Fund	\$11,734,000	\$16,019,000	\$4,285,000
4260-605-0001 SNF Quality & Accountability *	\$48,310,000	\$50,252,000	\$1,942,000
4260-605-3167 SNF Quality & Accountability	\$43,004,000	\$44,663,000	\$1,659,000
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$48,310,000)	(\$50,252,000)	(\$1,942,000)
4260-606-0834 SB 1100 DSH	\$151,893,000	\$166,365,000	\$14,472,000
4260-611-3158 Hospital Quality Assurance Revenue	\$4,871,254,000	\$6,276,427,000	\$1,405,173,000
Total Benefits	\$35,755,737,000	\$34,775,492,000	(\$980,245,000)
Total Benefits General Fund *	\$21,622,544,000	\$19,695,653,000	(\$1,926,891,000)
County Administration:			
4260-101-0001(1) *	\$1,222,511,000	\$801,168,000	(\$421,343,000)
4260-113-0001 Healthy Families *	\$5,507,000	\$5,669,000	\$162,000
4260-117-0001 HIPAA *	\$1,694,000	\$1,551,000	(\$143,000)
4260-601-0942 Home Health Program Account	\$317,000	\$317,000	\$0
4260-601-0995 Reimbursements	\$568,000	\$222,000	(\$346,000)
4260-602-3311 Healthcare Svc. Plans Fines and Penalties Fund	\$1,063,000	\$1,063,000	\$0
4260-605-3167 SNF Quality & Accountability Admin.	\$3,407,000	\$3,395,000	(\$12,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$0	\$0	\$0
Total County Administration	\$1,235,067,000	\$813,385,000	(\$421,682,000)
Total County Administration General Fund *	\$1,229,712,000	\$808,388,000	(\$421,324,000)
Fiscal Intermediary:			
4260-101-0001(2) *	\$109,642,000	\$172,656,000	\$63,014,000
4260-111-0001(2) CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Healthy Families *	\$585,000	\$585,000	\$0
4260-117-0001 HIPAA *	\$2,549,000	\$2,057,000	(\$492,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$112,776,000	\$175,298,000	\$62,522,000
Total Fiscal Intermediary General Fund *	\$112,776,000	\$175,298,000	\$62,522,000
Grand Total - State Funds	\$37,103,580,000	\$35,764,175,000	(\$1,339,405,000)
Grand Total - General Fund*	\$22,965,032,000	\$20,679,339,000	(\$2,285,693,000)

Medi-Cal Funding Summary
November 2018 Estimate Compared to Appropriation
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FEDERAL FUNDS

	<u>Federal Funds Appropriation</u>	<u>Nov 2018 Estimate</u>	<u>Difference Incr./.(Decr.)</u>
<u>Benefits:</u>			
4260-101-0890(3)	\$54,002,873,000	\$50,570,742,000	(\$3,432,131,000)
4260-102-0890 Capital Debt	\$66,145,000	\$70,931,000	\$4,786,000
4260-106-0890 Money Follows Person Federal Grant	\$10,173,000	\$10,152,000	(\$21,000)
4260-113-0890 Health Families	\$2,643,805,000	\$2,714,816,000	\$71,011,000
4260-601-7502 Demonstration DSH Fund	\$179,295,000	\$166,777,000	(\$12,518,000)
4260-601-7503 Health Care Support Fund	\$337,306,000	\$105,284,000	(\$232,022,000)
4260-611-0890 Hospital Quality Assurance	\$6,511,456,000	\$5,117,447,000	(\$1,394,009,000)
Total Benefits	<u>\$63,751,053,000</u>	<u>\$58,756,149,000</u>	<u>(\$4,994,904,000)</u>
<u>County Administration:</u>			
4260-101-0890(1)	\$3,266,489,000	\$3,724,672,000	\$458,183,000
4260-106-0890(1) Money Follows Person Fed. Grant	\$682,000	\$744,000	\$62,000
4260-113-0890 Healthy Families	\$57,154,000	\$60,038,000	\$2,884,000
4260-117-0890 HIPAA	\$7,918,000	\$7,799,000	(\$119,000)
Total County Administration	<u>\$3,332,243,000</u>	<u>\$3,793,253,000</u>	<u>\$461,010,000</u>
<u>Fiscal Intermediary:</u>			
4260-101-0890(2)	\$199,882,000	\$179,077,000	(\$20,805,000)
4260-113-0890 Healthy Families	\$4,286,000	\$4,286,000	\$0
4260-117-0890 HIPAA	\$11,396,000	\$9,045,000	(\$2,351,000)
Total Fiscal Intermediary	<u>\$215,564,000</u>	<u>\$192,408,000</u>	<u>(\$23,156,000)</u>
Grand Total - Federal Funds	<u>\$67,298,860,000</u>	<u>\$62,741,810,000</u>	<u>(\$4,557,050,000)</u>

Medi-Cal Funding Summary
November 2018 Estimate Comparison of FY 2018-19 to FY 2019-20

TOTAL FUNDS

<u>Benefits:</u>	<u>FY 2018-19</u> <u>Estimate</u>	<u>FY 2019-20</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
4260-101-0001/0890(3)	\$70,039,273,000	\$74,474,635,000	\$4,435,362,000
4260-101-0080 CLPP Funds	\$725,000	\$725,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$73,335,000	\$125,979,000	\$52,644,000
4260-101-0233 Prop 99 Physician Srvc. Acct	\$22,496,000	\$39,526,000	\$17,030,000
4260-101-0236 Prop 99 Unallocated Account	\$31,609,000	\$59,266,000	\$27,657,000
4260-101-3168 Emergency Air Transportation Fund	\$7,576,000	\$8,090,000	\$514,000
4260-101-3305 Healthcare Treatment Fund	\$935,138,000	\$1,052,018,000	\$116,880,000
4260-102-0001/0890 Capital Debt	\$105,845,000	\$107,956,000	\$2,111,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,425,000	\$1,900,000	(\$525,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$137,900,000	\$137,900,000	\$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	\$10,152,000	\$411,000	(\$9,741,000)
4260-111-0001(3) CHDP State Only *	\$0	\$2,000	\$2,000
4260-113-0001/0890 Healthy Families	\$2,736,472,000	\$3,310,172,000	\$573,700,000
4260-601-0942142 Local Trauma Centers	\$53,752,000	\$64,000,000	\$10,248,000
4260-601-0942 Home Health Program Account	\$265,000	\$8,551,000	\$8,286,000
4260-601-0995 Reimbursements	\$1,155,497,000	\$1,573,675,000	\$418,178,000
4260-601-3156 MCO Tax Fund	\$286,000	\$0	(\$286,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$843,924,000	\$666,000,000	(\$177,924,000)
4260-601-3213 LTC QA Fund	\$899,759,000	\$503,268,000	(\$396,491,000)
4260-601-3293 MCO Tax Fund 2016	\$2,526,905,000	\$806,432,000	(\$1,720,473,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$62,118,000	\$69,585,000	\$7,467,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$0	\$1,440,526,000	\$1,440,526,000
4260-601-7502 Demonstration DSH Fund	\$166,777,000	\$114,254,000	(\$52,523,000)
4260-601-7503 Health Care Support Fund	\$105,284,000	\$231,916,000	\$126,632,000
4260-601-8107 Whole Person Care Pilot Fund	\$419,861,000	\$323,365,000	(\$96,496,000)
4260-601-8108 Global Payment Program Fund	\$1,213,940,000	\$1,026,722,000	(\$187,218,000)
4260-601-8113 DPH GME Special Fund	\$359,406,000	\$154,404,000	(\$205,002,000)
4260-602-0309 Perinatal Insurance Fund	\$16,019,000	\$19,736,000	\$3,717,000
4260-605-0001 SNF Quality & Accountability *	\$50,252,000	\$50,083,000	(\$169,000)
4260-605-3167 SNF Quality & Accountability	\$44,663,000	\$44,000,000	(\$663,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$50,252,000)	(\$50,083,000)	\$169,000
4260-606-0834 SB 1100 DSH	\$166,365,000	\$144,317,000	(\$22,048,000)
4260-611-3158/0890 Hospital Quality Assurance	\$11,393,874,000	\$9,518,127,000	(\$1,875,747,000)
Total Benefits	\$93,531,641,000	\$96,027,458,000	\$2,495,817,000
County Administration:			
4260-101-0001/0890(1)	\$4,525,840,000	\$4,241,472,000	(\$284,368,000)
4260-106-0890(1) Money Follow Person Fed. Grant	\$744,000	\$340,000	(\$404,000)
4260-113-0001/0890 Healthy Families	\$65,707,000	\$66,008,000	\$301,000
4260-117-0001/0890 HIPPA	\$9,350,000	\$9,104,000	(\$246,000)
4260-601-0942 Home Health Program Account	\$317,000	\$317,000	\$0
4260-601-0995 Reimbursements	\$222,000	\$222,000	\$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$1,063,000	\$708,000	(\$355,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$3,395,000	\$3,250,000	(\$145,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$0	\$92,000	\$92,000
Total County Administration	\$4,606,638,000	\$4,321,513,000	(\$285,125,000)
Fiscal Intermediary:			
4260-101-0001/0890(2)	\$351,733,000	\$339,229,000	(\$12,504,000)
4260-111-0001(2) CHDP State Only *	\$0	\$1,000	\$1,000
4260-113-0001/0890 Healthy Families	\$4,871,000	\$4,737,000	(\$134,000)
4260-117-0001/0890 HIPAA	\$11,102,000	\$6,940,000	(\$4,162,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$367,706,000	\$350,907,000	(\$16,799,000)
Grand Total - Total Funds	\$98,505,985,000	\$100,699,878,000	\$2,193,893,000

Medi-Cal Funding Summary
November 2018 Estimate Comparison of FY 2018-19 to FY 2019-20

STATE FUNDS

<u>Benefits:</u>	FY 2018-19 Estimate	FY 2019-20 Estimate	Difference Incr./(Decr.)
4260-101-0001(3) *	\$19,468,531,000	\$21,109,403,000	\$1,640,872,000
4260-101-0080 CLPP Funds	\$725,000	\$725,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$73,335,000	\$125,979,000	\$52,644,000
4260-101-0233 Prop 99 Physician Srvc. Acct	\$22,496,000	\$39,526,000	\$17,030,000
4260-101-0236 Prop 99 Unallocated Account	\$31,609,000	\$59,266,000	\$27,657,000
4260-101-3168 Emergency Air Transportation Fund	\$7,576,000	\$8,090,000	\$514,000
4260-101-3305 Healthcare Treatment Fund	\$935,138,000	\$1,052,018,000	\$116,880,000
4260-102-0001 Capital Debt *	\$34,914,000	\$36,140,000	\$1,226,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$2,425,000	\$1,900,000	(\$525,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$1,900,000)	(\$1,900,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$118,400,000	\$118,400,000	\$0
4260-601-3097 Private Hosp Suppl	\$137,900,000	\$137,900,000	\$0
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-111-0001(3) CHDP State Only *	\$0	\$2,000	\$2,000
4260-113-0001 Healthy Families *	\$21,656,000	\$535,279,000	\$513,623,000
4260-601-0942142 Local Trauma Centers	\$53,752,000	\$64,000,000	\$10,248,000
4260-601-0942 Home Health Program Account	\$265,000	\$8,551,000	\$8,286,000
4260-601-0995 Reimbursements	\$1,155,497,000	\$1,573,675,000	\$418,178,000
4260-601-3156 MCO Tax Fund	\$286,000	\$0	(\$286,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$843,924,000	\$666,000,000	(\$177,924,000)
4260-601-3213 LTC QA Fund	\$899,759,000	\$503,268,000	(\$396,491,000)
4260-601-3293 MCO Tax Fund 2016	\$2,526,905,000	\$806,432,000	(\$1,720,473,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$62,118,000	\$69,585,000	\$7,467,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$0	\$1,440,526,000	\$1,440,526,000
4260-601-8107 Whole Person Care Pilot Fund	\$419,861,000	\$323,365,000	(\$96,496,000)
4260-601-8108 Global Payment Program Fund	\$1,213,940,000	\$1,026,722,000	(\$187,218,000)
4260-601-8113 DPH GME Special Fund	\$359,406,000	\$154,404,000	(\$205,002,000)
4260-602-0309 Perinatal Insurance Fund	\$16,019,000	\$19,736,000	\$3,717,000
4260-605-0001 SNF Quality & Accountability *	\$50,252,000	\$50,083,000	(\$169,000)
4260-605-3167 SNF Quality & Accountability	\$44,663,000	\$44,000,000	(\$663,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$50,252,000)	(\$50,083,000)	\$169,000
4260-606-0834 SB 1100 DSH	\$166,365,000	\$144,317,000	(\$22,048,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$6,276,427,000	\$4,359,240,000	(\$1,917,187,000)
Total Benefits	\$34,775,492,000	\$34,310,049,000	(\$465,443,000)
Total Benefits General Fund *	\$19,695,653,000	\$21,851,207,000	\$2,155,554,000
County Administration:			
4260-101-0001(1) *	\$801,168,000	\$895,165,000	\$93,997,000
4260-113-0001 Healthy Families *	\$5,669,000	\$10,095,000	\$4,426,000
4260-117-0001 HIPAA *	\$1,551,000	\$1,528,000	(\$23,000)
4260-601-0942 Home Health Program Account	\$317,000	\$317,000	\$0
4260-601-0995 Reimbursements	\$222,000	\$222,000	\$0
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$1,063,000	\$708,000	(\$355,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$3,395,000	\$3,250,000	(\$145,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$0	\$92,000	\$92,000
Total County Administration	\$813,385,000	\$911,377,000	\$97,992,000
Total County Administration General Fund *	\$808,388,000	\$906,788,000	\$98,400,000
Fiscal Intermediary:			
4260-101-0001(2) *	\$172,656,000	\$116,736,000	(\$55,920,000)
4260-111-0001(2) CHDP State Only *	\$0	\$1,000	\$1,000
4260-113-0001 Healthy Families *	\$585,000	\$977,000	\$392,000
4260-117-0001 HIPAA *	\$2,057,000	\$1,310,000	(\$747,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
Total Fiscal Intermediary	\$175,298,000	\$119,024,000	(\$56,274,000)
Total Fiscal Intermediary General Fund *	\$175,298,000	\$119,024,000	(\$56,274,000)
Grand Total - State Funds	\$35,764,175,000	\$35,340,450,000	(\$423,725,000)
Grand Total - General Fund*	\$20,679,339,000	\$22,877,019,000	\$2,197,680,000

Medi-Cal Funding Summary
November 2018 Estimate Comparison of FY 2018-19 to FY 2019-20

FEDERAL FUNDS

	FY 2018-19 Estimate	FY 2019-20 Estimate	Difference Incr./(Decr.)
Benefits:			
4260-101-0890(3)	\$50,570,742,000	\$53,365,232,000	\$2,794,490,000
4260-102-0890 Capital Debt	\$70,931,000	\$71,816,000	\$885,000
4260-106-0890 Money Follows Person Federal Grant	\$10,152,000	\$411,000	(\$9,741,000)
4260-113-0890 Health Families	\$2,714,816,000	\$2,774,893,000	\$60,077,000
4260-601-7502 Demonstration DSH Fund	\$166,777,000	\$114,254,000	(\$52,523,000)
4260-601-7503 Health Care Support Fund	\$105,284,000	\$231,916,000	\$126,632,000
4260-611-0890 Hospital Quality Assurance	\$5,117,447,000	\$5,158,887,000	\$41,440,000
Total Benefits	\$58,756,149,000	\$61,717,409,000	\$2,961,260,000
County Administration:			
4260-101-0890(1)	\$3,724,672,000	\$3,346,307,000	(\$378,365,000)
4260-106-0890(1) Money Follows Person Fed. Grant	\$744,000	\$340,000	(\$404,000)
4260-113-0890 Healthy Families	\$60,038,000	\$55,913,000	(\$4,125,000)
4260-117-0890 HIPAA	\$7,799,000	\$7,576,000	(\$223,000)
Total County Administration	\$3,793,253,000	\$3,410,136,000	(\$383,117,000)
Fiscal Intermediary:			
4260-101-0890(2)	\$179,077,000	\$222,493,000	\$43,416,000
4260-113-0890 Healthy Families	\$4,286,000	\$3,760,000	(\$526,000)
4260-117-0890 HIPAA	\$9,045,000	\$5,630,000	(\$3,415,000)
Total Fiscal Intermediary	\$192,408,000	\$231,883,000	\$39,475,000
Grand Total - Federal Funds	\$62,741,810,000	\$65,359,428,000	\$2,617,618,000

MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2018-19

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
I. BASE ESTIMATES				
A. C/Y FFS BASE	\$17,461,828,370	\$8,730,914,190	\$8,730,914,190	\$0
B. C/Y BASE POLICY CHANGES	\$46,183,467,990	\$31,436,593,150	\$14,614,863,840	\$132,011,000
C. BASE ADJUSTMENTS	(\$171,155,000)	(\$207,750,790)	(\$898,542,210)	\$935,138,000
D. ADJUSTED BASE	\$63,474,141,360	\$39,959,756,540	\$22,447,235,820	\$1,067,149,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	(\$44,517,000)	(\$1,151,082,570)	\$1,105,819,570	\$746,000
B. AFFORDABLE CARE ACT	\$1,487,687,000	\$1,436,695,230	\$50,991,770	\$0
C. BENEFITS	\$1,679,041,860	\$1,175,601,190	\$483,551,670	\$19,889,000
D. PHARMACY	(\$2,451,223,770)	(\$1,424,621,490)	(\$1,026,602,280)	\$0
E. DRUG MEDI-CAL	\$270,314,000	\$219,626,560	\$50,687,440	\$0
F. MENTAL HEALTH	\$59,126,000	\$49,420,500	\$9,505,500	\$200,000
G. WAIVER--MH/UCD & BTR	\$5,347,592,000	\$2,629,186,500	\$232,849,000	\$2,485,556,500
H. MANAGED CARE	\$6,153,890,370	\$3,580,909,280	(\$938,481,100)	\$3,511,462,200
I. PROVIDER RATES	\$950,547,810	\$1,058,782,580	(\$1,077,687,770)	\$969,453,000
J. SUPPLEMENTAL PMNTS.	\$15,547,057,570	\$8,851,930,960	\$1,184,356,610	\$5,510,770,000
K. OTHER	\$1,057,981,910	\$2,369,940,090	(\$2,826,571,170)	\$1,514,613,000
L. TOTAL CHANGES	\$30,057,497,740	\$18,796,388,820	(\$2,751,580,780)	\$14,012,689,700
III. TOTAL MEDI-CAL ESTIMATE	\$93,531,639,100	\$58,756,145,360	\$19,695,655,040	\$15,079,838,700

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
1	BREAST AND CERVICAL CANCER TREATMENT	\$71,405,000	\$25,238,050	\$46,166,950	\$0
2	MEDI-CAL STATE INMATE PROGRAMS	\$64,798,000	\$64,798,000	\$0	\$0
4	MEDI-CAL COUNTY INMATE PROGRAMS	\$46,739,000	\$45,927,780	\$811,220	\$0
7	NON-OTLCP CHIP	\$0	(\$156,948,120)	\$156,948,120	\$0
8	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$905,934,000)	\$905,934,000	\$0
9	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$94,438,960	(\$94,438,960)	\$0
10	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	(\$14,677,000)	\$14,677,000	\$0
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$746,000)	\$746,000
12	CDCR RETRO REPAYMENT	\$0	(\$17,206,000)	\$17,206,000	\$0
13	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	(\$6,971,000)	(\$103,068,800)	\$96,097,800	\$0
14	OTLCP PREMIUMS	(\$63,513,000)	(\$55,891,440)	(\$7,621,560)	\$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$156,975,000)	(\$127,760,000)	(\$29,215,000)	\$0
	ELIGIBILITY SUBTOTAL	(\$44,517,000)	(\$1,151,082,570)	\$1,105,819,570	\$746,000
<u>AFFORDABLE CARE ACT</u>					
16	COMMUNITY FIRST CHOICE OPTION	\$3,588,620,000	\$3,588,620,000	\$0	\$0
17	HEALTH INSURER FEE	\$287,808,000	\$190,284,980	\$97,523,020	\$0
18	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$15,806,000	\$15,806,000	\$0	\$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$44,182,250	(\$44,182,250)	\$0
20	ACA MAGI SAVINGS	\$0	\$0	\$0	\$0
21	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$2,349,000	(\$2,349,000)	\$0
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$4,547,000)	(\$4,547,000)	\$0	\$0
24	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$2,400,000,000)	(\$2,400,000,000)	\$0	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$1,487,687,000	\$1,436,695,230	\$50,991,770	\$0
<u>BENEFITS</u>					
25	BEHAVIORAL HEALTH TREATMENT	\$582,841,000	\$324,338,760	\$258,502,240	\$0
26	FAMILY PACT PROGRAM	\$410,507,000	\$281,374,200	\$129,132,800	\$0
27	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$266,213,000	\$266,213,000	\$0	\$0
28	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$132,312,000	\$132,312,000	\$0	\$0
29	FULL RESTORATION OF ADULT DENTAL BENEFITS	\$84,057,000	\$56,291,720	\$27,765,280	\$0
30	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	\$101,777,000	\$56,636,760	\$45,140,240	\$0
32	WHOLE CHILD MODEL IMPLEMENTATION	\$28,539,000	\$15,731,360	\$12,807,640	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>BENEFITS</u>					
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,125,000	\$10,062,500	(\$9,826,500)	\$19,889,000
34	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	\$19,895,000	\$12,168,180	\$7,726,820	\$0
35	CCS DEMONSTRATION PROJECT	\$11,234,000	\$6,192,320	\$5,041,680	\$0
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$10,308,000	\$8,787,000	\$1,521,000	\$0
37	MEDI-CAL NONMEDICAL TRANSPORTATION	\$4,239,730	\$2,630,700	\$1,609,030	\$0
38	YOUTH REGIONAL TREATMENT CENTERS	\$2,893,000	\$2,871,000	\$22,000	\$0
39	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$2,400,000	\$0	\$2,400,000	\$0
40	PROP 56 - CBAS PROGRAMS	\$2,000,000	\$0	\$2,000,000	\$0
41	PEDIATRIC PALLIATIVE CARE WAIVER	\$1,912,950	\$585,640	\$1,327,310	\$0
42	CCT FUND TRANSFER TO CDSS AND CDDS	\$1,365,000	\$1,365,000	\$0	\$0
44	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	(\$3,576,820)	(\$1,958,950)	(\$1,617,870)	\$0
	BENEFITS SUBTOTAL	\$1,679,041,860	\$1,175,601,190	\$483,551,670	\$19,889,000
<u>PHARMACY</u>					
45	HEPATITIS C REVISED CLINICAL GUIDELINES	\$64,295,960	\$44,042,070	\$20,253,890	\$0
47	PHARMACIST-DELIVERED MEDI-CAL SERVICES	\$250,270	\$155,790	\$94,490	\$0
48	LITIGATION SETTLEMENTS	(\$2,453,000)	\$0	(\$2,453,000)	\$0
49	BCCTP DRUG REBATES	(\$9,942,000)	(\$6,775,550)	(\$3,166,450)	\$0
50	FAMILY PACT DRUG REBATES	(\$23,327,000)	(\$20,260,200)	(\$3,066,800)	\$0
51	MEDICAL SUPPLY REBATES	(\$24,916,000)	(\$12,458,000)	(\$12,458,000)	\$0
52	PHARMACY REIMBURSEMENT & DISPENSING FEE	(\$18,000,000)	(\$11,482,220)	(\$6,517,780)	\$0
53	STATE SUPPLEMENTAL DRUG REBATES	(\$213,254,000)	(\$147,869,320)	(\$65,384,680)	\$0
54	FEDERAL DRUG REBATES	(\$2,223,878,000)	(\$1,269,974,060)	(\$953,903,940)	\$0
	PHARMACY SUBTOTAL	(\$2,451,223,770)	(\$1,424,621,490)	(\$1,026,602,280)	\$0
<u>DRUG MEDI-CAL</u>					
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$266,957,000	\$216,330,310	\$50,626,690	\$0
60	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$818,000)	(\$713,000)	(\$105,000)	\$0
201	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$4,175,000	\$4,009,250	\$165,750	\$0
	DRUG MEDI-CAL SUBTOTAL	\$270,314,000	\$219,626,560	\$50,687,440	\$0
<u>MENTAL HEALTH</u>					
63	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$46,640,000	\$46,640,000	\$0	\$0
64	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$17,103,000	\$7,737,500	\$9,365,500	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>MENTAL HEALTH</u>					
65	PATHWAYS TO WELL-BEING	\$9,521,000	\$9,521,000	\$0	\$0
66	TRANSITIONAL SMHS CLAIMS	\$909,000	\$0	\$909,000	\$0
67	LATE CLAIMS FOR SMHS	\$25,000	\$0	\$25,000	\$0
68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$1,055,000)	\$855,000	\$200,000
69	CHART REVIEW	(\$766,000)	(\$766,000)	\$0	\$0
70	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$14,306,000)	(\$12,657,000)	(\$1,649,000)	\$0
	MENTAL HEALTH SUBTOTAL	\$59,126,000	\$49,420,500	\$9,505,500	\$200,000
<u>WAIVER--MH/UCD & BTR</u>					
71	GLOBAL PAYMENT PROGRAM	\$2,427,881,000	\$1,213,941,000	\$0	\$1,213,940,000
72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,687,847,000	\$843,923,500	\$0	\$843,923,500
73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$839,722,000	\$419,861,000	\$0	\$419,861,000
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$115,244,000	\$57,622,000	\$57,622,000	\$0
75	MH/UCD—STABILIZATION FUNDING	\$110,930,000	\$0	\$110,930,000	\$0
76	BTR - LIHP - MCE	\$104,616,000	\$104,616,000	\$0	\$0
77	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$36,060,000	\$36,060,000	\$0	\$0
78	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$21,940,000	\$21,940,000	\$0	\$0
79	MH/UCD—SAFETY NET CARE POOL	\$2,989,000	\$2,989,000	\$0	\$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$363,000	\$363,000	\$0	\$0
81	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$37,727,000	(\$37,727,000)	\$0
82	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	\$6,205,000	(\$6,205,000)	\$0
83	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	\$0	(\$108,229,000)	\$108,229,000	\$0
84	LIHP MCE REPAYMENT	\$0	(\$7,832,000)	\$0	\$7,832,000
	WAIVER--MH/UCD & BTR SUBTOTAL	\$5,347,592,000	\$2,629,186,500	\$232,849,000	\$2,485,556,500
<u>MANAGED CARE</u>					
88	CCI-MANAGED CARE PAYMENTS	\$2,453,548,370	\$1,226,774,190	\$1,226,774,190	\$0
89	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	\$2,172,871,000	\$1,510,062,200	\$662,808,800	\$0
90	MANAGED CARE RATE RANGE IGTS	\$1,697,426,000	\$1,203,346,000	\$0	\$494,080,000
92	RETRO MC RATE ADJUSTMENTS	\$884,722,000	\$404,302,460	\$418,406,540	\$62,013,000
93	MANAGED CARE PUBLIC HOSPITAL EPP	\$835,015,000	\$586,064,770	\$248,950,230	\$0
98	CCI-QUALITY WITHHOLD REPAYMENTS	\$8,260,000	\$4,130,000	\$4,130,000	\$0
99	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$4,981,000	\$0	\$4,981,000	\$0
100	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$2,652,000	\$2,386,800	\$0	\$265,200

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>MANAGED CARE</u>					
102	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$571,000	\$285,500	\$285,500	\$0
103	PALLIATIVE CARE SERVICES IMPLEMENTATION	\$237,000	\$118,500	\$118,500	\$0
107	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	\$0	(\$286,000)	\$286,000
109	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$112,006,000)	\$112,006,000
110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$315,907,000)	\$315,907,000
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	\$0	\$0	(\$660,295,000)	\$660,295,000
112	MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,866,610,000)	\$1,866,610,000
113	MANAGED CARE DRUG REBATES	(\$1,906,393,000)	(\$1,356,561,140)	(\$549,831,860)	\$0
	MANAGED CARE SUBTOTAL	\$6,153,890,370	\$3,580,909,280	(\$938,481,100)	\$3,511,462,200
<u>PROVIDER RATES</u>					
114	DPH INTERIM & FINAL RECONS	\$242,884,000	\$242,884,000	\$0	\$0
115	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$101,879,540	\$63,495,660	\$38,383,880	\$0
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$172,631,000	\$117,414,000	(\$6,901,000)	\$62,118,000
117	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$163,939,000	\$102,173,510	\$61,765,490	\$0
118	AB 1629 ANNUAL RATE ADJUSTMENTS	\$127,180,950	\$63,590,470	\$63,590,470	\$0
119	DPH INTERIM RATE GROWTH	\$59,400,070	\$29,700,040	\$29,700,040	\$0
120	PROP 56 - HOME HEALTH RATE INCREASE	\$56,600,080	\$29,558,060	\$27,042,020	\$0
121	DENTAL RETROACTIVE RATE CHANGES	\$25,931,000	\$16,378,920	\$9,552,080	\$0
122	LTC RATE ADJUSTMENT	\$14,050,150	\$7,025,070	\$7,025,070	\$0
123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$11,972,000	\$5,986,000	(\$1,590,000)	\$7,576,000
124	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$11,752,950	\$6,133,070	\$5,619,880	\$0
125	HOSPICE RATE INCREASES	\$14,569,260	\$7,284,630	\$7,284,630	\$0
126	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	\$6,638,780	\$12,001,620	(\$5,362,850)	\$0
127	PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT	\$5,953,000	\$2,976,500	\$2,976,500	\$0
128	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$1,957,920	\$978,960	\$978,960	\$0
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$899,759,000)	\$899,759,000
130	DPH INTERIM RATE	\$0	\$384,598,010	(\$384,598,010)	\$0
131	10% PROVIDER PAYMENT REDUCTION	(\$13,939,770)	(\$6,969,890)	(\$6,969,890)	\$0
132	LABORATORY RATE METHODOLOGY CHANGE	(\$18,609,220)	(\$9,304,610)	(\$9,304,610)	\$0
133	REDUCTION TO RADIOLOGY RATES	(\$34,242,900)	(\$17,121,450)	(\$17,121,450)	\$0
	PROVIDER RATES SUBTOTAL	\$950,547,800	\$1,058,782,580	(\$1,077,687,770)	\$969,453,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>SUPPLEMENTAL PMNTS.</u>					
134	HOSPITAL QAF - FFS PAYMENTS	\$6,261,304,000	\$2,538,763,000	\$0	\$3,722,541,000
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$3,746,122,000	\$2,578,684,000	\$0	\$1,167,438,000
136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$894,195,000	\$557,144,000	\$0	\$337,051,000
137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,275,269,280	\$873,723,390	\$401,545,890	\$0
138	PRIVATE HOSPITAL DSH REPLACEMENT	\$566,597,000	\$283,298,500	\$283,298,500	\$0
139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$503,241,000	\$503,241,000	\$0	\$0
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$510,070,000	\$315,679,030	\$194,390,970	\$0
141	DSH PAYMENT	\$415,063,000	\$290,920,000	\$16,543,000	\$107,600,000
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$317,899,000	\$179,999,000	\$118,400,000	\$19,500,000
143	NDPH IGT SUPPLEMENTAL PAYMENTS	\$160,421,000	\$111,755,000	(\$10,099,000)	\$58,765,000
144	DPH PHYSICIAN & NON-PHYS. COST	\$147,389,000	\$147,389,000	\$0	\$0
145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$145,438,000	\$145,438,000	\$0	\$0
146	CAPITAL PROJECT DEBT REIMBURSEMENT	\$126,344,000	\$91,430,500	\$34,913,500	\$0
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$119,213,000	\$69,532,900	\$493,100	\$49,187,000
148	FFP FOR LOCAL TRAUMA CENTERS	\$116,107,000	\$62,355,000	\$0	\$53,752,000
149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$89,326,000	\$44,663,000	\$50,252,000	(\$5,589,000)
150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$61,120,160	\$44,806,560	\$16,313,600	\$0
151	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$37,505,000	\$37,505,000	\$0	\$0
152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$8,378,280	\$4,458,460	\$3,919,820	\$0
153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,001,000	\$5,000,500	\$5,000,500	\$0
154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$9,389,000	\$9,389,000	\$0	\$0
155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$4,000,000	\$0
156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,534,800	\$3,267,400	\$3,267,400	\$0
157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS	\$6,189,050	\$3,195,720	\$2,993,330	\$0
158	NDPH SUPPLEMENTAL PAYMENT	\$5,830,000	\$3,405,000	\$1,900,000	\$525,000
159	IGT PAYMENTS FOR HOSPITAL SERVICES	\$112,000	\$112,000	\$0	\$0
161	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$0	(\$57,224,000)	\$57,224,000	\$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$15,547,057,570	\$8,851,930,960	\$1,184,356,610	\$5,510,770,000
<u>OTHER</u>					
167	QAF WITHHOLD TRANSFER	\$581,878,000	\$290,939,000	\$290,939,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>OTHER</u>					
170	CCI IHSS RECONCILIATION	\$142,263,000	\$142,263,000	\$0	\$0
171	ARRA HITECH - PROVIDER PAYMENTS	\$91,440,000	\$91,440,000	\$0	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$130,514,000	\$130,514,000	\$0	\$0
174	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$29,097,560	\$14,548,780	\$14,548,780	\$0
177	INFANT DEVELOPMENT PROGRAM	\$46,546,000	\$46,546,000	\$0	\$0
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$19,468,000	\$11,061,000	\$8,407,000	\$0
179	MEDI-CAL ESTATE RECOVERIES	\$13,383,660	\$6,691,830	\$6,691,830	\$0
180	OVERTIME FOR WPCS PROVIDERS	\$8,088,000	\$4,044,000	\$4,044,000	\$0
181	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	\$5,176,140	\$2,588,070	\$2,588,070	\$0
182	WPCS WORKERS' COMPENSATION	\$3,322,000	\$1,661,000	\$1,661,000	\$0
184	INDIAN HEALTH SERVICES	\$1,265,000	\$11,265,000	(\$10,000,000)	\$0
187	AUDIT SETTLEMENTS	\$0	(\$191,648,000)	\$191,648,000	\$0
188	IMD ANCILLARY SERVICES	\$0	(\$34,524,000)	\$34,524,000	\$0
189	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$127,440,000)	\$127,440,000
190	COUNTY SHARE OF OTLICP-CCS COSTS	\$0	\$0	\$0	\$0
191	CLPP FUND	\$0	\$0	(\$725,000)	\$725,000
192	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$1,386,448,000)	\$1,386,448,000
193	CMS DEFERRED CLAIMS	\$0	(\$243,175,000)	\$243,175,000	\$0
194	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	\$0	(\$25,856,000)	\$25,856,000	\$0
195	ASSISTED LIVING WAIVER EXPANSION	(\$14,825,450)	(\$7,412,730)	(\$7,412,730)	\$0
198	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,912,603,770	(\$1,912,603,770)	\$0
199	FUNDING ADJUST.—OTLICP	\$366,000	\$206,390,360	(\$206,024,360)	\$0
	OTHER SUBTOTAL	\$1,057,981,910	\$2,369,940,090	(\$2,826,571,170)	\$1,514,613,000
	GRAND TOTAL	\$30,057,497,750	\$18,796,388,820	(\$2,751,580,780)	\$14,012,689,700

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2018-19

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	\$8,128,796,600	\$4,775,083,140	\$1,917,570,100	\$1,436,143,360
PHYSICIANS	\$992,731,980	\$647,493,370	\$291,655,870	\$53,582,740
OTHER MEDICAL	\$4,417,459,970	\$2,623,100,260	\$1,517,501,720	\$276,857,980
CO. & COMM. OUTPATIENT	\$2,718,604,640	\$1,504,489,500	\$108,412,500	\$1,105,702,630
PHARMACY	\$1,414,045,250	\$1,004,575,150	\$334,320,690	\$75,149,410
HOSPITAL INPATIENT	\$15,442,366,570	\$8,804,125,620	\$1,777,073,840	\$4,861,167,110
COUNTY INPATIENT	\$3,724,653,380	\$2,332,118,870	\$94,268,460	\$1,298,266,050
COMMUNITY INPATIENT	\$11,717,713,190	\$6,472,006,750	\$1,682,805,380	\$3,562,901,060
LONG TERM CARE	\$3,353,425,080	\$1,728,848,840	\$1,403,918,960	\$220,657,280
NURSING FACILITIES	\$2,910,105,880	\$1,506,216,560	\$1,227,206,750	\$176,682,570
ICF-DD	\$443,319,200	\$222,632,280	\$176,712,210	\$43,974,710
OTHER SERVICES	\$1,229,199,320	\$726,142,040	\$449,534,630	\$53,522,650
MEDICAL TRANSPORTATION	\$148,442,990	\$102,958,620	\$28,221,260	\$17,263,110
OTHER SERVICES	\$810,109,230	\$484,414,460	\$292,273,230	\$33,421,540
HOME HEALTH	\$270,647,110	\$138,768,970	\$129,040,130	\$2,838,000
TOTAL FEE-FOR-SERVICE	\$29,567,832,820	\$17,038,774,790	\$5,882,418,220	\$6,646,639,810
MANAGED CARE	\$44,108,372,670	\$27,798,671,870	\$9,105,665,710	\$7,204,035,100
TWO PLAN MODEL	\$26,395,737,870	\$16,587,119,300	\$5,509,192,860	\$4,299,425,710
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,703,351,200	\$6,855,781,080	\$2,091,059,290	\$1,756,510,840
GEOGRAPHIC MANAGED CARE	\$4,670,266,100	\$2,941,194,990	\$933,995,280	\$795,075,820
PHP & OTHER MANAG. CARE	\$887,572,720	\$484,995,090	\$312,950,100	\$89,627,540
REGIONAL MODEL	\$1,451,444,790	\$929,581,420	\$258,468,180	\$263,395,190
DENTAL	\$1,149,047,000	\$671,236,450	\$454,356,860	\$23,453,690
MENTAL HEALTH	\$2,964,593,980	\$2,746,414,530	(\$28,835,920)	\$247,015,370
AUDITS/ LAWSUITS	\$30,668,300	(\$526,501,310)	\$557,169,610	\$0
EPSDT SCREENS	\$747,000	\$380,630	(\$358,630)	\$725,000
MEDICARE PAYMENTS	\$5,445,670,000	\$1,546,190,500	\$3,899,479,500	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$99,725,000	\$99,725,000	\$0	\$0
MISC. SERVICES	\$10,112,308,800	\$9,253,015,160	(\$98,676,090)	\$957,969,740
RECOVERIES	(\$368,457,340)	(\$233,838,170)	(\$134,619,170)	\$0
DRUG MEDI-CAL	\$421,130,870	\$362,075,920	\$59,054,950	\$0
GRAND TOTAL MEDI-CAL	\$93,531,639,100	\$58,756,145,360	\$19,695,655,040	\$15,079,838,700

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

<u>SERVICE CATEGORY</u>	<u>2018-19 APPROPRIATION</u>	<u>NOV. 2018 EST. FOR 2018-19</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$8,040,750,790	\$8,128,796,600	\$88,045,800	1.09%
PHYSICIANS	\$1,379,094,630	\$992,731,980	(\$386,362,650)	-28.02%
OTHER MEDICAL	\$4,296,278,720	\$4,417,459,970	\$121,181,250	2.82%
CO. & COMM. OUTPATIENT	\$2,365,377,440	\$2,718,604,640	\$353,227,200	14.93%
PHARMACY	\$2,347,140,750	\$1,414,045,250	(\$933,095,500)	-39.75%
HOSPITAL INPATIENT	\$15,218,343,130	\$15,442,366,570	\$224,023,440	1.47%
COUNTY INPATIENT	\$3,667,495,890	\$3,724,653,380	\$57,157,490	1.56%
COMMUNITY INPATIENT	\$11,550,847,240	\$11,717,713,190	\$166,865,950	1.44%
LONG TERM CARE	\$3,361,749,480	\$3,353,425,080	(\$8,324,400)	-0.25%
NURSING FACILITIES	\$2,912,466,410	\$2,910,105,880	(\$2,360,540)	-0.08%
ICF-DD	\$449,283,060	\$443,319,200	(\$5,963,860)	-1.33%
OTHER SERVICES	\$1,286,691,310	\$1,229,199,320	(\$57,491,990)	-4.47%
MEDICAL TRANSPORTATION	\$148,353,720	\$148,442,990	\$89,270	0.06%
OTHER SERVICES	\$864,463,880	\$810,109,230	(\$54,354,660)	-6.29%
HOME HEALTH	\$273,873,710	\$270,647,110	(\$3,226,600)	-1.18%
TOTAL FEE-FOR-SERVICE	\$30,254,675,470	\$29,567,832,820	(\$686,842,650)	-2.27%
MANAGED CARE	\$47,383,031,560	\$44,108,372,670	(\$3,274,658,890)	-6.91%
TWO PLAN MODEL	\$28,300,224,320	\$26,395,737,870	(\$1,904,486,460)	-6.73%
COUNTY ORGANIZED HEALTH SYSTEMS	\$11,600,806,850	\$10,703,351,200	(\$897,455,650)	-7.74%
GEOGRAPHIC MANAGED CARE	\$5,135,089,090	\$4,670,266,100	(\$464,822,990)	-9.05%
PHP & OTHER MANAG. CARE	\$776,573,310	\$887,572,720	\$110,999,410	14.29%
REGIONAL MODEL	\$1,570,337,990	\$1,451,444,790	(\$118,893,200)	-7.57%
DENTAL	\$2,070,791,990	\$1,149,047,000	(\$921,745,000)	-44.51%
MENTAL HEALTH	\$3,073,513,840	\$2,964,593,980	(\$108,919,850)	-3.54%
AUDITS/ LAWSUITS	\$32,860,810	\$30,668,300	(\$2,192,510)	-6.67%
EPSDT SCREENS	\$4,956,000	\$747,000	(\$4,209,000)	-84.93%
MEDICARE PAYMENTS	\$5,491,406,000	\$5,445,670,000	(\$45,736,000)	-0.83%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$155,445,000	\$99,725,000	(\$55,720,000)	-35.85%
MISC. SERVICES	\$10,358,639,000	\$10,112,308,800	(\$246,330,200)	-2.38%
RECOVERIES	(\$326,854,360)	(\$368,457,340)	(\$41,602,980)	12.73%
DRUG MEDI-CAL	\$1,008,321,320	\$421,130,870	(\$587,190,450)	-58.23%
GRAND TOTAL MEDI-CAL	\$99,506,786,630	\$93,531,639,100	(\$5,975,147,530)	-6.00%
GENERAL FUNDS	\$21,622,542,410	\$19,695,655,040	(\$1,926,887,370)	-8.91%
OTHER STATE FUNDS	\$14,133,192,300	\$15,079,838,700	\$946,646,400	6.70%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>								
2	1	BREAST AND CERVICAL CANCER TREATMENT	\$72,314,000	\$46,500,100	\$71,405,000	\$46,166,950	(\$909,000)	(\$333,150)
1	2	MEDI-CAL STATE INMATE PROGRAMS	\$98,931,000	\$0	\$64,798,000	\$0	(\$34,133,000)	\$0
3	4	MEDI-CAL COUNTY INMATE PROGRAMS	\$90,569,000	\$292,610	\$46,739,000	\$811,220	(\$43,830,000)	\$518,610
9	7	NON-OTLIPC CHIP	\$0	\$187,461,280	\$0	\$156,948,120	\$0	(\$30,513,160)
10	8	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$881,430,000	\$0	\$905,934,000	\$0	\$24,504,000
11	9	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$56,906,960)	\$0	(\$94,438,960)	\$0	(\$37,532,000)
--	10	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$0	\$0	\$14,677,000	\$0	\$14,677,000
8	11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$356,000)	\$0	(\$746,000)	\$0	(\$390,000)
--	12	CDCR RETRO REPAYMENT	\$0	\$0	\$0	\$17,206,000	\$0	\$17,206,000
16	13	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	(\$41,213,000)	\$93,005,020	(\$6,971,000)	\$96,097,800	\$34,242,000	\$3,092,780
14	14	OTLIPC PREMIUMS	(\$66,373,000)	(\$7,964,760)	(\$63,513,000)	(\$7,621,560)	\$2,860,000	\$343,200
15	15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$363,996,000)	(\$77,752,990)	(\$156,975,000)	(\$29,215,000)	\$207,021,000	\$48,537,990
13	--	PARIS-VETERANS	(\$32,109,420)	(\$16,054,710)	\$0	\$0	\$32,109,420	\$16,054,710
ELIGIBILITY SUBTOTAL			(\$241,877,420)	\$1,049,653,590	(\$44,517,000)	\$1,105,819,570	\$197,360,420	\$56,165,980
<u>AFFORDABLE CARE ACT</u>								
17	16	COMMUNITY FIRST CHOICE OPTION	\$3,373,170,000	\$0	\$3,588,620,000	\$0	\$215,450,000	\$0
18	17	HEALTH INSURER FEE	\$287,808,000	\$97,122,150	\$287,808,000	\$97,523,020	\$0	\$400,870
19	18	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$15,806,000	\$0	\$15,806,000	\$0	\$0	\$0
21	19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$36,043,000)	\$0	(\$44,182,250)	\$0	(\$8,139,250)
23	20	ACA MAGI SAVINGS	\$0	\$0	\$0	\$0	\$0	\$0
22	21	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$1,341,000)	\$0	(\$2,349,000)	\$0	(\$1,008,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>AFFORDABLE CARE ACT</u>						
--	23	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$0	\$0	(\$4,547,000)	\$0	(\$4,547,000)	\$0
25	24	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$2,000,000,000)	\$0	(\$2,400,000,000)	\$0	(\$400,000,000)	\$0
		AFFORDABLE CARE ACT SUBTOTAL	\$1,676,784,000	\$59,738,150	\$1,487,687,000	\$50,991,770	(\$189,097,000)	(\$8,746,380)
		<u>BENEFITS</u>						
27	25	BEHAVIORAL HEALTH TREATMENT	\$544,531,000	\$243,237,300	\$582,841,000	\$258,502,240	\$38,310,000	\$15,264,940
28	26	FAMILY PACT PROGRAM	\$322,281,000	\$77,180,300	\$410,507,000	\$129,132,800	\$88,226,000	\$51,952,500
29	27	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$278,779,000	\$0	\$266,213,000	\$0	(\$12,566,000)	\$0
30	28	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$123,374,000	\$0	\$132,312,000	\$0	\$8,938,000	\$0
36	29	FULL RESTORATION OF ADULT DENTAL BENEFITS	\$209,650,000	\$63,668,780	\$84,057,000	\$27,765,280	(\$125,593,000)	(\$35,903,500)
44	30	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	\$109,231,000	\$48,792,760	\$101,777,000	\$45,140,240	(\$7,454,000)	(\$3,652,520)
209	32	WHOLE CHILD MODEL IMPLEMENTATION	\$29,235,000	\$13,224,420	\$28,539,000	\$12,807,640	(\$696,000)	(\$416,780)
32	33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$21,112,000	\$0	\$20,125,000	(\$9,826,500)	(\$987,000)	(\$9,826,500)
35	34	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	\$43,770,000	\$16,901,760	\$19,895,000	\$7,726,820	(\$23,875,000)	(\$9,174,940)
31	35	CCS DEMONSTRATION PROJECT	\$70,982,000	\$31,981,700	\$11,234,000	\$5,041,680	(\$59,748,000)	(\$26,940,020)
34	36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$10,569,000	\$1,679,000	\$10,308,000	\$1,521,000	(\$261,000)	(\$158,000)
207	37	MEDI-CAL NONMEDICAL TRANSPORTATION	\$4,220,070	\$1,619,350	\$4,239,730	\$1,609,030	\$19,660	(\$10,320)
38	38	YOUTH REGIONAL TREATMENT CENTERS	\$5,140,000	\$227,000	\$2,893,000	\$22,000	(\$2,247,000)	(\$205,000)
40	39	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,600,000	\$1,600,000	\$2,400,000	\$2,400,000	\$800,000	\$800,000
230	40	PROP 56 - CBAS PROGRAMS	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>								
39	41	PEDIATRIC PALLIATIVE CARE WAIVER	\$3,211,530	\$1,452,900	\$3,270,000	\$2,268,900	\$58,470	\$816,000
41	42	CCT FUND TRANSFER TO CDSS AND CDDS	\$1,283,000	\$0	\$1,365,000	\$0	\$82,000	\$0
46	44	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	(\$1,536,360)	(\$694,870)	(\$4,248,000)	(\$1,921,460)	(\$2,711,640)	(\$1,226,590)
33	--	ANNUAL CONTRACEPTIVE COVERAGE	\$33,827,260	\$7,629,640	\$0	\$0	(\$33,827,260)	(\$7,629,640)
37	--	DENTAL BENEFICIARY OUTREACH EFFORTS - BENEFITS	\$117,707,000	\$58,853,500	\$0	\$0	(\$117,707,000)	(\$58,853,500)
45	--	DIABETES PREVENTION PROGRAM	\$498,150	\$148,740	\$0	\$0	(\$498,150)	(\$148,740)
BENEFITS SUBTOTAL			\$1,931,464,640	\$569,502,280	\$1,679,727,730	\$484,189,670	(\$251,736,910)	(\$85,312,610)
<u>PHARMACY</u>								
225	45	HEPATITIS C REVISED CLINICAL GUIDELINES	\$70,387,000	\$21,820,000	\$64,619,050	\$20,355,660	(\$5,767,950)	(\$1,464,340)
--	47	PHARMACIST-DELIVERED MEDI-CAL SERVICES	\$0	\$0	\$250,270	\$94,490	\$250,270	\$94,490
--	48	LITIGATION SETTLEMENTS	\$0	\$0	(\$2,453,000)	(\$2,453,000)	(\$2,453,000)	(\$2,453,000)
51	49	BCCTP DRUG REBATES	(\$11,951,000)	(\$3,823,050)	(\$9,942,000)	(\$3,166,450)	\$2,009,000	\$656,600
52	50	FAMILY PACT DRUG REBATES	(\$20,067,000)	(\$2,661,600)	(\$23,327,000)	(\$3,066,800)	(\$3,260,000)	(\$405,200)
53	51	MEDICAL SUPPLY REBATES	(\$24,916,000)	(\$12,458,000)	(\$24,916,000)	(\$12,458,000)	\$0	\$0
49	52	PHARMACY REIMBURSEMENT & DISPENSING FEE	(\$36,000,000)	(\$14,147,730)	(\$18,000,000)	(\$6,517,780)	\$18,000,000	\$7,629,950
54	53	STATE SUPPLEMENTAL DRUG REBATES	(\$197,608,000)	(\$66,569,240)	(\$213,254,000)	(\$65,384,680)	(\$15,646,000)	\$1,184,560
55	54	FEDERAL DRUG REBATES	(\$1,559,326,000)	(\$472,825,060)	(\$2,223,878,000)	(\$953,903,940)	(\$664,552,000)	(\$481,078,880)
47	--	NEW HIGH COST TREATMENTS FOR SPECIFIC CONDITIONS	\$86,880,460	\$39,788,990	\$0	\$0	(\$86,880,460)	(\$39,788,990)
PHARMACY SUBTOTAL			(\$1,692,600,540)	(\$510,875,690)	(\$2,450,900,680)	(\$1,026,500,500)	(\$758,300,130)	(\$515,624,810)
<u>DRUG MEDI-CAL</u>								
56	55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$796,705,000	\$148,305,690	\$266,957,000	\$50,626,690	(\$529,748,000)	(\$97,679,000)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DRUG MEDI-CAL</u>								
61	60	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,000,000	\$100,000	(\$818,000)	(\$105,000)	(\$3,818,000)	(\$205,000)
--	201	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$0	\$0	\$4,175,000	\$165,750	\$4,175,000	\$165,750
DRUG MEDI-CAL SUBTOTAL			\$799,705,000	\$148,405,690	\$270,314,000	\$50,687,440	(\$529,391,000)	(\$97,718,250)
<u>MENTAL HEALTH</u>								
65	63	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$100,548,000	\$0	\$46,640,000	\$0	(\$53,908,000)	\$0
67	64	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$19,894,000	\$10,717,000	\$17,103,000	\$9,365,500	(\$2,791,000)	(\$1,351,500)
66	65	PATHWAYS TO WELL-BEING	\$14,475,000	\$0	\$9,521,000	\$0	(\$4,954,000)	\$0
68	66	TRANSITIONAL SMHS CLAIMS	\$544,000	\$544,000	\$909,000	\$909,000	\$365,000	\$365,000
69	67	LATE CLAIMS FOR SMHS	\$25,000	\$25,000	\$25,000	\$25,000	\$0	\$0
70	68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$855,000	\$0	\$855,000	\$0	\$0
71	69	CHART REVIEW	(\$670,000)	\$0	(\$766,000)	\$0	(\$96,000)	\$0
72	70	INTERIM AND FINAL COST SETTLEMENTS - SMHS	\$68,685,000	\$3,186,000	(\$14,306,000)	(\$1,649,000)	(\$82,991,000)	(\$4,835,000)
MENTAL HEALTH SUBTOTAL			\$203,501,000	\$15,327,000	\$59,126,000	\$9,505,500	(\$144,375,000)	(\$5,821,500)
<u>WAIVER--MH/UCD & BTR</u>								
73	71	GLOBAL PAYMENT PROGRAM	\$2,492,086,000	\$0	\$2,427,881,000	\$0	(\$64,205,000)	\$0
74	72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,524,894,000	\$0	\$1,687,847,000	\$0	\$162,953,000	\$0
75	73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$874,842,000	\$0	\$839,722,000	\$0	(\$35,120,000)	\$0
76	74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$155,000,000	\$77,500,000	\$115,244,000	\$57,622,000	(\$39,756,000)	(\$19,878,000)
78	75	MH/UCD—STABILIZATION FUNDING	\$55,530,000	\$55,530,000	\$110,930,000	\$110,930,000	\$55,400,000	\$55,400,000
77	76	BTR - LIHP - MCE	\$198,363,000	\$0	\$104,616,000	\$0	(\$93,747,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>WAIVER--MH/UCD & BTR</u>								
79	77	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$231,547,000	\$0	\$36,060,000	\$0	(\$195,487,000)	\$0
81	78	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$20,678,000	\$0	\$21,940,000	\$0	\$1,262,000	\$0
86	79	MH/UCD—SAFETY NET CARE POOL	\$9,712,000	\$0	\$2,989,000	\$0	(\$6,723,000)	\$0
80	80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$369,000	\$0	\$363,000	\$0	(\$6,000)	\$0
83	81	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	(\$75,000,000)	\$0	(\$37,727,000)	\$0	\$37,273,000
--	82	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	\$0	\$0	(\$6,205,000)	\$0	(\$6,205,000)
85	83	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	\$0	\$108,511,000	\$0	\$108,229,000	\$0	(\$282,000)
--	84	LIHP MCE REPAYMENT	\$0	\$0	\$0	\$0	\$0	\$0
WAIVER--MH/UCD & BTR SUBTOTAL			\$5,563,021,000	\$166,541,000	\$5,347,592,000	\$232,849,000	(\$215,429,000)	\$66,308,000
<u>MANAGED CARE</u>								
91	88	CCI-MANAGED CARE PAYMENTS	\$7,835,790,000	\$3,917,895,000	\$7,705,868,000	\$3,852,934,000	(\$129,922,000)	(\$64,961,000)
92	89	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	\$2,240,199,000	\$675,354,450	\$2,172,871,000	\$662,808,800	(\$67,328,000)	(\$12,545,650)
90	90	MANAGED CARE RATE RANGE IGTS	\$1,686,877,000	\$0	\$1,697,426,000	\$0	\$10,549,000	\$0
117	92	RETRO MC RATE ADJUSTMENTS	\$493,754,000	\$171,028,640	\$884,722,000	\$418,406,540	\$390,968,000	\$247,377,900
--	93	MANAGED CARE PUBLIC HOSPITAL EPP	\$0	\$0	\$835,015,000	\$248,950,230	\$835,015,000	\$248,950,230
101	98	CCI-QUALITY WITHHOLD REPAYMENTS	\$11,412,000	\$5,706,000	\$8,260,000	\$4,130,000	(\$3,152,000)	(\$1,576,000)
112	99	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$4,981,000	\$4,981,000	\$4,981,000	\$4,981,000	\$0	\$0
108	100	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$3,468,000	\$0	\$2,652,000	\$0	(\$816,000)	\$0
99	102	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$1,595,000	\$797,500	\$571,000	\$285,500	(\$1,024,000)	(\$512,000)
103	103	PALLIATIVE CARE SERVICES IMPLEMENTATION	\$49,000	\$39,290	\$237,000	\$118,500	\$188,000	\$79,210

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE								
109	107	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	(\$21,286,000)	\$0	(\$286,000)	\$0	\$21,000,000
111	109	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	(\$125,944,000)	\$0	(\$112,006,000)	\$0	\$13,938,000
113	110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$815,656,000)	\$0	(\$315,907,000)	\$0	\$499,749,000
114	111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	\$0	(\$669,704,000)	\$0	(\$660,295,000)	\$0	\$9,409,000
115	112	MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,850,459,000)	\$0	(\$1,866,610,000)	\$0	(\$16,151,000)
116	113	MANAGED CARE DRUG REBATES	(\$2,095,878,000)	(\$639,597,580)	(\$1,906,393,000)	(\$549,831,860)	\$189,485,000	\$89,765,720
105	--	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,461,677,000	\$443,476,870	\$0	\$0	(\$1,461,677,000)	(\$443,476,870)
106	--	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$640,000,000	\$191,423,480	\$0	\$0	(\$640,000,000)	(\$191,423,480)
107	--	CAPITATED RATE ADJUSTMENT FOR FY 2018-19	\$0	\$0	\$0	\$0	\$0	\$0
110	--	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0	\$0	\$0	\$0
219	--	HEALTH CARE SERVICES FOR REENTRY PROGRAMS	\$9,702,000	\$0	\$0	\$0	(\$9,702,000)	\$0
222	--	INDIAN HEALTH SERVICES MANAGED CARE PROGRAM	\$0	(\$9,467,000)	\$0	\$0	\$0	\$9,467,000
MANAGED CARE SUBTOTAL			\$12,293,626,000	\$1,278,588,650	\$11,406,210,000	\$1,687,678,710	(\$887,416,000)	\$409,090,060
PROVIDER RATES								
118	114	DPH INTERIM & FINAL RECONS	\$889,000	\$0	\$242,884,000	\$0	\$241,995,000	\$0
122	115	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$156,647,930	\$59,460,080	\$200,195,600	\$75,425,190	\$43,547,670	\$15,965,110
214	116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$167,635,000	(\$6,819,000)	\$172,631,000	(\$6,901,000)	\$4,996,000	(\$82,000)
120	117	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$164,723,000	\$62,525,500	\$163,939,000	\$61,765,490	(\$784,000)	(\$760,010)
121	118	AB 1629 ANNUAL RATE ADJUSTMENTS	\$95,903,520	\$47,951,760	\$148,784,450	\$74,392,220	\$52,880,920	\$26,440,460
124	119	DPH INTERIM RATE GROWTH	\$76,030,180	\$38,015,090	\$59,400,070	\$29,700,040	(\$16,630,110)	(\$8,315,060)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>								
204	120	PROP 56 - HOME HEALTH RATE INCREASE	\$56,742,720	\$27,625,690	\$56,600,080	\$27,042,020	(\$142,630)	(\$583,670)
119	121	DENTAL RETROACTIVE RATE CHANGES	(\$62,840,000)	(\$21,562,360)	\$25,931,000	\$9,552,080	\$88,771,000	\$31,114,440
123	122	LTC RATE ADJUSTMENT	\$36,066,000	\$18,033,000	\$25,062,690	\$12,531,350	(\$11,003,310)	(\$5,501,650)
127	123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$12,138,000	(\$2,456,000)	\$11,972,000	(\$1,590,000)	(\$166,000)	\$866,000
229	124	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$14,230,000	\$6,977,000	\$11,752,950	\$5,619,880	(\$2,477,050)	(\$1,357,120)
125	125	HOSPICE RATE INCREASES	\$36,462,360	\$18,231,180	\$15,332,830	\$7,666,420	(\$21,129,520)	(\$10,564,760)
129	126	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	\$6,502,810	(\$5,627,130)	\$6,638,780	(\$5,362,850)	\$135,960	\$264,280
--	127	PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT	\$0	\$0	\$5,953,000	\$2,976,500	\$5,953,000	\$2,976,500
126	128	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$7,918,530	\$3,959,260	\$2,037,380	\$1,018,690	(\$5,881,150)	(\$2,940,580)
133	129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$460,098,000)	\$0	(\$899,759,000)	\$0	(\$439,661,000)
134	130	DPH INTERIM RATE	\$0	(\$384,886,340)	\$0	(\$384,598,010)	\$0	\$288,330
137	131	10% PROVIDER PAYMENT REDUCTION	(\$199,420,000)	(\$99,710,000)	(\$194,418,000)	(\$97,209,000)	\$5,002,000	\$2,501,000
135	132	LABORATORY RATE METHODOLOGY CHANGE	(\$28,948,000)	(\$14,474,000)	(\$30,452,000)	(\$15,226,000)	(\$1,504,000)	(\$752,000)
136	133	REDUCTION TO RADIOLOGY RATES	(\$56,119,230)	(\$28,059,620)	(\$56,863,000)	(\$28,431,500)	(\$743,770)	(\$371,880)
130	--	ALTERNATIVE BIRTHING CENTER REIMBURSEMENT	\$52,420	\$26,210	\$0	\$0	(\$52,420)	(\$26,210)
PROVIDER RATES SUBTOTAL			\$484,614,240	(\$740,887,670)	\$867,381,830	(\$1,131,387,480)	\$382,767,600	(\$390,499,800)
<u>SUPPLEMENTAL PMNTS.</u>								
139	134	HOSPITAL QAF - FFS PAYMENTS	\$4,938,537,000	\$0	\$6,261,304,000	\$0	\$1,322,767,000	\$0
138	135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$5,485,404,000	\$0	\$3,746,122,000	\$0	(\$1,739,282,000)	\$0
140	136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$1,453,448,000	\$0	\$894,195,000	\$0	(\$559,253,000)	\$0

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>SUPPLEMENTAL PMNTS.</u>						
141	137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,250,000,000	\$500,000,000	\$1,299,438,840	\$409,156,190	\$49,438,840	(\$90,843,810)
142	138	PRIVATE HOSPITAL DSH REPLACEMENT	\$581,964,000	\$290,982,000	\$566,597,000	\$283,298,500	(\$15,367,000)	(\$7,683,500)
143	139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$414,677,000	\$0	\$503,241,000	\$0	\$88,564,000	\$0
147	140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$525,000,000	\$210,000,000	\$510,070,000	\$194,390,970	(\$14,930,000)	(\$15,609,030)
144	141	DSH PAYMENT	\$401,603,000	\$13,504,000	\$415,063,000	\$16,543,000	\$13,460,000	\$3,039,000
145	142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$297,172,000	\$118,400,000	\$317,899,000	\$118,400,000	\$20,727,000	\$0
146	143	NDPH IGT SUPPLEMENTAL PAYMENTS	\$130,216,000	(\$7,179,000)	\$160,421,000	(\$10,099,000)	\$30,205,000	(\$2,920,000)
149	144	DPH PHYSICIAN & NON-PHYS. COST	\$205,803,000	\$0	\$147,389,000	\$0	(\$58,414,000)	\$0
155	145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$59,011,000	\$0	\$145,438,000	\$0	\$86,427,000	\$0
150	146	CAPITAL PROJECT DEBT REIMBURSEMENT	\$123,280,000	\$36,635,000	\$126,344,000	\$34,913,500	\$3,064,000	(\$1,721,500)
152	147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$117,693,000	\$0	\$119,213,000	\$493,100	\$1,520,000	\$493,100
151	148	FFP FOR LOCAL TRAUMA CENTERS	\$134,881,000	\$0	\$116,107,000	\$0	(\$18,774,000)	\$0
153	149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$86,007,000	\$48,310,000	\$89,326,000	\$50,252,000	\$3,319,000	\$1,942,000
148	150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$183,302,000	\$49,044,000	\$203,057,000	\$54,198,000	\$19,755,000	\$5,154,000
154	151	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$37,900,000	\$0	\$37,505,000	\$0	(\$395,000)	\$0
156	152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$26,524,000	\$12,273,000	\$29,376,870	\$13,744,110	\$2,852,870	\$1,471,110
157	153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,001,000	\$5,000,500	\$1,000	\$500
162	154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$4,769,000	\$0	\$9,389,000	\$0	\$4,620,000	\$0
158	155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$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
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>SUPPLEMENTAL PMNTS.</u>						
160	156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,800,000	\$3,400,000	\$6,800,000	\$3,400,000	\$0	\$0
--	157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS	\$0	\$0	\$6,189,050	\$2,993,330	\$6,189,050	\$2,993,330
161	158	NDPH SUPPLEMENTAL PAYMENT	\$4,273,000	\$1,900,000	\$5,830,000	\$1,900,000	\$1,557,000	\$0
159	159	IGT PAYMENTS FOR HOSPITAL SERVICES	\$273,000	\$0	\$112,000	\$0	(\$161,000)	\$0
164	161	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$0	\$57,224,000	\$0	\$57,224,000	\$0	\$0
		SUPPLEMENTAL PMNTS. SUBTOTAL	\$16,486,537,000	\$1,343,493,000	\$15,734,427,760	\$1,239,808,200	(\$752,109,240)	(\$103,684,800)
		<u>OTHER</u>						
223	167	QAF WITHHOLD TRANSFER	\$627,756,000	\$313,878,000	\$581,878,000	\$290,939,000	(\$45,878,000)	(\$22,939,000)
170	170	CCI IHSS RECONCILIATION	\$339,270,000	\$0	\$142,263,000	\$0	(\$197,007,000)	\$0
171	171	ARRA HITECH - PROVIDER PAYMENTS	\$231,917,000	\$0	\$91,440,000	\$0	(\$140,477,000)	\$0
174	172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$82,326,000	\$0	\$130,514,000	\$0	\$48,188,000	\$0
180	174	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$42,755,580	\$21,377,790	\$42,803,120	\$21,401,560	\$47,540	\$23,770
178	177	INFANT DEVELOPMENT PROGRAM	\$29,676,000	\$0	\$46,546,000	\$0	\$16,870,000	\$0
179	178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$14,059,000	\$6,236,000	\$19,468,000	\$8,407,000	\$5,409,000	\$2,171,000
185	179	MEDI-CAL ESTATE RECOVERIES	\$38,906,000	\$19,453,000	\$38,906,000	\$19,453,000	\$0	\$0
182	180	OVERTIME FOR WPCS PROVIDERS	\$10,119,000	\$5,059,500	\$8,088,000	\$4,044,000	(\$2,031,000)	(\$1,015,500)
212	181	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	\$4,730,000	\$2,365,000	\$5,176,140	\$2,588,070	\$446,140	\$223,070
186	182	WPCS WORKERS' COMPENSATION	\$3,322,000	\$1,661,000	\$3,322,000	\$1,661,000	\$0	\$0
184	184	INDIAN HEALTH SERVICES	\$8,710,000	(\$20,813,000)	\$1,265,000	(\$10,000,000)	(\$7,445,000)	\$10,813,000
181	187	AUDIT SETTLEMENTS	\$0	\$180,889,000	\$0	\$191,648,000	\$0	\$10,759,000
199	188	IMD ANCILLARY SERVICES	\$0	\$30,340,000	\$0	\$34,524,000	\$0	\$4,184,000

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
200	189	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$127,440,000)	\$0	(\$127,440,000)	\$0	\$0
198	190	COUNTY SHARE OF OTLICP-CCS COSTS	\$0	\$0	\$0	\$0	\$0	\$0
194	191	CLPP FUND	\$0	(\$725,000)	\$0	(\$725,000)	\$0	\$0
196	192	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$958,769,000)	\$0	(\$1,386,448,000)	\$0	(\$427,679,000)
84	193	CMS DEFERRED CLAIMS	\$0	\$511,509,000	\$0	\$243,175,000	\$0	(\$268,334,000)
215	194	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	\$0	\$25,856,000	\$0	\$25,856,000	\$0	\$0
211	195	ASSISTED LIVING WAIVER EXPANSION	(\$12,350,520)	(\$6,175,260)	(\$14,825,450)	(\$7,412,730)	(\$2,474,930)	(\$1,237,470)
197	198	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,912,496,130)	\$0	(\$1,912,603,770)	\$0	(\$107,640)
191	199	FUNDING ADJUST.—OTLICP	\$154,000	(\$192,489,640)	\$366,000	(\$206,024,360)	\$212,000	(\$13,534,720)
193	--	HEALTH CARE SVCS. PLANS FINES AND PENALTIES FUND	\$0	\$0	\$0	\$0	\$0	\$0
201	--	INTEGRATION OF THE SF CLSB INTO THE ALW	(\$1,592,000)	(\$796,000)	\$0	\$0	\$1,592,000	\$796,000
202	--	MEDI-CAL RECOVERIES SETTLEMENTS AND LEGAL COSTS	(\$1,730,000)	(\$865,000)	\$0	\$0	\$1,730,000	\$865,000
226	--	RECONCILIATION	\$370,848,000	\$0	\$0	\$0	(\$370,848,000)	\$0
228	--	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$220,000,000	\$0	\$0	\$0	(\$220,000,000)	\$0
		OTHER SUBTOTAL	\$2,008,876,070	(\$2,101,944,740)	\$1,097,209,810	(\$2,806,957,230)	(\$911,666,260)	(\$705,012,490)
		GRAND TOTAL	\$39,513,650,990	\$1,277,541,270	\$35,454,258,450	(\$103,315,340)	(\$4,059,392,530)	(\$1,380,856,610)

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

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$8,115,300	\$132,497,580	\$78,919,280	\$42,171,240	\$1,345,580	\$42,717,140
OTHER MEDICAL	\$82,747,800	\$1,116,996,050	\$426,011,890	\$323,640,360	\$5,701,470	\$38,846,310
CO. & COMM. OUTPATIENT	\$4,296,740	\$128,313,830	\$127,072,910	\$28,301,590	\$596,900	\$50,832,830
PHARMACY	\$3,576,600	\$422,648,090	\$570,846,710	\$56,929,230	\$1,645,970	\$19,670,790
COUNTY INPATIENT	\$4,727,930	\$611,890,390	\$30,815,780	\$25,530,190	\$1,942,550	\$44,980,710
COMMUNITY INPATIENT	\$64,360,760	\$1,207,105,610	\$601,861,930	\$251,489,020	\$16,965,060	\$244,912,040
NURSING FACILITIES	\$208,105,100	\$141,470,730	\$530,052,900	\$2,592,390	\$1,208,160,530	\$1,264,540
ICF-DD	\$1,312,240	\$7,075,770	\$194,250,070	\$289,400	\$49,404,160	\$0
MEDICAL TRANSPORTATION	\$6,921,700	\$22,611,540	\$21,839,630	\$3,411,610	\$2,959,440	\$3,478,210
OTHER SERVICES	\$85,765,680	\$29,112,050	\$276,863,720	\$38,269,270	\$59,334,470	\$1,143,020
HOME HEALTH	\$1,922,530	\$2,334,710	\$160,837,170	\$5,005,700	\$12,390	\$90,440
FFS SUBTOTAL	\$471,852,370	\$3,822,056,360	\$3,019,372,000	\$777,630,010	\$1,348,068,530	\$447,936,030
DENTAL	\$53,790,510	\$195,053,020	\$53,790,510	\$53,790,510	\$53,790,510	\$0
MENTAL HEALTH	\$9,546,640	\$292,949,220	\$1,023,323,790	\$741,258,960	\$887,640	\$8,407,420
TWO PLAN MODEL	\$1,121,251,020	\$7,939,692,980	\$5,293,164,150	\$1,309,514,640	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$328,122,890	\$3,060,640,730	\$1,420,271,990	\$313,053,850	\$773,931,700	\$0
GEOGRAPHIC MANAGED CARE	\$180,650,810	\$1,342,318,160	\$999,079,020	\$212,326,770	\$0	\$0
PHP & OTHER MANAG. CARE	\$253,348,890	\$22,577,460	\$161,959,780	\$13,162,790	\$11,517,540	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$123,310	\$0	\$0
MEDICARE PAYMENTS	\$1,730,917,220	\$0	\$1,617,184,140	\$2,794,630	\$162,631,310	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$5,706,540	\$0	\$12,730,070	\$14,784,110	\$551,150	\$0
MISC. SERVICES	\$719,383,050	\$0	\$5,571,680,690	\$5,652,450	\$0	\$0
DRUG MEDI-CAL	\$10,819,030	\$145,262,670	\$63,302,710	\$33,272,490	\$865,070	\$0
REGIONAL MODEL	\$13,759,060	\$442,395,230	\$321,149,860	\$65,619,570	\$0	\$0
NON-FFS SUBTOTAL	\$4,427,295,640	\$13,440,889,470	\$16,537,636,690	\$2,765,354,060	\$1,004,174,920	\$8,407,420
TOTAL DOLLARS (1)	\$4,899,148,010	\$17,262,945,820	\$19,557,008,690	\$3,542,984,060	\$2,352,243,440	\$456,343,450
ELIGIBLES ***	435,900	3,796,900	972,400	1,129,300	42,100	31,900
ANNUAL \$/ELIGIBLE	\$11,239	\$4,547	\$20,112	\$3,137	\$55,873	\$14,305
AVG. MO. \$/ELIGIBLE	\$937	\$379	\$1,676	\$261	\$4,656	\$1,192

(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 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$1,375,790	\$21,082,000	\$21,940,520	\$6,768,970	\$131,282,980	\$23,258,930
OTHER MEDICAL	\$3,651,840	\$204,444,410	\$153,910,500	\$71,234,100	\$951,594,650	\$83,665,510
CO. & COMM. OUTPATIENT	\$463,660	\$29,528,720	\$17,166,930	\$8,699,370	\$113,634,070	\$10,420,000
PHARMACY	\$2,648,740	\$41,045,090	\$13,789,020	\$23,158,410	\$146,862,710	\$27,641,750
COUNTY INPATIENT	\$3,653,360	\$4,124,110	\$64,013,040	\$16,702,840	\$135,055,710	\$7,110,630
COMMUNITY INPATIENT	\$16,611,830	\$113,838,390	\$148,042,530	\$41,776,510	\$722,068,970	\$68,482,560
NURSING FACILITIES	\$232,545,290	\$2,484,160	\$209,128,830	\$38,312,560	\$24,055,840	\$3,374,220
ICF-DD	\$176,557,820	\$15,690	\$1,719,560	\$7,078,550	\$1,139,130	\$1,829,610
MEDICAL TRANSPORTATION	\$1,115,580	\$873,760	\$11,814,240	\$9,082,150	\$8,337,740	\$1,545,200
OTHER SERVICES	\$10,310,320	\$25,149,130	\$79,450,220	\$60,624,180	\$89,816,180	\$11,617,100
HOME HEALTH	\$6,010	\$12,806,220	\$1,122,700	\$52,408,780	\$9,635,140	\$14,038,140
FFS SUBTOTAL	\$448,940,260	\$455,391,690	\$722,098,100	\$335,846,420	\$2,333,483,130	\$252,983,640
DENTAL	\$53,790,510	\$151,685,740	\$53,790,510	\$53,790,510	\$53,790,510	\$50,289,730
MENTAL HEALTH	\$2,173,810	\$78,562,860	\$12,897,920	\$96,567,240	\$511,453,820	\$76,418,870
TWO PLAN MODEL	\$0	\$938,108,840	\$1,269,964,470	\$547,113,500	\$3,179,198,680	\$37,366,060
COUNTY ORGANIZED HEALTH SYSTEMS	\$196,644,910	\$497,497,170	\$478,071,770	\$349,064,330	\$1,266,623,650	\$44,851,760
GEOGRAPHIC MANAGED CARE	\$0	\$189,234,150	\$189,386,770	\$113,458,980	\$557,794,690	\$5,635,000
PHP & OTHER MANAG. CARE	\$385,290	\$2,604,480	\$262,753,670	\$32,364,910	\$6,536,500	\$6,084,590
EPSDT SCREENS	\$0	\$101,270	\$0	\$0	\$379,230	\$16,860
MEDICARE PAYMENTS	\$15,477,950	\$0	\$1,279,682,550	\$522,489,660	\$114,492,550	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$140,080	\$0	\$6,511,660	\$2,162,700	\$45,218,980	\$2,009,530
MISC. SERVICES	\$0	(\$24,678,590)	\$804,006,800	\$945,379,260	\$16,329,920	\$757,140
DRUG MEDI-CAL	\$221,290	\$19,274,810	\$12,255,640	\$7,855,770	\$93,521,600	\$3,748,040
REGIONAL MODEL	\$0	\$60,942,650	\$38,005,010	\$34,412,890	\$195,330,110	\$1,426,480
NON-FFS SUBTOTAL	\$268,833,840	\$1,913,333,370	\$4,407,326,770	\$2,704,659,740	\$6,040,670,230	\$228,604,050
TOTAL DOLLARS (1)	\$717,774,100	\$2,368,725,050	\$5,129,424,870	\$3,040,506,160	\$8,374,153,360	\$481,587,690
ELIGIBLES ***	10,700	924,900	505,700	170,700	3,463,600	154,000
ANNUAL \$/ELIGIBLE	\$67,082	\$2,561	\$10,143	\$17,812	\$2,418	\$3,127
AVG. MO. \$/ELIGIBLE	\$5,590	\$213	\$845	\$1,484	\$201	\$261

(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 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$888,290	\$40,110	\$141,570	\$110,698,180	\$15,766,030	\$7,082,560
OTHER MEDICAL	\$2,643,530	\$454,960	\$30,310	\$248,187,150	\$209,112,580	\$89,150,990
CO. & COMM. OUTPATIENT	\$597,810	\$55,590	\$29,120	\$26,287,780	\$18,131,750	\$10,484,350
PHARMACY	\$1,310,680	\$76,340	\$238,360	\$13,189,750	\$17,656,240	\$19,364,720
COUNTY INPATIENT	\$4,799,880	\$11,760	\$92,350	\$80,403,550	\$3,049,280	\$3,037,880
COMMUNITY INPATIENT	\$2,666,020	\$97,800	\$990,790	\$739,456,480	\$100,038,280	\$43,848,800
NURSING FACILITIES	\$21,399,550	\$50	\$6,379,550	\$1,114,860	\$7,918,470	\$943,520
ICF-DD	\$959,160	\$0	\$321,960	\$193,310	\$786,670	\$12,560
MEDICAL TRANSPORTATION	\$177,380	\$1,600	\$39,620	\$3,235,500	\$1,014,590	\$343,320
OTHER SERVICES	\$521,190	\$12,720	\$6,550	\$12,338,550	\$17,255,890	\$10,819,690
HOME HEALTH	\$1,640	\$0	\$0	\$2,631,780	\$6,214,000	\$1,362,700
FFS SUBTOTAL	\$35,965,120	\$750,940	\$8,270,170	\$1,237,736,890	\$396,943,770	\$186,451,090
DENTAL	\$53,790,510	\$53,790,510	\$53,790,510	\$53,790,510	\$50,289,730	\$50,289,730
MENTAL HEALTH	\$0	\$181,200	\$182,270	\$2,168,960	\$23,878,870	\$36,296,530
TWO PLAN MODEL	\$16,090	\$338,090	\$0	\$212,224,440	\$830,180,640	\$309,284,330
COUNTY ORGANIZED HEALTH SYSTEMS	\$87,540	\$72,730	\$26,070	\$93,521,740	\$352,127,380	\$190,913,700
GEOGRAPHIC MANAGED CARE	\$5,920	\$209,280	\$0	\$38,950,090	\$147,484,260	\$77,086,220
PHP & OTHER MANAG. CARE	\$6,321,690	\$0	\$0	\$6,321,690	\$6,077,110	\$6,077,110
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$83,530	\$42,810
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$129,600	\$0	\$6,550	\$4,668,390	\$0	\$5,105,640
MISC. SERVICES	\$2,250	\$0	\$0	\$51,580	\$3,342,520	\$1,674,950
DRUG MEDI-CAL	\$218,140	\$12,230	\$0	\$7,453,070	\$15,596,970	\$8,294,470
REGIONAL MODEL	\$0	\$1,210	\$0	\$13,646,230	\$49,595,560	\$24,131,070
NON-FFS SUBTOTAL	\$60,571,730	\$54,605,260	\$54,005,380	\$432,796,700	\$1,478,656,570	\$709,196,550
TOTAL DOLLARS (1)	\$96,536,850	\$55,356,200	\$62,275,560	\$1,670,533,590	\$1,875,600,340	\$895,647,650
ELIGIBLES ***	9,900	600	500	359,300	763,700	390,900
ANNUAL \$/ELIGIBLE	\$9,751	\$92,260	\$124,551	\$4,649	\$2,456	\$2,291
AVG. MO. \$/ELIGIBLE	\$813	\$7,688	\$10,379	\$387	\$205	\$191

(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 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$646,092,050
OTHER MEDICAL	\$4,012,024,420
CO. & COMM. OUTPATIENT	\$574,913,960
PHARMACY	\$1,382,299,200
COUNTY INPATIENT	\$1,041,941,930
COMMUNITY INPATIENT	\$4,384,613,390
NURSING FACILITIES	\$2,639,303,090
ICF-DD	\$442,945,660
MEDICAL TRANSPORTATION	\$98,802,820
OTHER SERVICES	\$808,409,920
HOME HEALTH	\$270,430,060
FFS SUBTOTAL	\$16,301,776,490
DENTAL	\$1,143,094,000
MENTAL HEALTH	\$2,917,156,000
TWO PLAN MODEL	\$22,987,417,910
COUNTY ORGANIZED HEALTH SYSTEMS	\$9,365,523,900
GEOGRAPHIC MANAGED CARE	\$4,053,620,140
PHP & OTHER MANAG. CARE	\$798,093,500
EPSDT SCREENS	\$747,000
MEDICARE PAYMENTS	\$5,445,670,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$99,725,000
MISC. SERVICES	\$8,043,582,000
DRUG MEDI-CAL	\$421,974,000
REGIONAL MODEL	\$1,260,414,940
NON-FFS SUBTOTAL	\$56,537,018,390
TOTAL DOLLARS (1)	\$72,838,794,880
ELIGIBLES ***	13,163,000
ANNUAL \$/ELIGIBLE	\$5,534
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 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

	PROPOSITION 56 FUNDS TRANSFER
1	BREAST AND CERVICAL CANCER TREATMENT
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
7	NON-OTLICP CHIP
10	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
13	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
20	ACA MAGI SAVINGS
21	1% FMAP INCREASE FOR PREVENTIVE SERVICES
22	ACA DSH REDUCTION
26	FAMILY PACT PROGRAM
40	PROP 56 - CBAS PROGRAMS
50	FAMILY PACT DRUG REBATES
60	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
63	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
66	TRANSITIONAL SMHS CLAIMS
68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
71	GLOBAL PAYMENT PROGRAM
72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
75	MH/UCD—STABILIZATION FUNDING
76	BTR - LIHP - MCE
77	BTR - LOW INCOME HEALTH PROGRAM - HCCI
78	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
79	MH/UCD—SAFETY NET CARE POOL
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
81	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
82	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
83	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
84	LIHP MCE REPAYMENT
99	GENERAL FUND REIMBURSEMENTS FROM DPHS
101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
103	PALLIATIVE CARE SERVICES IMPLEMENTATION

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

107	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
109	MANAGED CARE IGT ADMIN. & PROCESSING FEE
110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
112	MCO ENROLLMENT TAX MANAGED CARE PLANS
121	DENTAL RETROACTIVE RATE CHANGES
123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
127	PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
134	HOSPITAL QAF - FFS PAYMENTS
135	HOSPITAL QAF - MANAGED CARE PAYMENTS
136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
138	PRIVATE HOSPITAL DSH REPLACEMENT
139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
141	DSH PAYMENT
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
143	NDPH IGT SUPPLEMENTAL PAYMENTS
144	DPH PHYSICIAN & NON-PHYS. COST
145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
146	CAPITAL PROJECT DEBT REIMBURSEMENT
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
148	FFP FOR LOCAL TRAUMA CENTERS
149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
151	GEMT SUPPLEMENTAL PAYMENT PROGRAM
152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS
158	NDPH SUPPLEMENTAL PAYMENT
159	IGT PAYMENTS FOR HOSPITAL SERVICES

FISCAL YEAR 2018-19 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

160	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
161	DP-NF CAPITAL PROJECT DEBT REPAYMENT
171	ARRA HITECH - PROVIDER PAYMENTS
176	MEDI-CAL TCM PROGRAM
187	AUDIT SETTLEMENTS
189	CIGARETTE AND TOBACCO SURTAX FUNDS
191	CLPP FUND
192	HOSPITAL QAF - CHILDREN'S HEALTH CARE
193	CMS DEFERRED CLAIMS
194	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES
205	PROP 56 - VALUE-BASED PAYMENT PROGRAM
206	PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS
207	PROP 56 - MEDI-CAL FAMILY PLANNING
208	WHOLE PERSON CARE FLEXIBLE HOUSING POOL

MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2019-20

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
I. BASE ESTIMATES				
A. B/Y FFS BASE	\$17,775,899,230	\$8,887,949,610	\$8,887,949,610	\$0
B. B/Y BASE POLICY CHANGES	\$47,852,463,000	\$32,254,482,530	\$15,457,998,480	\$139,982,000
C. BASE ADJUSTMENTS	(\$138,700,000)	(\$197,792,200)	(\$992,925,810)	\$1,052,018,000
D. ADJUSTED BASE	\$65,489,662,230	\$40,944,639,950	\$23,353,022,280	\$1,192,000,000
II. REGULAR POLICY CHANGES				
A. ELIGIBILITY	\$240,172,000	(\$572,967,420)	\$812,210,410	\$929,000
B. AFFORDABLE CARE ACT	\$3,221,875,000	\$3,535,416,430	(\$120,411,430)	(\$193,130,000)
C. BENEFITS	\$1,844,729,030	\$1,264,511,750	\$560,328,280	\$19,889,000
D. PHARMACY	(\$1,899,188,380)	(\$1,847,522,800)	(\$1,492,191,570)	\$1,440,526,000
E. DRUG MEDI-CAL	\$380,225,000	\$318,953,660	\$61,271,350	\$0
F. MENTAL HEALTH	\$33,208,000	\$22,320,000	\$10,688,000	\$200,000
G. WAIVER--MH/UCD & BTR	\$5,097,823,000	\$2,714,051,000	\$174,555,000	\$2,209,217,000
H. MANAGED CARE	\$5,953,157,960	\$3,089,863,840	\$656,472,520	\$2,206,821,600
I. PROVIDER RATES	\$935,267,600	\$962,767,400	(\$608,442,800)	\$580,943,000
J. SUPPLEMENTAL PMNTS.	\$14,186,051,160	\$9,001,273,080	\$1,485,394,090	\$3,699,384,000
K. OTHER	\$544,472,660	\$2,284,101,150	(\$3,041,690,480)	\$1,302,062,000
L. TOTAL CHANGES	\$30,537,793,040	\$20,772,768,080	(\$1,501,816,640)	\$11,266,841,600
III. TOTAL MEDI-CAL ESTIMATE	\$96,027,455,270	\$61,717,408,030	\$21,851,205,650	\$12,458,841,600

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
1	BREAST AND CERVICAL CANCER TREATMENT	\$72,722,000	\$25,510,450	\$47,211,550	\$0
2	MEDI-CAL STATE INMATE PROGRAMS	\$42,342,000	\$42,342,000	\$0	\$0
4	MEDI-CAL COUNTY INMATE PROGRAMS	\$152,018,000	\$151,048,390	\$969,610	\$0
7	NON-OTLICP CHIP	\$0	\$173,975,950	(\$173,975,950)	\$0
8	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$886,182,000)	\$886,182,000	\$0
9	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$83,130,260	(\$83,130,260)	\$0
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$929,000)	\$929,000
14	OTLICP PREMIUMS	(\$63,537,000)	(\$50,432,580)	(\$13,104,420)	\$0
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$218,606,000)	(\$173,980,000)	(\$44,626,000)	\$0
200	CCHIP DELIVERY SYSTEM	(\$1,869,000)	(\$1,468,880)	(\$400,120)	\$0
204	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$257,102,000	\$63,089,000	\$194,013,000	\$0
	ELIGIBILITY SUBTOTAL	\$240,172,000	(\$572,967,420)	\$812,210,420	\$929,000
<u>AFFORDABLE CARE ACT</u>					
16	COMMUNITY FIRST CHOICE OPTION	\$3,814,150,000	\$3,814,150,000	\$0	\$0
18	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$15,452,000	\$15,452,000	\$0	\$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$42,667,430	(\$42,667,430)	\$0
20	ACA MAGI SAVINGS	\$0	\$0	\$0	\$0
21	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$2,372,000	(\$2,372,000)	\$0
22	ACA DSH REDUCTION	(\$603,179,000)	(\$334,677,000)	(\$75,372,000)	(\$193,130,000)
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$4,548,000)	(\$4,548,000)	\$0	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$3,221,875,000	\$3,535,416,430	(\$120,411,430)	(\$193,130,000)
<u>BENEFITS</u>					
25	BEHAVIORAL HEALTH TREATMENT	\$695,404,000	\$379,980,750	\$315,423,250	\$0
26	FAMILY PACT PROGRAM	\$417,392,000	\$286,092,900	\$131,299,100	\$0
27	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$276,138,000	\$276,138,000	\$0	\$0
28	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$135,275,000	\$135,275,000	\$0	\$0
29	FULL RESTORATION OF ADULT DENTAL BENEFITS	\$79,032,000	\$52,310,480	\$26,721,520	\$0
30	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	\$150,352,000	\$82,157,220	\$68,194,780	\$0
32	WHOLE CHILD MODEL IMPLEMENTATION	\$791,000	\$426,320	\$364,680	\$0
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,125,000	\$10,062,500	(\$9,826,500)	\$19,889,000
34	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	\$25,419,000	\$15,158,080	\$10,260,920	\$0
35	CCS DEMONSTRATION PROJECT	\$13,722,000	\$7,418,370	\$6,303,630	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>BENEFITS</u>					
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$548,000	\$411,000	\$137,000	\$0
37	MEDI-CAL NONMEDICAL TRANSPORTATION	\$23,849,700	\$14,640,100	\$9,209,600	\$0
38	YOUTH REGIONAL TREATMENT CENTERS	\$3,079,000	\$3,055,000	\$24,000	\$0
39	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,600,000	\$0	\$1,600,000	\$0
43	DIABETES PREVENTION PROGRAM	\$2,002,330	\$1,386,030	\$616,300	\$0
	BENEFITS SUBTOTAL	\$1,844,729,030	\$1,264,511,750	\$560,328,280	\$19,889,000
<u>PHARMACY</u>					
45	HEPATITIS C REVISED CLINICAL GUIDELINES	\$70,077,300	\$47,330,520	\$22,746,780	\$0
47	PHARMACIST-DELIVERED MEDI-CAL SERVICES	\$911,320	\$564,560	\$346,760	\$0
49	BCCTP DRUG REBATES	(\$6,956,000)	(\$6,956,000)	\$0	\$0
50	FAMILY PACT DRUG REBATES	(\$21,226,000)	(\$21,226,000)	\$0	\$0
51	MEDICAL SUPPLY REBATES	(\$27,408,000)	(\$13,704,000)	(\$13,704,000)	\$0
52	PHARMACY REIMBURSEMENT & DISPENSING FEE	(\$168,000,000)	(\$106,944,880)	(\$61,055,120)	\$0
53	STATE SUPPLEMENTAL DRUG REBATES	(\$158,281,000)	(\$158,281,000)	\$0	\$0
54	FEDERAL DRUG REBATES	(\$1,588,306,000)	(\$1,588,306,000)	\$0	\$0
202	MEDI-CAL DRUG REBATES FUND	\$0	\$0	(\$1,440,526,000)	\$1,440,526,000
	PHARMACY SUBTOTAL	(\$1,899,188,380)	(\$1,847,522,800)	(\$1,492,191,570)	\$1,440,526,000
<u>DRUG MEDI-CAL</u>					
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$374,862,000	\$314,021,660	\$60,840,340	\$0
201	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$5,363,000	\$4,931,990	\$431,010	\$0
	DRUG MEDI-CAL SUBTOTAL	\$380,225,000	\$318,953,660	\$61,271,340	\$0
<u>MENTAL HEALTH</u>					
64	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$20,148,000	\$9,260,000	\$10,888,000	\$0
65	PATHWAYS TO WELL-BEING	\$14,554,000	\$14,554,000	\$0	\$0
68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
69	CHART REVIEW	(\$1,494,000)	(\$1,494,000)	\$0	\$0
	MENTAL HEALTH SUBTOTAL	\$33,208,000	\$22,320,000	\$10,688,000	\$200,000
<u>WAIVER--MH/UCD & BTR</u>					
71	GLOBAL PAYMENT PROGRAM	\$2,439,704,000	\$1,219,852,000	\$0	\$1,219,852,000
72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,332,000,000	\$666,000,000	\$0	\$666,000,000
73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$646,730,000	\$323,365,000	\$0	\$323,365,000
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$149,110,000	\$74,555,000	\$74,555,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>WAIVER--MH/UCD & BTR</u>					
76	BTR - LIHP - MCE	\$198,363,000	\$198,363,000	\$0	\$0
77	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$231,547,000	\$231,547,000	\$0	\$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$369,000	\$369,000	\$0	\$0
208	WHOLE PERSON CARE HOUSING SERVICES	\$100,000,000	\$0	\$100,000,000	\$0
	WAIVER--MH/UCD & BTR SUBTOTAL	\$5,097,823,000	\$2,714,051,000	\$174,555,000	\$2,209,217,000
<u>MANAGED CARE</u>					
88	CCI-MANAGED CARE PAYMENTS	\$2,548,780,960	\$1,274,390,480	\$1,274,390,480	\$0
89	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	\$187,902,000	\$130,584,910	\$57,317,090	\$0
92	RETRO MC RATE ADJUSTMENTS	\$264,478,000	\$137,681,750	\$126,796,250	\$0
93	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,513,188,000	\$1,055,705,710	\$457,482,290	\$0
98	CCI-QUALITY WITHHOLD REPAYMENTS	\$16,822,000	\$8,411,000	\$8,411,000	\$0
100	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$85,506,000	\$76,955,400	\$0	\$8,550,600
104	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,754,616,000	\$1,198,441,110	\$556,174,890	\$0
105	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$640,000,000	\$449,192,280	\$190,807,720	\$0
106	CAPITATED RATE ADJUSTMENT FOR FY 2019-20	\$384,038,000	\$200,674,200	\$183,363,800	\$0
109	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$9,428,000)	\$9,428,000
110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,382,411,000)	\$1,382,411,000
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	\$0	\$0	(\$223,020,000)	\$223,020,000
112	MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$583,412,000)	\$583,412,000
113	MANAGED CARE DRUG REBATES	(\$1,442,173,000)	(\$1,442,173,000)	\$0	\$0
	MANAGED CARE SUBTOTAL	\$5,953,157,960	\$3,089,863,840	\$656,472,520	\$2,206,821,600
<u>PROVIDER RATES</u>					
114	DPH INTERIM & FINAL RECONS	(\$7,318,000)	(\$7,318,000)	\$0	\$0
115	RATE INCREASE FOR FQHCs/RHCS/CBRCS	\$237,279,020	\$146,538,050	\$90,740,970	\$0
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$187,109,000	\$124,488,000	(\$6,964,000)	\$69,585,000
117	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$107,027,000	\$66,097,130	\$40,929,870	\$0
118	AB 1629 ANNUAL RATE ADJUSTMENTS	\$187,505,550	\$93,752,770	\$93,752,770	\$0
119	DPH INTERIM RATE GROWTH	\$132,978,400	\$66,489,200	\$66,489,200	\$0
120	PROP 56 - HOME HEALTH RATE INCREASE	\$64,834,000	\$33,629,020	\$31,204,980	\$0
122	LTC RATE ADJUSTMENT	\$23,389,420	\$11,694,710	\$11,694,710	\$0
123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$13,000,000	\$6,500,000	(\$1,590,000)	\$8,090,000

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>PROVIDER RATES</u>					
124	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$14,246,000	\$7,365,940	\$6,880,060	\$0
125	HOSPICE RATE INCREASES	\$15,016,180	\$7,508,090	\$7,508,090	\$0
126	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	\$3,643,810	\$5,875,510	(\$2,231,700)	\$0
128	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,418,040	\$1,209,020	\$1,209,020	\$0
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$503,268,000)	\$503,268,000
130	DPH INTERIM RATE	\$0	\$421,868,360	(\$421,868,360)	\$0
131	10% PROVIDER PAYMENT REDUCTION	(\$13,939,770)	(\$6,969,890)	(\$6,969,890)	\$0
132	LABORATORY RATE METHODOLOGY CHANGE	(\$5,620,040)	(\$2,810,020)	(\$2,810,020)	\$0
133	REDUCTION TO RADIOLOGY RATES	(\$26,301,000)	(\$13,150,500)	(\$13,150,500)	\$0
	PROVIDER RATES SUBTOTAL	\$935,267,600	\$962,767,390	(\$608,442,800)	\$580,943,000
<u>SUPPLEMENTAL PMNTS.</u>					
134	HOSPITAL QAF - FFS PAYMENTS	\$4,444,161,000	\$2,402,993,000	\$0	\$2,041,168,000
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,897,400,000	\$1,307,993,000	\$0	\$589,407,000
136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$377,133,000	\$232,157,000	\$0	\$144,976,000
137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,363,032,240	\$915,410,270	\$447,621,970	\$0
138	PRIVATE HOSPITAL DSH REPLACEMENT	\$598,332,000	\$299,166,000	\$299,166,000	\$0
139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$244,740,000	\$244,740,000	\$0	\$0
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$546,633,000	\$330,009,290	\$216,623,710	\$0
141	DSH PAYMENT	\$409,669,000	\$295,049,000	\$16,000,000	\$98,620,000
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$297,033,000	\$159,133,000	\$118,400,000	\$19,500,000
143	NDPH IGT SUPPLEMENTAL PAYMENTS	\$111,637,000	\$69,965,000	(\$4,025,000)	\$45,697,000
144	DPH PHYSICIAN & NON-PHYS. COST	\$221,505,000	\$221,505,000	\$0	\$0
145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$65,669,000	\$65,669,000	\$0	\$0
146	CAPITAL PROJECT DEBT REIMBURSEMENT	\$128,455,000	\$92,315,500	\$36,139,500	\$0
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$119,092,000	\$69,092,000	\$0	\$50,000,000
148	FFP FOR LOCAL TRAUMA CENTERS	\$138,617,000	\$74,617,000	\$0	\$64,000,000
149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$88,000,000	\$44,000,000	\$50,083,000	(\$6,083,000)
150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$17,621,390	\$12,990,880	\$4,630,510	\$0
151	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$6,826,000	\$6,826,000	\$0	\$0
152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$6,821,220	\$3,623,490	\$3,197,730	\$0
153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$5,000,000	\$0

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

SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>SUPPLEMENTAL PMNTS.</u>					
154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$8,039,000	\$8,039,000	\$0	\$0
155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$4,000,000	\$0
156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,561,320	\$3,280,660	\$3,280,660	\$0
157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS	\$1,811,000	\$934,990	\$876,010	\$0
158	NDPH SUPPLEMENTAL PAYMENT	\$4,263,000	\$2,363,000	\$1,900,000	\$0
160	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$2,100,000,000	\$1,447,901,000	\$0	\$652,099,000
205	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$360,000,000	\$180,000,000	\$180,000,000	\$0
206	PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS	\$105,000,000	\$52,500,000	\$52,500,000	\$0
207	PROP 56 - MEDI-CAL FAMILY PLANNING	\$500,000,000	\$450,000,000	\$50,000,000	\$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$14,186,051,170	\$9,001,273,080	\$1,485,394,090	\$3,699,384,000
<u>OTHER</u>					
167	QAF WITHHOLD TRANSFER	\$139,858,000	\$69,929,000	\$69,929,000	\$0
170	CCI IHSS RECONCILIATION	\$200,000,000	\$200,000,000	\$0	\$0
171	ARRA HITECH - PROVIDER PAYMENTS	\$49,016,000	\$49,016,000	\$0	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$64,181,000	\$64,181,000	\$0	\$0
174	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$46,829,220	\$23,414,610	\$23,414,610	\$0
177	INFANT DEVELOPMENT PROGRAM	\$32,763,000	\$32,763,000	\$0	\$0
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$13,595,000	\$7,406,000	\$6,189,000	\$0
179	MEDI-CAL ESTATE RECOVERIES	\$28,268,280	\$14,134,140	\$14,134,140	\$0
180	OVERTIME FOR WPCS PROVIDERS	\$8,356,000	\$4,178,000	\$4,178,000	\$0
181	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	(\$1,576,840)	(\$788,420)	(\$788,420)	\$0
182	WPCS WORKERS' COMPENSATION	\$3,649,000	\$1,824,500	\$1,824,500	\$0
184	INDIAN HEALTH SERVICES	\$1,884,000	\$11,884,000	(\$10,000,000)	\$0
188	IMD ANCILLARY SERVICES	\$0	(\$19,223,000)	\$19,223,000	\$0
189	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$224,771,000)	\$224,771,000
190	COUNTY SHARE OF OTLICP-CCS COSTS	\$0	\$0	\$0	\$0
191	CLPP FUND	\$0	\$0	(\$725,000)	\$725,000
192	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$1,076,566,000)	\$1,076,566,000
193	CMS DEFERRED CLAIMS	\$0	(\$200,000,000)	\$200,000,000	\$0
195	ASSISTED LIVING WAIVER EXPANSION	(\$42,687,000)	(\$21,343,500)	(\$21,343,500)	\$0
198	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,881,957,460	(\$1,881,957,460)	\$0

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

**SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2019-20**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>OTHER</u>				
199	FUNDING ADJUST.—OTLICP	\$337,000	\$164,768,360	(\$164,431,360)	\$0
	OTHER SUBTOTAL	\$544,472,660	\$2,284,101,150	(\$3,041,690,480)	\$1,302,062,000
	GRAND TOTAL	<u>\$30,537,793,040</u>	<u>\$20,772,768,080</u>	<u>(\$1,501,816,640)</u>	<u>\$11,266,841,600</u>

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2019-20

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
PROFESSIONAL	\$7,884,670,470	\$4,852,363,130	\$1,907,592,980	\$1,124,714,360
PHYSICIANS	\$1,077,320,370	\$739,589,180	\$291,150,700	\$46,580,490
OTHER MEDICAL	\$4,458,804,120	\$2,697,934,090	\$1,611,680,140	\$149,189,880
CO. & COMM. OUTPATIENT	\$2,348,545,980	\$1,414,839,870	\$4,762,130	\$928,943,980
PHARMACY	\$2,046,910,420	\$649,033,950	(\$103,813,760)	\$1,501,690,220
HOSPITAL INPATIENT	\$12,415,860,140	\$7,796,811,200	\$1,628,152,060	\$2,990,896,880
COUNTY INPATIENT	\$3,381,856,110	\$2,145,610,860	\$7,522,930	\$1,228,722,320
COMMUNITY INPATIENT	\$9,034,004,020	\$5,651,200,340	\$1,620,629,130	\$1,762,174,560
LONG TERM CARE	\$3,299,971,970	\$1,718,212,540	\$1,454,427,250	\$127,332,180
NURSING FACILITIES	\$2,865,586,220	\$1,500,698,810	\$1,268,037,950	\$96,849,460
ICF-DD	\$434,385,750	\$217,513,730	\$186,389,300	\$30,482,720
OTHER SERVICES	\$1,182,219,490	\$690,565,750	\$439,366,720	\$52,287,030
MEDICAL TRANSPORTATION	\$142,080,150	\$87,630,980	\$34,254,860	\$20,194,310
OTHER SERVICES	\$771,312,370	\$465,060,930	\$276,280,170	\$29,971,270
HOME HEALTH	\$268,826,970	\$137,873,830	\$128,831,690	\$2,121,450
TOTAL FEE-FOR-SERVICE	\$26,829,632,480	\$15,706,986,570	\$5,325,725,250	\$5,796,920,670
MANAGED CARE	\$47,792,086,780	\$30,606,162,250	\$11,594,387,040	\$5,591,537,490
TWO PLAN MODEL	\$28,685,988,720	\$18,277,427,880	\$7,020,091,630	\$3,388,469,200
COUNTY ORGANIZED HEALTH SYSTEMS	\$11,594,429,920	\$7,617,144,690	\$2,643,043,010	\$1,334,242,210
GEOGRAPHIC MANAGED CARE	\$5,074,976,110	\$3,230,172,080	\$1,235,564,880	\$609,239,150
PHP & OTHER MANAG. CARE	\$848,624,550	\$455,722,300	\$334,042,200	\$58,860,050
REGIONAL MODEL	\$1,588,067,490	\$1,025,695,300	\$361,645,320	\$200,726,870
DENTAL	\$1,735,912,580	\$1,038,011,190	\$652,243,280	\$45,658,120
MENTAL HEALTH	\$3,177,635,840	\$2,923,145,730	\$28,300,220	\$226,189,890
AUDITS/ LAWSUITS	\$32,350,000	(\$183,825,000)	\$216,175,000	\$0
EPSDT SCREENS	\$717,000	\$378,920	(\$386,920)	\$725,000
MEDICARE PAYMENTS	\$5,716,631,000	\$1,619,870,500	\$4,096,760,500	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$65,300,000	\$65,300,000	\$0	\$0
MISC. SERVICES	\$10,487,549,320	\$9,674,960,360	\$14,778,520	\$797,810,440
RECOVERIES	(\$342,370,720)	(\$194,241,860)	(\$148,128,860)	\$0
DRUG MEDI-CAL	\$532,011,000	\$460,659,380	\$71,351,620	\$0
GRAND TOTAL MEDI-CAL	\$96,027,455,270	\$61,717,408,030	\$21,851,205,650	\$12,458,841,600

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

<u>SERVICE CATEGORY</u>	<u>NOV. 2018 EST. FOR 2018-19</u>	<u>NOV. 2018 EST. FOR 2019-20</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
PROFESSIONAL	\$8,128,796,600	\$7,884,670,470	(\$244,126,130)	-3.00%
PHYSICIANS	\$992,731,980	\$1,077,320,370	\$84,588,390	8.52%
OTHER MEDICAL	\$4,417,459,970	\$4,458,804,120	\$41,344,150	0.94%
CO. & COMM. OUTPATIENT	\$2,718,604,640	\$2,348,545,980	(\$370,058,660)	-13.61%
PHARMACY	\$1,414,045,250	\$2,046,910,420	\$632,865,170	44.76%
HOSPITAL INPATIENT	\$15,442,366,570	\$12,415,860,140	(\$3,026,506,440)	-19.60%
COUNTY INPATIENT	\$3,724,653,380	\$3,381,856,110	(\$342,797,260)	-9.20%
COMMUNITY INPATIENT	\$11,717,713,190	\$9,034,004,020	(\$2,683,709,170)	-22.90%
LONG TERM CARE	\$3,353,425,080	\$3,299,971,970	(\$53,453,110)	-1.59%
NURSING FACILITIES	\$2,910,105,880	\$2,865,586,220	(\$44,519,660)	-1.53%
ICF-DD	\$443,319,200	\$434,385,750	(\$8,933,450)	-2.02%
OTHER SERVICES	\$1,229,199,320	\$1,182,219,490	(\$46,979,830)	-3.82%
MEDICAL TRANSPORTATION	\$148,442,990	\$142,080,150	(\$6,362,840)	-4.29%
OTHER SERVICES	\$810,109,230	\$771,312,370	(\$38,796,860)	-4.79%
HOME HEALTH	\$270,647,110	\$268,826,970	(\$1,820,130)	-0.67%
TOTAL FEE-FOR-SERVICE	\$29,567,832,820	\$26,829,632,480	(\$2,738,200,340)	-9.26%
MANAGED CARE	\$44,108,372,670	\$47,792,086,780	\$3,683,714,110	8.35%
TWO PLAN MODEL	\$26,395,737,870	\$28,685,988,720	\$2,290,250,850	8.68%
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,703,351,200	\$11,594,429,920	\$891,078,720	8.33%
GEOGRAPHIC MANAGED CARE	\$4,670,266,100	\$5,074,976,110	\$404,710,010	8.67%
PHP & OTHER MANAG. CARE	\$887,572,720	\$848,624,550	(\$38,948,170)	-4.39%
REGIONAL MODEL	\$1,451,444,790	\$1,588,067,490	\$136,622,710	9.41%
DENTAL	\$1,149,047,000	\$1,735,912,580	\$586,865,580	51.07%
MENTAL HEALTH	\$2,964,593,980	\$3,177,635,840	\$213,041,860	7.19%
AUDITS/ LAWSUITS	\$30,668,300	\$32,350,000	\$1,681,700	5.48%
EPSDT SCREENS	\$747,000	\$717,000	(\$30,000)	-4.02%
MEDICARE PAYMENTS	\$5,445,670,000	\$5,716,631,000	\$270,961,010	4.98%
STATE HOSP./DEVELOPMENTAL CNTRS.	\$99,725,000	\$65,300,000	(\$34,425,000)	-34.52%
MISC. SERVICES	\$10,112,308,800	\$10,487,549,320	\$375,240,510	3.71%
RECOVERIES	(\$368,457,340)	(\$342,370,720)	\$26,086,620	-7.08%
DRUG MEDI-CAL	\$421,130,870	\$532,011,000	\$110,880,130	26.33%
GRAND TOTAL MEDI-CAL	\$93,531,639,100	\$96,027,455,270	\$2,495,816,170	2.67%
GENERAL FUNDS	\$19,695,655,040	\$21,851,205,650	\$2,155,550,610	10.94%
OTHER STATE FUNDS	\$15,079,838,700	\$12,458,841,600	(\$2,620,997,100)	-17.38%

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>							
1	BREAST AND CERVICAL CANCER TREATMENT	\$71,405,000	\$46,166,950	\$72,722,000	\$47,211,550	\$1,317,000	\$1,044,600
2	MEDI-CAL STATE INMATE PROGRAMS	\$64,798,000	\$0	\$42,342,000	\$0	(\$22,456,000)	\$0
4	MEDI-CAL COUNTY INMATE PROGRAMS	\$46,739,000	\$811,220	\$152,018,000	\$969,610	\$105,279,000	\$158,390
7	NON-OTLICP CHIP	\$0	\$156,948,120	\$0	(\$173,975,950)	\$0	(\$330,924,070)
8	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$905,934,000	\$0	\$886,182,000	\$0	(\$19,752,000)
9	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$94,438,960)	\$0	(\$83,130,260)	\$0	\$11,308,700
10	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$14,677,000	\$0	\$0	\$0	(\$14,677,000)
11	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$746,000)	\$0	(\$929,000)	\$0	(\$183,000)
12	CDCR RETRO REPAYMENT	\$0	\$17,206,000	\$0	\$0	\$0	(\$17,206,000)
13	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	(\$6,971,000)	\$96,097,800	\$0	\$0	\$6,971,000	(\$96,097,800)
14	OTLICP PREMIUMS	(\$63,513,000)	(\$7,621,560)	(\$63,537,000)	(\$13,104,420)	(\$24,000)	(\$5,482,860)
15	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$156,975,000)	(\$29,215,000)	(\$218,606,000)	(\$44,626,000)	(\$61,631,000)	(\$15,411,000)
200	CCHIP DELIVERY SYSTEM	\$0	\$0	(\$1,869,000)	(\$400,120)	(\$1,869,000)	(\$400,120)
204	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$0	\$0	\$257,102,000	\$194,013,000	\$257,102,000	\$194,013,000
	ELIGIBILITY SUBTOTAL	(\$44,517,000)	\$1,105,819,570	\$240,172,000	\$812,210,420	\$284,689,000	(\$293,609,160)
<u>AFFORDABLE CARE ACT</u>							
16	COMMUNITY FIRST CHOICE OPTION	\$3,588,620,000	\$0	\$3,814,150,000	\$0	\$225,530,000	\$0
17	HEALTH INSURER FEE	\$287,808,000	\$97,523,020	\$0	\$0	(\$287,808,000)	(\$97,523,020)
18	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$15,806,000	\$0	\$15,452,000	\$0	(\$354,000)	\$0
19	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$44,182,250)	\$0	(\$42,667,430)	\$0	\$1,514,820
20	ACA MAGI SAVINGS	\$0	\$0	\$0	\$0	\$0	\$0
21	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$2,349,000)	\$0	(\$2,372,000)	\$0	(\$23,000)

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 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>AFFORDABLE CARE ACT</u>							
22	ACA DSH REDUCTION	\$0	\$0	(\$603,179,000)	(\$75,372,000)	(\$603,179,000)	(\$75,372,000)
23	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$4,547,000)	\$0	(\$4,548,000)	\$0	(\$1,000)	\$0
24	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$2,400,000,000)	\$0	\$0	\$0	\$2,400,000,000	\$0
	AFFORDABLE CARE ACT SUBTOTAL	\$1,487,687,000	\$50,991,770	\$3,221,875,000	(\$120,411,430)	\$1,734,188,000	(\$171,403,200)
<u>BENEFITS</u>							
25	BEHAVIORAL HEALTH TREATMENT	\$582,841,000	\$258,502,240	\$695,404,000	\$315,423,250	\$112,563,000	\$56,921,010
26	FAMILY PACT PROGRAM	\$410,507,000	\$129,132,800	\$417,392,000	\$131,299,100	\$6,885,000	\$2,166,300
27	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$266,213,000	\$0	\$276,138,000	\$0	\$9,925,000	\$0
28	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$132,312,000	\$0	\$135,275,000	\$0	\$2,963,000	\$0
29	FULL RESTORATION OF ADULT DENTAL BENEFITS	\$84,057,000	\$27,765,280	\$79,032,000	\$26,721,520	(\$5,025,000)	(\$1,043,760)
30	BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION	\$101,777,000	\$45,140,240	\$150,352,000	\$68,194,780	\$48,575,000	\$23,054,540
32	WHOLE CHILD MODEL IMPLEMENTATION	\$28,539,000	\$12,807,640	\$791,000	\$364,680	(\$27,748,000)	(\$12,442,960)
33	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,125,000	(\$9,826,500)	\$20,125,000	(\$9,826,500)	\$0	\$0
34	DENTAL TRANSFORMATION INITIATIVE UTILIZATION	\$19,895,000	\$7,726,820	\$25,419,000	\$10,260,920	\$5,524,000	\$2,534,100
35	CCS DEMONSTRATION PROJECT	\$11,234,000	\$5,041,680	\$13,722,000	\$6,303,630	\$2,488,000	\$1,261,950
36	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$10,308,000	\$1,521,000	\$548,000	\$137,000	(\$9,760,000)	(\$1,384,000)
37	MEDI-CAL NONMEDICAL TRANSPORTATION	\$4,239,730	\$1,609,030	\$23,849,700	\$9,209,600	\$19,609,970	\$7,600,570
38	YOUTH REGIONAL TREATMENT CENTERS	\$2,893,000	\$22,000	\$3,079,000	\$24,000	\$186,000	\$2,000
39	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$2,400,000	\$2,400,000	\$1,600,000	\$1,600,000	(\$800,000)	(\$800,000)
40	PROP 56 - CBAS PROGRAMS	\$2,000,000	\$2,000,000	\$0	\$0	(\$2,000,000)	(\$2,000,000)
41	PEDIATRIC PALLIATIVE CARE WAIVER	\$3,270,000	\$2,268,900	\$0	\$0	(\$3,270,000)	(\$2,268,900)
42	CCT FUND TRANSFER TO CDSS AND CDSS	\$1,365,000	\$0	\$0	\$0	(\$1,365,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>BENEFITS</u>							
43	DIABETES PREVENTION PROGRAM	\$0	\$0	\$2,002,330	\$616,300	\$2,002,330	\$616,300
44	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS	(\$4,248,000)	(\$1,921,460)	\$0	\$0	\$4,248,000	\$1,921,460
	BENEFITS SUBTOTAL	\$1,679,727,730	\$484,189,670	\$1,844,729,030	\$560,328,280	\$165,001,300	\$76,138,610
<u>PHARMACY</u>							
45	HEPATITIS C REVISED CLINICAL GUIDELINES	\$64,619,050	\$20,355,660	\$70,387,000	\$22,847,310	\$5,767,950	\$2,491,650
47	PHARMACIST-DELIVERED MEDI-CAL SERVICES	\$250,270	\$94,490	\$911,320	\$346,760	\$661,050	\$252,280
48	LITIGATION SETTLEMENTS	(\$2,453,000)	(\$2,453,000)	\$0	\$0	\$2,453,000	\$2,453,000
49	BCCTP DRUG REBATES	(\$9,942,000)	(\$3,166,450)	(\$6,956,000)	\$0	\$2,986,000	\$3,166,450
50	FAMILY PACT DRUG REBATES	(\$23,327,000)	(\$3,066,800)	(\$21,226,000)	\$0	\$2,101,000	\$3,066,800
51	MEDICAL SUPPLY REBATES	(\$24,916,000)	(\$12,458,000)	(\$27,408,000)	(\$13,704,000)	(\$2,492,000)	(\$1,246,000)
52	PHARMACY REIMBURSEMENT & DISPENSING FEE	(\$18,000,000)	(\$6,517,780)	(\$168,000,000)	(\$61,055,120)	(\$150,000,000)	(\$54,537,340)
53	STATE SUPPLEMENTAL DRUG REBATES	(\$213,254,000)	(\$65,384,680)	(\$158,281,000)	\$0	\$54,973,000	\$65,384,680
54	FEDERAL DRUG REBATES	(\$2,223,878,000)	(\$953,903,940)	(\$1,588,306,000)	\$0	\$635,572,000	\$953,903,940
202	MEDI-CAL DRUG REBATES FUND	\$0	\$0	\$0	(\$1,440,526,000)	\$0	(\$1,440,526,000)
	PHARMACY SUBTOTAL	(\$2,450,900,680)	(\$1,026,500,500)	(\$1,898,878,680)	(\$1,492,091,050)	\$552,022,000	(\$465,590,550)
<u>DRUG MEDI-CAL</u>							
55	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$266,957,000	\$50,626,690	\$374,862,000	\$60,840,340	\$107,905,000	\$10,213,640
60	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	(\$818,000)	(\$105,000)	\$0	\$0	\$818,000	\$105,000
201	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$4,175,000	\$165,750	\$5,363,000	\$431,010	\$1,188,000	\$265,260
	DRUG MEDI-CAL SUBTOTAL	\$270,314,000	\$50,687,440	\$380,225,000	\$61,271,340	\$109,911,000	\$10,583,900

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>MENTAL HEALTH</u>							
63	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$46,640,000	\$0	\$0	\$0	(\$46,640,000)	\$0
64	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$17,103,000	\$9,365,500	\$20,148,000	\$10,888,000	\$3,045,000	\$1,522,500
65	PATHWAYS TO WELL-BEING	\$9,521,000	\$0	\$14,554,000	\$0	\$5,033,000	\$0
66	TRANSITIONAL SMHS CLAIMS	\$909,000	\$909,000	\$0	\$0	(\$909,000)	(\$909,000)
67	LATE CLAIMS FOR SMHS	\$25,000	\$25,000	\$0	\$0	(\$25,000)	(\$25,000)
68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$855,000	\$0	(\$200,000)	\$0	(\$1,055,000)
69	CHART REVIEW	(\$766,000)	\$0	(\$1,494,000)	\$0	(\$728,000)	\$0
70	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$14,306,000)	(\$1,649,000)	\$0	\$0	\$14,306,000	\$1,649,000
	MENTAL HEALTH SUBTOTAL	\$59,126,000	\$9,505,500	\$33,208,000	\$10,688,000	(\$25,918,000)	\$1,182,500
<u>WAIVER--MH/UCD & BTR</u>							
71	GLOBAL PAYMENT PROGRAM	\$2,427,881,000	\$0	\$2,439,704,000	\$0	\$11,823,000	\$0
72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,687,847,000	\$0	\$1,332,000,000	\$0	(\$355,847,000)	\$0
73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$839,722,000	\$0	\$646,730,000	\$0	(\$192,992,000)	\$0
74	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$115,244,000	\$57,622,000	\$149,110,000	\$74,555,000	\$33,866,000	\$16,933,000
75	MH/UCD—STABILIZATION FUNDING	\$110,930,000	\$110,930,000	\$0	\$0	(\$110,930,000)	(\$110,930,000)
76	BTR - LIHP - MCE	\$104,616,000	\$0	\$198,363,000	\$0	\$93,747,000	\$0
77	BTR - LOW INCOME HEALTH PROGRAM - HCCI	\$36,060,000	\$0	\$231,547,000	\$0	\$195,487,000	\$0
78	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$21,940,000	\$0	\$0	\$0	(\$21,940,000)	\$0
79	MH/UCD—SAFETY NET CARE POOL	\$2,989,000	\$0	\$0	\$0	(\$2,989,000)	\$0
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$363,000	\$0	\$369,000	\$0	\$6,000	\$0
81	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	(\$37,727,000)	\$0	\$0	\$0	\$37,727,000

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>WAIVER--MH/UCD & BTR</u>							
82	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	(\$6,205,000)	\$0	\$0	\$0	\$6,205,000
83	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT	\$0	\$108,229,000	\$0	\$0	\$0	(\$108,229,000)
84	LIHP MCE REPAYMENT	\$0	\$0	\$0	\$0	\$0	\$0
208	WHOLE PERSON CARE HOUSING SERVICES	\$0	\$0	\$100,000,000	\$100,000,000	\$100,000,000	\$100,000,000
	WAIVER--MH/UCD & BTR SUBTOTAL	\$5,347,592,000	\$232,849,000	\$5,097,823,000	\$174,555,000	(\$249,769,000)	(\$58,294,000)
<u>MANAGED CARE</u>							
88	CCI-MANAGED CARE PAYMENTS	\$7,705,868,000	\$3,852,934,000	\$7,982,402,000	\$3,991,201,000	\$276,534,000	\$138,267,000
89	MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.RATES	\$2,172,871,000	\$662,808,800	\$187,902,000	\$57,317,090	(\$1,984,969,000)	(\$605,491,710)
90	MANAGED CARE RATE RANGE IGTS	\$1,697,426,000	\$0	\$0	\$0	(\$1,697,426,000)	\$0
92	RETRO MC RATE ADJUSTMENTS	\$884,722,000	\$418,406,540	\$264,478,000	\$126,796,250	(\$620,244,000)	(\$291,610,290)
93	MANAGED CARE PUBLIC HOSPITAL EPP	\$835,015,000	\$248,950,230	\$1,513,188,000	\$457,482,290	\$678,173,000	\$208,532,060
98	CCI-QUALITY WITHHOLD REPAYMENTS	\$8,260,000	\$4,130,000	\$16,822,000	\$8,411,000	\$8,562,000	\$4,281,000
99	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$4,981,000	\$4,981,000	\$0	\$0	(\$4,981,000)	(\$4,981,000)
100	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$2,652,000	\$0	\$85,506,000	\$0	\$82,854,000	\$0
102	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$571,000	\$285,500	\$0	\$0	(\$571,000)	(\$285,500)
103	PALLIATIVE CARE SERVICES IMPLEMENTATION	\$237,000	\$118,500	\$0	\$0	(\$237,000)	(\$118,500)
104	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$0	\$0	\$1,754,616,000	\$556,174,890	\$1,754,616,000	\$556,174,890
105	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$0	\$0	\$640,000,000	\$190,807,720	\$640,000,000	\$190,807,720
106	CAPITATED RATE ADJUSTMENT FOR FY 2019-20	\$0	\$0	\$384,038,000	\$183,363,800	\$384,038,000	\$183,363,800
107	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	(\$286,000)	\$0	\$0	\$0	\$286,000

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE							
109	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	(\$112,006,000)	\$0	(\$9,428,000)	\$0	\$102,578,000
110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$315,907,000)	\$0	(\$1,382,411,000)	\$0	(\$1,066,504,000)
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.	\$0	(\$660,295,000)	\$0	(\$223,020,000)	\$0	\$437,275,000
112	MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,866,610,000)	\$0	(\$583,412,000)	\$0	\$1,283,198,000
113	MANAGED CARE DRUG REBATES	(\$1,906,393,000)	(\$549,831,860)	(\$1,442,173,000)	\$0	\$464,220,000	\$549,831,860
	MANAGED CARE SUBTOTAL	\$11,406,210,000	\$1,687,678,710	\$11,386,779,000	\$3,373,283,040	(\$19,431,000)	\$1,685,604,330
PROVIDER RATES							
114	DPH INTERIM & FINAL RECONS	\$242,884,000	\$0	(\$7,318,000)	\$0	(\$250,202,000)	\$0
115	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$200,195,600	\$75,425,190	\$238,831,420	\$91,334,640	\$38,635,820	\$15,909,450
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$172,631,000	(\$6,901,000)	\$187,109,000	(\$6,964,000)	\$14,478,000	(\$63,000)
117	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$163,939,000	\$61,765,490	\$107,027,000	\$40,929,870	(\$56,912,000)	(\$20,835,620)
118	AB 1629 ANNUAL RATE ADJUSTMENTS	\$148,784,450	\$74,392,220	\$215,029,300	\$107,514,650	\$66,244,850	\$33,122,430
119	DPH INTERIM RATE GROWTH	\$59,400,070	\$29,700,040	\$132,978,400	\$66,489,200	\$73,578,320	\$36,789,160
120	PROP 56 - HOME HEALTH RATE INCREASE	\$56,600,080	\$27,042,020	\$64,834,000	\$31,204,980	\$8,233,920	\$4,162,950
121	DENTAL RETROACTIVE RATE CHANGES	\$25,931,000	\$9,552,080	\$0	\$0	(\$25,931,000)	(\$9,552,080)
122	LTC RATE ADJUSTMENT	\$25,062,690	\$12,531,350	\$23,389,420	\$11,694,710	(\$1,673,270)	(\$836,640)
123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$11,972,000	(\$1,590,000)	\$13,000,000	(\$1,590,000)	\$1,028,000	\$0
124	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$11,752,950	\$5,619,880	\$14,246,000	\$6,880,060	\$2,493,050	\$1,260,180
125	HOSPICE RATE INCREASES	\$15,332,830	\$7,666,420	\$15,704,020	\$7,852,010	\$371,180	\$185,590
126	ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE	\$6,638,780	(\$5,362,850)	\$3,643,810	(\$2,231,700)	(\$2,994,970)	\$3,131,150
127	PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT	\$5,953,000	\$2,976,500	\$0	\$0	(\$5,953,000)	(\$2,976,500)

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CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>PROVIDER RATES</u>							
128	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,037,380	\$1,018,690	\$2,506,000	\$1,253,000	\$468,620	\$234,310
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$899,759,000)	\$0	(\$503,268,000)	\$0	\$396,491,000
130	DPH INTERIM RATE	\$0	(\$384,598,010)	\$0	(\$421,868,360)	\$0	(\$37,270,350)
131	10% PROVIDER PAYMENT REDUCTION	(\$194,418,000)	(\$97,209,000)	(\$194,418,000)	(\$97,209,000)	\$0	\$0
132	LABORATORY RATE METHODOLOGY CHANGE	(\$30,452,000)	(\$15,226,000)	(\$12,295,000)	(\$6,147,500)	\$18,157,000	\$9,078,500
133	REDUCTION TO RADIOLOGY RATES	(\$56,863,000)	(\$28,431,500)	(\$48,923,000)	(\$24,461,500)	\$7,940,000	\$3,970,000
	PROVIDER RATES SUBTOTAL	\$867,381,830	(\$1,131,387,480)	\$755,344,370	(\$698,586,940)	(\$112,037,470)	\$432,800,540
<u>SUPPLEMENTAL PMNTS.</u>							
134	HOSPITAL QAF - FFS PAYMENTS	\$6,261,304,000	\$0	\$4,444,161,000	\$0	(\$1,817,143,000)	\$0
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$3,746,122,000	\$0	\$1,897,400,000	\$0	(\$1,848,722,000)	\$0
136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$894,195,000	\$0	\$377,133,000	\$0	(\$517,062,000)	\$0
137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,299,438,840	\$409,156,190	\$1,387,168,980	\$455,548,520	\$87,730,140	\$46,392,330
138	PRIVATE HOSPITAL DSH REPLACEMENT	\$566,597,000	\$283,298,500	\$598,332,000	\$299,166,000	\$31,735,000	\$15,867,500
139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$503,241,000	\$0	\$244,740,000	\$0	(\$258,501,000)	\$0
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$510,070,000	\$194,390,970	\$546,633,000	\$216,623,710	\$36,563,000	\$22,232,740
141	DSH PAYMENT	\$415,063,000	\$16,543,000	\$409,669,000	\$16,000,000	(\$5,394,000)	(\$543,000)
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$317,899,000	\$118,400,000	\$297,033,000	\$118,400,000	(\$20,866,000)	\$0
143	NDPH IGT SUPPLEMENTAL PAYMENTS	\$160,421,000	(\$10,099,000)	\$111,637,000	(\$4,025,000)	(\$48,784,000)	\$6,074,000
144	DPH PHYSICIAN & NON-PHYS. COST	\$147,389,000	\$0	\$221,505,000	\$0	\$74,116,000	\$0
145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$145,438,000	\$0	\$65,669,000	\$0	(\$79,769,000)	\$0
146	CAPITAL PROJECT DEBT REIMBURSEMENT	\$126,344,000	\$34,913,500	\$128,455,000	\$36,139,500	\$2,111,000	\$1,226,000

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		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>SUPPLEMENTAL PMNTS.</u>							
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$119,213,000	\$493,100	\$119,092,000	\$0	(\$121,000)	(\$493,100)
148	FFP FOR LOCAL TRAUMA CENTERS	\$116,107,000	\$0	\$138,617,000	\$0	\$22,510,000	\$0
149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$89,326,000	\$50,252,000	\$88,000,000	\$50,083,000	(\$1,326,000)	(\$169,000)
150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$203,057,000	\$54,198,000	\$159,614,000	\$41,943,000	(\$43,443,000)	(\$12,255,000)
151	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$37,505,000	\$0	\$6,826,000	\$0	(\$30,679,000)	\$0
152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$29,376,870	\$13,744,110	\$27,819,000	\$13,041,300	(\$1,557,870)	(\$702,810)
153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,001,000	\$5,000,500	\$10,000,000	\$5,000,000	(\$1,000)	(\$500)
154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$9,389,000	\$0	\$8,039,000	\$0	(\$1,350,000)	\$0
155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$0	\$0
156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,800,000	\$3,400,000	\$6,800,000	\$3,400,000	\$0	\$0
157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS	\$6,189,050	\$2,993,330	\$1,811,000	\$876,010	(\$4,378,050)	(\$2,117,320)
158	NDPH SUPPLEMENTAL PAYMENT	\$5,830,000	\$1,900,000	\$4,263,000	\$1,900,000	(\$1,567,000)	\$0
159	IGT PAYMENTS FOR HOSPITAL SERVICES	\$112,000	\$0	\$0	\$0	(\$112,000)	\$0
160	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$0	\$0	\$2,100,000,000	\$0	\$2,100,000,000	\$0
161	DP-NF CAPITAL PROJECT DEBT REPAYMENT	\$0	\$57,224,000	\$0	\$0	\$0	(\$57,224,000)
205	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$0	\$0	\$360,000,000	\$180,000,000	\$360,000,000	\$180,000,000
206	PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS	\$0	\$0	\$105,000,000	\$52,500,000	\$105,000,000	\$52,500,000
207	PROP 56 - MEDI-CAL FAMILY PLANNING	\$0	\$0	\$500,000,000	\$50,000,000	\$500,000,000	\$50,000,000
	SUPPLEMENTAL PMNTS. SUBTOTAL	\$15,734,427,760	\$1,239,808,200	\$14,373,416,980	\$1,540,596,040	(\$1,361,010,780)	\$300,787,830

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		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
167	QAF WITHHOLD TRANSFER	\$581,878,000	\$290,939,000	\$139,858,000	\$69,929,000	(\$442,020,000)	(\$221,010,000)
170	CCI IHSS RECONCILIATION	\$142,263,000	\$0	\$200,000,000	\$0	\$57,737,000	\$0
171	ARRA HITECH - PROVIDER PAYMENTS	\$91,440,000	\$0	\$49,016,000	\$0	(\$42,424,000)	\$0
172	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$130,514,000	\$0	\$64,181,000	\$0	(\$66,333,000)	\$0
174	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$42,803,120	\$21,401,560	\$46,829,220	\$23,414,610	\$4,026,100	\$2,013,050
177	INFANT DEVELOPMENT PROGRAM	\$46,546,000	\$0	\$32,763,000	\$0	(\$13,783,000)	\$0
178	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$19,468,000	\$8,407,000	\$13,595,000	\$6,189,000	(\$5,873,000)	(\$2,218,000)
179	MEDI-CAL ESTATE RECOVERIES	\$38,906,000	\$19,453,000	\$50,660,000	\$25,330,000	\$11,754,000	\$5,877,000
180	OVERTIME FOR WPCS PROVIDERS	\$8,088,000	\$4,044,000	\$8,356,000	\$4,178,000	\$268,000	\$134,000
181	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL	\$5,176,140	\$2,588,070	(\$1,576,840)	(\$788,420)	(\$6,752,980)	(\$3,376,490)
182	WPCS WORKERS' COMPENSATION	\$3,322,000	\$1,661,000	\$3,649,000	\$1,824,500	\$327,000	\$163,500
184	INDIAN HEALTH SERVICES	\$1,265,000	(\$10,000,000)	\$1,884,000	(\$10,000,000)	\$619,000	\$0
187	AUDIT SETTLEMENTS	\$0	\$191,648,000	\$0	\$0	\$0	(\$191,648,000)
188	IMD ANCILLARY SERVICES	\$0	\$34,524,000	\$0	\$19,223,000	\$0	(\$15,301,000)
189	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$127,440,000)	\$0	(\$224,771,000)	\$0	(\$97,331,000)
190	COUNTY SHARE OF OTLICP-CCS COSTS	\$0	\$0	\$0	\$0	\$0	\$0
191	CLPP FUND	\$0	(\$725,000)	\$0	(\$725,000)	\$0	\$0
192	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$1,386,448,000)	\$0	(\$1,076,566,000)	\$0	\$309,882,000
193	CMS DEFERRED CLAIMS	\$0	\$243,175,000	\$0	\$200,000,000	\$0	(\$43,175,000)
194	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES	\$0	\$25,856,000	\$0	\$0	\$0	(\$25,856,000)
195	ASSISTED LIVING WAIVER EXPANSION	(\$14,825,450)	(\$7,412,730)	(\$42,687,000)	(\$21,343,500)	(\$27,861,550)	(\$13,930,770)
198	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,912,603,770)	\$0	(\$1,881,957,460)	\$0	\$30,646,310
199	FUNDING ADJUST.—OTLICP	\$366,000	(\$206,024,360)	\$337,000	(\$164,431,360)	(\$29,000)	\$41,593,000

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 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER SUBTOTAL	\$1,097,209,810	(\$2,806,957,230)	\$566,864,380	(\$3,030,494,620)	(\$530,345,420)	(\$223,537,400)
	GRAND TOTAL	<u>\$35,454,258,450</u>	<u>(\$103,315,340)</u>	<u>\$36,001,558,090</u>	<u>\$1,191,348,080</u>	<u>\$547,299,640</u>	<u>\$1,294,663,420</u>

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

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	PA-OAS	NEWLY	PA-ATD	PA-AFDC	LT-OAS	H-PE
PHYSICIANS	\$7,798,570	\$133,344,820	\$76,201,130	\$41,557,920	\$1,384,810	\$42,659,990
OTHER MEDICAL	\$81,553,950	\$1,110,020,380	\$420,190,990	\$321,046,720	\$5,746,380	\$39,863,190
CO. & COMM. OUTPATIENT	\$4,143,600	\$127,369,960	\$123,091,920	\$27,154,290	\$617,000	\$51,406,320
PHARMACY	\$4,528,320	\$668,584,780	\$773,336,920	\$85,001,250	\$2,477,840	\$19,674,490
COUNTY INPATIENT	\$3,972,930	\$556,208,770	\$26,366,550	\$21,534,990	\$1,723,720	\$44,510,700
COMMUNITY INPATIENT	\$63,419,720	\$1,261,850,110	\$581,178,310	\$240,180,570	\$17,409,770	\$247,263,700
NURSING FACILITIES	\$207,242,920	\$145,642,660	\$526,847,380	\$2,434,970	\$1,242,836,890	\$1,288,840
ICF-DD	\$1,224,470	\$7,195,220	\$182,599,870	\$270,880	\$51,557,090	\$0
MEDICAL TRANSPORTATION	\$8,450,360	\$28,315,280	\$26,591,640	\$4,218,270	\$3,736,280	\$3,391,600
OTHER SERVICES	\$76,150,060	\$28,642,980	\$254,756,420	\$38,634,240	\$57,480,970	\$1,183,070
HOME HEALTH	\$1,853,490	\$2,442,220	\$160,208,340	\$5,083,200	\$12,470	\$88,280
FFS SUBTOTAL	\$460,338,390	\$4,069,617,180	\$3,151,369,470	\$787,117,290	\$1,384,983,220	\$451,330,170
DENTAL	\$81,421,630	\$284,591,910	\$81,421,630	\$81,421,630	\$81,421,630	\$0
MENTAL HEALTH	\$10,658,870	\$328,400,440	\$1,110,163,490	\$806,192,520	\$991,050	\$9,067,590
TWO PLAN MODEL	\$1,142,155,230	\$9,369,551,850	\$5,305,460,100	\$1,306,778,980	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$333,177,840	\$3,682,857,740	\$1,442,187,420	\$320,383,790	\$703,882,000	\$0
GEOGRAPHIC MANAGED CARE	\$184,395,660	\$1,597,942,180	\$1,007,917,230	\$214,746,940	\$0	\$0
PHP & OTHER MANAG. CARE	\$253,121,060	\$17,620,170	\$160,289,480	\$12,799,820	\$11,261,130	\$0
EPSDT SCREENS	\$0	\$0	\$0	\$118,350	\$0	\$0
MEDICARE PAYMENTS	\$1,817,043,830	\$0	\$1,697,626,390	\$2,944,650	\$170,718,340	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$3,748,850	\$0	\$8,362,890	\$9,713,990	\$362,070	\$0
MISC. SERVICES	\$793,206,380	\$0	\$5,809,056,120	\$5,427,370	\$0	\$0
DRUG MEDI-CAL	\$14,432,000	\$177,383,330	\$71,824,000	\$42,778,850	\$1,212,090	\$0
REGIONAL MODEL	\$15,053,170	\$522,721,640	\$327,513,640	\$66,762,040	\$0	\$0
NON-FFS SUBTOTAL	\$4,648,414,520	\$15,981,069,250	\$17,021,822,400	\$2,870,068,930	\$969,848,310	\$9,067,590
TOTAL DOLLARS (1)	\$5,108,752,900	\$20,050,686,430	\$20,173,191,880	\$3,657,186,220	\$2,354,831,530	\$460,397,760
ELIGIBLES ***	435,900	3,822,400	972,400	1,129,500	42,100	31,900
ANNUAL \$/ELIGIBLE	\$11,720	\$5,246	\$20,746	\$3,238	\$55,934	\$14,433
AVG. MO. \$/ELIGIBLE	\$977	\$437	\$1,729	\$270	\$4,661	\$1,203

(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 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-ATD	MN-AFDC	MI-C
PHYSICIANS	\$1,397,530	\$21,443,010	\$22,610,960	\$6,509,020	\$129,005,980	\$22,386,630
OTHER MEDICAL	\$3,695,300	\$210,131,890	\$152,365,710	\$70,315,910	\$951,976,160	\$85,108,920
CO. & COMM. OUTPATIENT	\$485,920	\$29,373,800	\$17,552,970	\$8,488,610	\$111,013,470	\$10,122,380
PHARMACY	\$4,092,100	\$66,095,300	\$19,706,060	\$30,871,040	\$216,335,680	\$40,630,460
COUNTY INPATIENT	\$3,700,910	\$4,095,820	\$55,902,820	\$14,579,000	\$114,637,860	\$5,711,370
COMMUNITY INPATIENT	\$17,778,900	\$119,939,770	\$147,098,480	\$43,570,830	\$705,795,820	\$72,348,690
NURSING FACILITIES	\$240,538,260	\$2,529,890	\$209,446,980	\$38,221,500	\$24,139,770	\$3,321,310
ICF-DD	\$177,593,600	\$17,540	\$1,622,710	\$6,701,860	\$1,097,130	\$1,812,400
MEDICAL TRANSPORTATION	\$1,430,820	\$1,109,570	\$15,206,210	\$11,624,330	\$10,237,220	\$1,901,630
OTHER SERVICES	\$10,228,610	\$26,860,700	\$75,529,910	\$56,488,600	\$91,367,590	\$11,495,770
HOME HEALTH	\$5,480	\$12,948,890	\$1,073,720	\$51,502,530	\$9,536,760	\$13,840,910
FFS SUBTOTAL	\$460,947,420	\$494,546,190	\$718,116,520	\$338,873,230	\$2,365,143,440	\$268,680,480
DENTAL	\$81,421,630	\$239,705,570	\$81,421,630	\$81,421,630	\$81,850,630	\$77,899,170
MENTAL HEALTH	\$2,427,070	\$82,535,810	\$14,400,600	\$105,026,430	\$561,365,820	\$80,310,030
TWO PLAN MODEL	\$0	\$936,787,160	\$1,326,586,280	\$548,008,560	\$3,205,015,370	\$37,678,430
COUNTY ORGANIZED HEALTH SYSTEMS	\$178,877,080	\$509,458,420	\$494,402,580	\$354,049,090	\$1,307,768,860	\$45,993,470
GEOGRAPHIC MANAGED CARE	\$0	\$191,462,810	\$196,360,000	\$114,483,210	\$569,759,630	\$5,708,610
PHP & OTHER MANAG. CARE	\$376,090	\$2,027,870	\$261,243,960	\$30,557,280	\$4,992,410	\$4,733,220
EPSDT SCREENS	\$0	\$97,220	\$0	\$0	\$363,980	\$16,190
MEDICARE PAYMENTS	\$16,308,820	\$0	\$1,343,321,520	\$548,483,960	\$120,183,490	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$92,020	\$0	\$4,435,150	\$1,420,760	\$29,431,780	\$1,305,520
MISC. SERVICES	\$0	(\$41,330,030)	\$886,514,240	\$985,599,500	\$15,679,660	\$726,990
DRUG MEDI-CAL	\$309,500	\$26,929,510	\$16,377,590	\$9,270,000	\$122,332,490	\$5,028,400
REGIONAL MODEL	\$0	\$62,004,370	\$40,860,640	\$34,931,930	\$200,614,260	\$1,451,400
NON-FFS SUBTOTAL	\$279,812,220	\$2,009,678,710	\$4,665,924,200	\$2,813,252,360	\$6,219,358,390	\$260,851,420
TOTAL DOLLARS (1)	\$740,759,630	\$2,504,224,900	\$5,384,040,720	\$3,152,125,590	\$8,584,501,830	\$529,531,900
ELIGIBLES ***	10,700	920,500	524,000	170,700	3,446,500	153,300
ANNUAL \$/ELIGIBLE	\$69,230	\$2,721	\$10,275	\$18,466	\$2,491	\$3,454
AVG. MO. \$/ELIGIBLE	\$5,769	\$227	\$856	\$1,539	\$208	\$288

(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 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	MI-A	REFUGEE	OBRA	POV 185	POV 133	POV 100
PHYSICIANS	\$856,860	\$58,620	\$128,810	\$108,841,360	\$15,266,590	\$6,842,860
OTHER MEDICAL	\$2,629,280	\$597,130	\$31,760	\$248,204,860	\$207,284,920	\$87,711,650
CO. & COMM. OUTPATIENT	\$581,190	\$73,760	\$26,320	\$25,823,450	\$17,306,850	\$9,872,740
PHARMACY	\$1,852,330	\$122,560	\$317,370	\$19,652,920	\$28,783,270	\$27,625,560
COUNTY INPATIENT	\$4,836,300	\$11,560	\$84,740	\$69,674,640	\$2,543,820	\$2,681,220
COMMUNITY INPATIENT	\$2,858,240	\$71,100	\$935,280	\$765,588,030	\$101,970,100	\$45,722,980
NURSING FACILITIES	\$21,116,150	\$50	\$6,166,870	\$1,061,490	\$7,804,750	\$926,540
ICF-DD	\$942,960	\$0	\$316,240	\$200,150	\$772,630	\$2,760
MEDICAL TRANSPORTATION	\$219,130	\$2,410	\$48,570	\$3,912,090	\$1,286,380	\$406,720
OTHER SERVICES	\$515,670	\$15,290	\$6,190	\$11,858,780	\$17,512,760	\$10,872,840
HOME HEALTH	\$1,520	\$0	\$0	\$2,529,950	\$6,143,400	\$1,340,360
FFS SUBTOTAL	\$36,409,640	\$952,470	\$8,062,150	\$1,257,347,720	\$406,675,490	\$194,006,250
DENTAL	\$81,421,630	\$81,421,630	\$81,421,630	\$81,850,630	\$77,899,170	\$77,899,170
MENTAL HEALTH	\$0	\$202,370	\$204,020	\$2,450,290	\$25,094,750	\$38,144,710
TWO PLAN MODEL	\$17,010	\$358,880	\$0	\$210,448,390	\$832,833,750	\$430,178,390
COUNTY ORGANIZED HEALTH SYSTEMS	\$88,680	\$81,340	\$25,750	\$95,641,760	\$362,008,260	\$195,690,960
GEOGRAPHIC MANAGED CARE	\$5,870	\$206,170	\$0	\$39,018,470	\$149,942,400	\$78,090,410
PHP & OTHER MANAG. CARE	\$4,891,810	\$0	\$0	\$4,933,650	\$4,731,700	\$4,731,700
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$80,170	\$41,080
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$85,140	\$0	\$4,300	\$3,013,530	\$0	\$3,324,000
MISC. SERVICES	\$2,360	\$0	\$0	\$54,180	\$3,197,130	\$1,602,100
DRUG MEDI-CAL	\$299,930	\$17,180	\$0	\$10,395,820	\$21,901,330	\$11,518,990
REGIONAL MODEL	\$0	\$1,180	\$0	\$13,823,170	\$50,731,060	\$24,571,840
NON-FFS SUBTOTAL	\$86,812,440	\$82,288,750	\$81,655,710	\$461,629,870	\$1,528,419,720	\$865,793,340
TOTAL DOLLARS (1)	\$123,222,080	\$83,241,220	\$89,717,850	\$1,718,977,590	\$1,935,095,200	\$1,059,799,590
ELIGIBLES ***	9,900	700	500	357,500	759,900	389,000
ANNUAL \$/ELIGIBLE	\$12,447	\$118,916	\$179,436	\$4,808	\$2,547	\$2,724
AVG. MO. \$/ELIGIBLE	\$1,037	\$9,910	\$14,953	\$401	\$212	\$227

(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 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

SERVICE CATEGORY	TOTAL
PHYSICIANS	\$638,295,490
OTHER MEDICAL	\$3,998,475,080
CO. & COMM. OUTPATIENT	\$564,504,550
PHARMACY	\$2,009,688,260
COUNTY INPATIENT	\$932,777,720
COMMUNITY INPATIENT	\$4,434,980,400
NURSING FACILITIES	\$2,681,567,220
ICF-DD	\$433,927,530
MEDICAL TRANSPORTATION	\$122,088,480
OTHER SERVICES	\$769,600,450
HOME HEALTH	\$268,611,530
FFS SUBTOTAL	\$16,854,516,710
DENTAL	\$1,735,912,580
MENTAL HEALTH	\$3,177,635,840
TWO PLAN MODEL	\$24,651,858,360
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,026,575,040
GEOGRAPHIC MANAGED CARE	\$4,350,039,590
PHP & OTHER MANAG. CARE	\$778,311,350
EPSDT SCREENS	\$717,000
MEDICARE PAYMENTS	\$5,716,631,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$65,300,000
MISC. SERVICES	\$8,459,736,000
DRUG MEDI-CAL	\$532,011,000
REGIONAL MODEL	\$1,361,040,360
NON-FFS SUBTOTAL	\$60,855,768,120
TOTAL DOLLARS (1)	\$77,710,284,830
ELIGIBLES ***	13,177,400
ANNUAL \$/ELIGIBLE	\$5,897
AVG. MO. \$/ELIGIBLE	\$491

(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 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

	PROPOSITION 56 FUNDS TRANSFER
1	BREAST AND CERVICAL CANCER TREATMENT
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
7	NON-OTLICP CHIP
10	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
13	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
20	ACA MAGI SAVINGS
21	1% FMAP INCREASE FOR PREVENTIVE SERVICES
22	ACA DSH REDUCTION
26	FAMILY PACT PROGRAM
40	PROP 56 - CBAS PROGRAMS
50	FAMILY PACT DRUG REBATES
60	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
63	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
66	TRANSITIONAL SMHS CLAIMS
68	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
71	GLOBAL PAYMENT PROGRAM
72	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
73	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
75	MH/UCD—STABILIZATION FUNDING
76	BTR - LIHP - MCE
77	BTR - LOW INCOME HEALTH PROGRAM - HCCI
78	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
79	MH/UCD—SAFETY NET CARE POOL
80	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
81	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
82	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
83	CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT
84	LIHP MCE REPAYMENT
99	GENERAL FUND REIMBURSEMENTS FROM DPHS
101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
103	PALLIATIVE CARE SERVICES IMPLEMENTATION

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

107	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
109	MANAGED CARE IGT ADMIN. & PROCESSING FEE
110	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
111	MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.
112	MCO ENROLLMENT TAX MANAGED CARE PLANS
121	DENTAL RETROACTIVE RATE CHANGES
123	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
127	PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
134	HOSPITAL QAF - FFS PAYMENTS
135	HOSPITAL QAF - MANAGED CARE PAYMENTS
136	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
137	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
138	PRIVATE HOSPITAL DSH REPLACEMENT
139	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
141	DSH PAYMENT
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
143	NDPH IGT SUPPLEMENTAL PAYMENTS
144	DPH PHYSICIAN & NON-PHYS. COST
145	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
146	CAPITAL PROJECT DEBT REIMBURSEMENT
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
148	FFP FOR LOCAL TRAUMA CENTERS
149	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
150	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
151	GEMT SUPPLEMENTAL PAYMENT PROGRAM
152	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
153	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
154	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
155	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
156	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
157	PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS
158	NDPH SUPPLEMENTAL PAYMENT
159	IGT PAYMENTS FOR HOSPITAL SERVICES

FISCAL YEAR 2019-20 COST PER ELIGIBLE BASED ON NOVEMBER 2018 ESTIMATE

EXCLUDED POLICY CHANGES: 81

160	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
161	DP-NF CAPITAL PROJECT DEBT REPAYMENT
171	ARRA HITECH - PROVIDER PAYMENTS
176	MEDI-CAL TCM PROGRAM
187	AUDIT SETTLEMENTS
189	CIGARETTE AND TOBACCO SURTAX FUNDS
191	CLPP FUND
192	HOSPITAL QAF - CHILDREN'S HEALTH CARE
193	CMS DEFERRED CLAIMS
194	REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES
205	PROP 56 - VALUE-BASED PAYMENT PROGRAM
206	PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS
207	PROP 56 - MEDI-CAL FAMILY PLANNING
208	WHOLE PERSON CARE HOUSING SERVICES

**Estimated Average Monthly Certified Eligibles
November 2018 Estimate
Fiscal Years 2017-2018, 2018-2019 & 2019-2020**

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

	2017-2018	2018-2019	2019-2020	17-18 To 18-19 % Change	18-19 To 19-20 % Change
Public Assistance	2,614,000	2,537,600	2,537,800	-2.92%	0.01%
Seniors	435,700	435,900	435,900	0.05%	0.00%
Persons with Disabilities	980,800	972,400	972,400	-0.86%	0.00%
Families ¹	1,197,500	1,129,300	1,129,500	-5.70%	0.02%
Long Term	53,300	52,800	52,800	-0.94%	0.00%
Seniors	42,200	42,100	42,100	-0.24%	0.00%
Persons with Disabilities	11,100	10,700	10,700	-3.60%	0.00%
Medically Needy	4,162,100	4,126,200	4,150,300	-0.86%	0.58%
Seniors	477,900	497,400	515,700	4.08%	3.68%
Persons with Disabilities	163,500	165,200	165,200	1.04%	0.00%
Families ¹	3,520,700	3,463,600	3,469,400	-1.62%	0.17%
Medically Indigent	176,100	163,900	163,200	-6.93%	-0.43%
Children	165,200	154,000	153,300	-6.78%	-0.45%
Adults	10,900	9,900	9,900	-9.17%	0.00%
Other	6,321,100	6,287,800	6,316,000	-0.53%	0.45%
Refugees	900	600	700	-33.33%	16.67%
OBRA ²	700	500	500	-28.57%	0.00%
185% Poverty ³	360,600	359,300	358,600	-0.36%	-0.19%
133% Poverty	769,300	763,700	759,900	-0.73%	-0.50%
100% Poverty	387,500	390,900	389,000	0.88%	-0.49%
Opt. Targeted Low Income Children	926,400	924,900	920,500	-0.16%	-0.48%
ACA Optional Expansion	3,825,600	3,796,900	3,835,800	-0.75%	1.02%
Hospital PE	31,600	31,900	31,900	0.95%	0.00%
Medi-Cal Access Program	4,700	5,300	5,300	12.77%	0.00%
QMB	13,800	13,800	13,800	0.00%	0.00%
GRAND TOTAL ⁴	13,326,600	13,168,300	13,220,100	-1.19%	0.39%
Seniors and Persons with Disabilities	2,111,200	2,123,700	2,142,000	0.59%	0.86%
Families and Children ⁵	7,327,200	7,185,700	7,180,200	-1.93%	-0.08%

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

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

¹ The 1931(b) category of eligibility is included in MN-Families and PA-Families.

² OBRA includes aid codes 55 & 58. Aid codes 55 & 58 include Medically Needy & Medically Indigent; however, this is not a full count of Unverified Persons in Medi-Cal. All other unverified persons are included in the category for which they are eligible.

³ Includes the following presumptive eligibility for pregnant women program eligibles:

	<u>2017-2018</u>	<u>2018-2019</u>	<u>2019-2020</u>
Presumptive Eligibility	25,400	31,300	31,300

⁴ The following Medi-Cal special program eligibles (average monthly during FY 2016-17 shown in parenthesis) are not included above: BCCTP (6,834), Tuberculosis (82), Dialysis (151), TPN (2).

Family PACT eligibles are also not included above.

⁵ Includes Public Assistance Families, Medically Needy Families, Medically Indigent Children, 185% Poverty, 133% Poverty, 100% Poverty, and Optional Targeted LowIncome Children categories.

**Caseload Changes Identified in Policy Changes
(Portion not in the base estimate)**

<u>Policy Change</u>	<u>Budget Aid Category</u>	Caseload Change Average Monthly Eligibles not in the Base Estimate		
		<u>2017-18</u>	<u>2018-19</u>	<u>2019-20</u>
PC 1 Medi-Cal State Inmates	LT Seniors	1	5	5
	MN Seniors	34	34	34
	MN Persons with Disabilities	7	7	7
	MI Children	4	4	4
	185% Poverty	2	2	2
	ACA Optional Expansion	273	274	274
	Total	321	326	326
PC 4 Medi-Cal Access Program Mothers 213-322%	MCAP Mothers	3,874	4,491	4,488
	Total	3,874	4,491	4,488
PC 8 Medi-Cal Access Program Infants 266-322%	MCAP Infants	821	816	816
	Total	821	816	816
PC 15 Minimum Wage Increase - Caseload Savings	MN Families	(7,173)	(9,736)	(27,050)
	MI Children	(483)	(433)	(1,201)
	185% Poverty	0	(1,006)	(2,780)
	133% Poverty	0	(1,311)	(5,180)
	100% Poverty	(646)	(1,100)	(3,056)
	OTLICP	0	(2,615)	(7,308)
	ACA Optional Expansion	(17,187)	(28,800)	(65,925)
	Total	(25,489)	(45,000)	(112,500)
PC 204 Undocumented Young Adults Full Scope Expansion	MN Families			22,839
	185% Poverty			1,123
	ACA Optional Expansion			13,479
	Total			37,441
Total by Aid Category	<u>Budget Aid Category</u>	<u>2017-18</u>	<u>2018-19</u>	<u>2019-20</u>
	PA Seniors	0	0	0
	PA Persons with Disabilities	0	0	0
	PA Families	0	0	0
	LT Seniors	1	5	5
	LT Persons with Disabilities	0	0	0
	MN Seniors	34	34	34
	MN Persons with Disabilities	7	7	7
	MN Families	(7,173)	(9,736)	(4,211)
	MI Children	(479)	(428)	(1,197)
	MI Adults	0	0	0
	Undocumented Persons	0	0	0
	185% Poverty	2	(1,004)	(1,655)
	133% Poverty	0	(1,311)	(5,180)
	100% Poverty	(646)	(1,100)	(3,056)
	OTLICP	0	(2,615)	(7,308)
	ACA Optional Expansion	(16,914)	(28,526)	(52,172)
	MCAP Infants	821	816	816
	MCAP Mothers	3,874	4,491	4,488
	Total	(20,473)	(39,367)	(69,429)

Comparison of Average Monthly Certified Eligibles
November 2018 Estimate
Fiscal Year 2018-19

(With Estimated Impact of Eligibility Policy Changes)

	Appropriation 2018-2019	November 2018 2018-2019	Change	% Change
Public Assistance	2,628,100	2,537,600	(90,500)	-3.44%
Seniors	442,900	435,900	(7,000)	-1.58%
Persons with Disabilities	982,500	972,400	(10,100)	-1.03%
Families	1,202,700	1,129,300	(73,400)	-6.10%
Long Term	53,300	52,800	(500)	-0.94%
Seniors	42,100	42,100	0	0.00%
Persons with Disabilities	11,200	10,700	(500)	-4.46%
Medically Needy	4,135,800	4,126,200	(9,600)	-0.23%
Seniors	495,000	497,400	2,400	0.48%
Persons with Disabilities	166,200	165,200	(1,000)	-0.60%
Families	3,474,600	3,463,600	(11,000)	-0.32%
Medically Indigent	176,400	163,900	(12,500)	-7.09%
Children	161,100	154,000	(7,100)	-4.41%
Adults	15,300	9,900	(5,400)	-35.29%
Other	6,334,600	6,287,800	(46,800)	-0.74%
Refugees	1,200	600	(600)	-50.00%
OBRA	400	500	100	25.00%
185% Poverty	350,800	359,300	8,500	2.42%
133% Poverty	770,500	763,700	(6,800)	-0.88%
100% Poverty	386,100	390,900	4,800	1.24%
Opt. Targeted Low Income Children	926,100	924,900	(1,200)	-0.13%
ACA Optional Expansion	3,850,100	3,796,900	(53,200)	-1.38%
Hospital PE	30,900	31,900	1,000	3.24%
Medi-Cal Access Program	4,700	5,300	600	12.77%
QMB	13,800	13,800	0	0.00%
GRAND TOTAL	13,328,200	13,168,300	(159,900)	-1.20%
Seniors and Persons with Disabilities	2,139,900	2,123,700	(16,200)	-0.76%
Families and Children	7,271,900	7,185,700	(86,200)	-1.19%

**Estimated Average Monthly Certified Eligibles
November 2018 Estimate
Fiscal Years 2017-2018, 2018-2019 & 2019-2020**

Managed Care¹					
<i>(With Estimated Impact of Eligibility Policy Changes)**</i>					
	2017-2018	2018-2019	2019-2020	17-18 To 18-19 % Change	18-19 To 19-20 % Change
Public Assistance	2,259,260	2,197,720	2,200,950	-2.72%	0.15%
Seniors	332,230	334,000	336,510	0.53%	0.75%
Persons with Disabilities	839,460	836,420	837,060	-0.36%	0.08%
Families	1,087,570	1,027,300	1,027,380	-5.54%	0.01%
Long Term	29,480	29,340	29,330	-0.47%	-0.03%
Seniors	23,550	23,670	23,660	0.51%	-0.04%
Persons with Disabilities	5,930	5,670	5,670	-4.38%	0.00%
Medically Needy	3,203,310	3,191,420	3,188,750	-0.37%	-0.08%
Seniors	341,220	355,020	365,870	4.04%	3.06%
Persons with Disabilities	113,210	115,110	115,140	1.68%	0.03%
Families	2,748,880	2,721,290	2,707,740	-1.00%	-0.50%
Medically Indigent	44,010	43,230	43,170	-1.77%	-0.14%
Children	43,710	43,170	43,110	-1.24%	-0.14%
Adults	300	60	60	-80.00%	0.00%
Other	5,325,520	5,325,980	5,357,480	0.01%	0.59%
Refugees	640	350	370	-45.31%	5.71%
OBRA	10	10	10	0.00%	0.00%
185% Poverty	202,030	202,140	201,170	0.05%	-0.48%
133% Poverty	726,350	725,040	721,670	-0.18%	-0.46%
100% Poverty	371,810	377,370	375,550	1.50%	-0.48%
Opt. Targeted Low Income Children	871,340	872,220	867,960	0.10%	-0.49%
ACA Optional Expansion	3,148,850	3,143,750	3,185,650	-0.16%	1.33%
Medi-Cal Access Program	4,490	5,100	5,100	13.59%	0.00%
GRAND TOTAL ¹	10,861,580	10,787,690	10,819,680	-0.68%	0.30%
Percent of Statewide	81.50%	81.92%	81.84%		
Seniors and Persons with Disabilities Families and Children	1,655,600	1,669,890	1,683,910	0.86%	0.84%
	6,051,690	5,968,530	5,944,580	-1.37%	-0.40%

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

¹ Eligibles enrolled or estimated to be enrolled in a medical Managed Care plan.

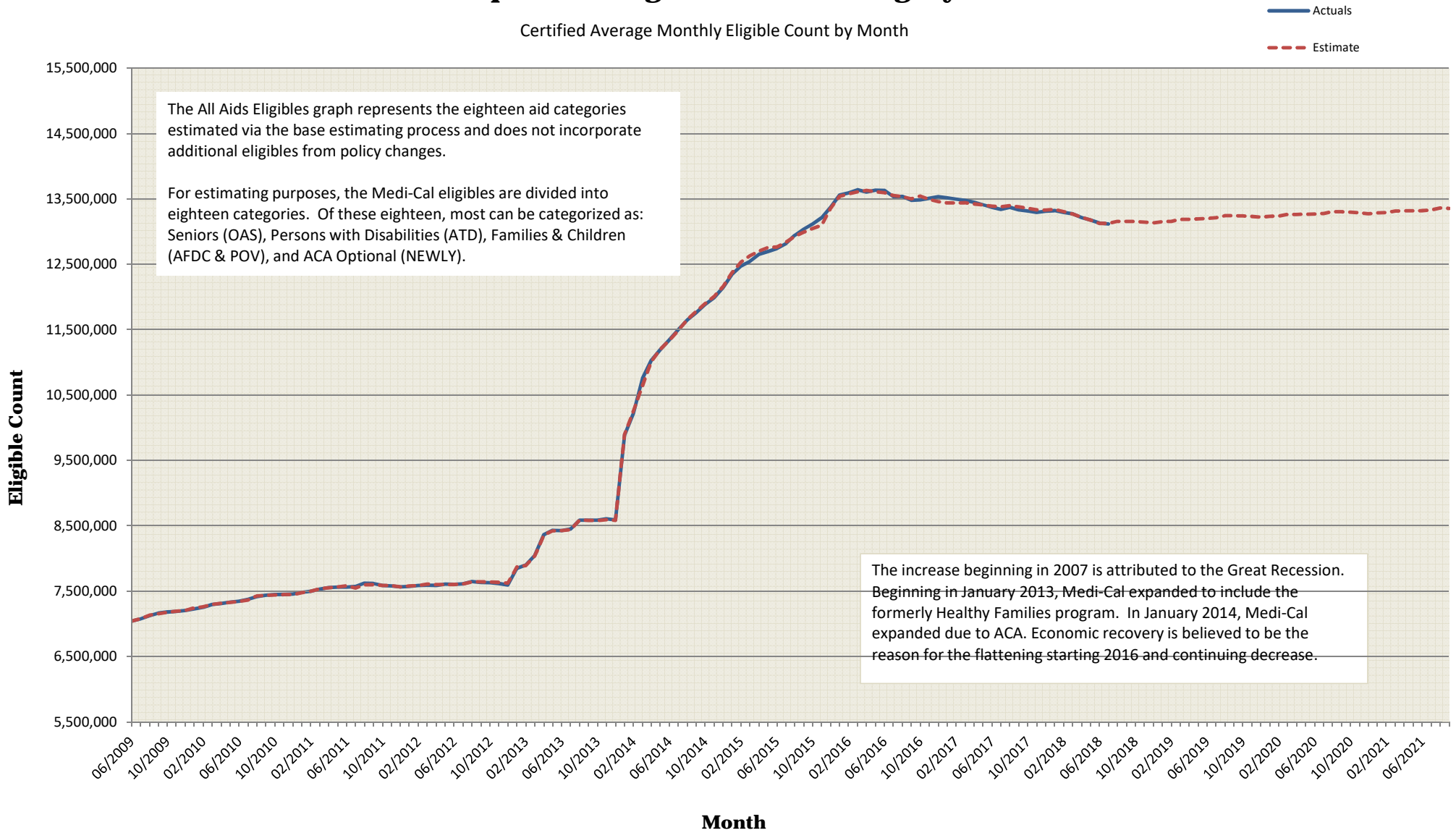
**Estimated Average Monthly Certified Eligibles
November 2018 Estimate
Fiscal Years 2017-2018, 2018-2019 & 2019-2020**

Fee-For-Service					
(With Estimated Impact of Eligibility Policy Changes)***					
	2017-2018	2018-2019	2019-2020	17-18 To 18-19 % Change	18-19 To 19-20 % Change
Public Assistance	354,740	339,880	336,850	-4.19%	-0.89%
Seniors	103,470	101,900	99,390	-1.52%	-2.46%
Persons with Disabilities	141,340	135,980	135,340	-3.79%	-0.47%
Families	109,930	102,000	102,120	-7.21%	0.12%
Long Term	23,820	23,460	23,470	-1.51%	0.04%
Seniors	18,650	18,430	18,440	-1.18%	0.05%
Persons with Disabilities	5,170	5,030	5,030	-2.71%	0.00%
Medically Needy	958,790	934,780	961,550	-2.50%	2.86%
Seniors	136,680	142,380	149,830	4.17%	5.23%
Persons with Disabilities	50,290	50,090	50,060	-0.40%	-0.06%
Families	771,820	742,310	761,660	-3.82%	2.61%
Medically Indigent	132,090	120,670	120,030	-8.65%	-0.53%
Children	121,490	110,830	110,190	-8.77%	-0.58%
Adults	10,600	9,840	9,840	-7.17%	0.00%
Other	995,580	961,820	958,520	-3.39%	-0.34%
Refugees	260	250	330	-3.85%	32.00%
OBRA	690	490	490	-28.99%	0.00%
185% Poverty	158,570	157,160	157,430	-0.89%	0.17%
133% Poverty	42,950	38,660	38,230	-9.99%	-1.11%
100% Poverty	15,690	13,530	13,450	-13.77%	-0.59%
Opt. Targeted Low Income Children	55,060	52,680	52,540	-4.32%	-0.27%
ACA Optional Expansion	676,750	653,150	650,150	-3.49%	-0.46%
Hospital PE	31,600	31,900	31,900	0.95%	0.00%
Medi-Cal Access Program	210	200	200	-4.76%	0.00%
QMB	13,800	13,800	13,800	0.00%	0.00%
GRAND TOTAL	2,465,020	2,380,610	2,400,420	-3.42%	0.83%
Percent of Statewide	18.50%	18.08%	18.16%		
Seniors and Persons with Disabilities Families and Children	455,600	453,810	458,090	-0.39%	0.94%
	1,275,510	1,217,170	1,235,620	-4.57%	1.52%

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

Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month



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

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

The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Healthy Families program. In January 2014, Medi-Cal expanded due to ACA. Economic recovery is believed to be the reason for the flattening starting 2016 and continuing decrease.

Statewide Expanded Eligible for Aid Category: Families and Children (including Pregnant Women)

Certified Average Monthly Eligible Count by Month

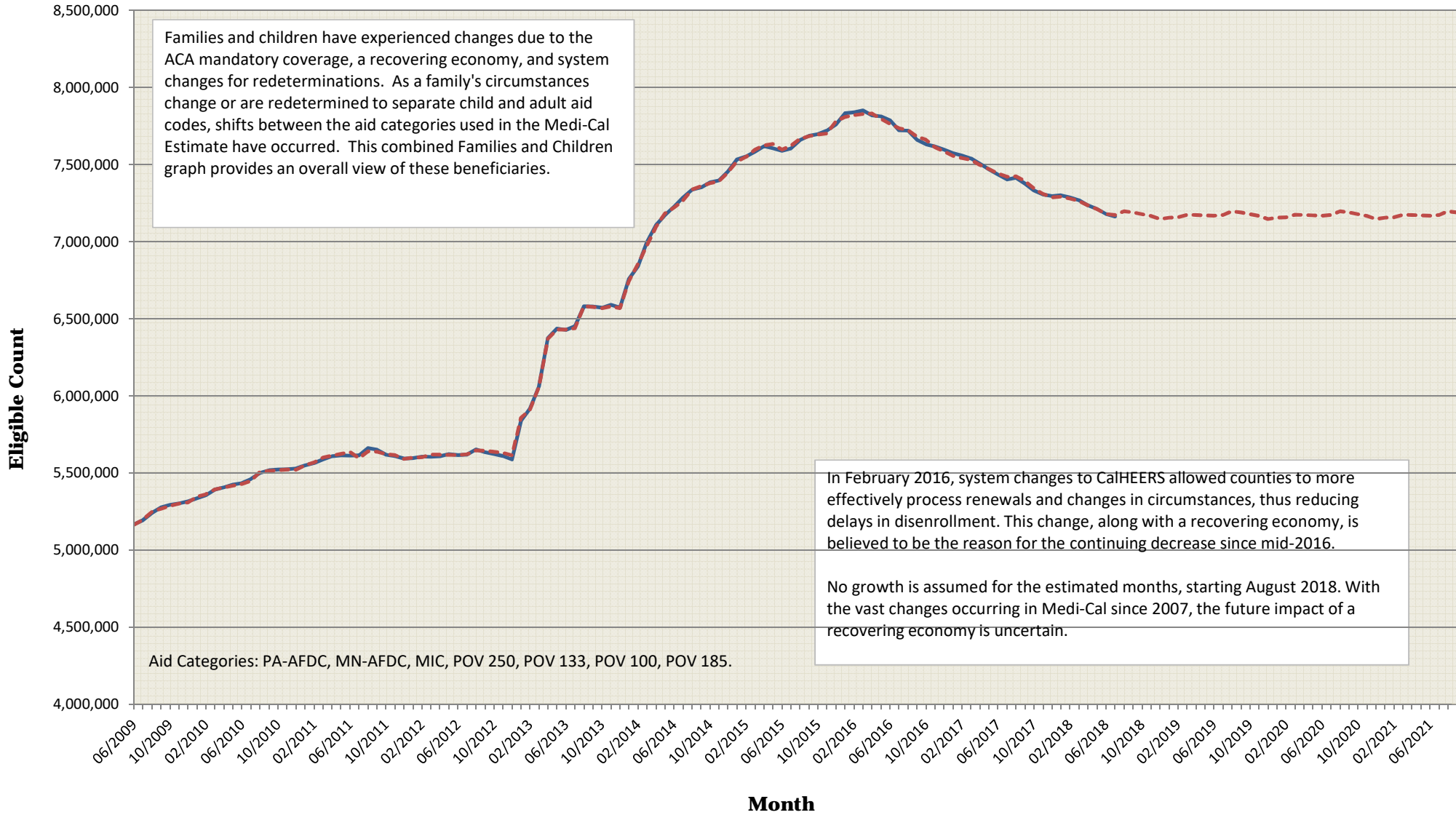
— Actuals
 - - - Estimate

Families and children have experienced changes due to the ACA mandatory coverage, a recovering economy, and system changes for redeterminations. As a family's circumstances change or are redetermined to separate child and adult aid codes, shifts between the aid categories used in the Medi-Cal Estimate have occurred. This combined Families and Children graph provides an overall view of these beneficiaries.

In February 2016, system changes to CalHEERS allowed counties to more effectively process renewals and changes in circumstances, thus reducing delays in disenrollment. This change, along with a recovering economy, is believed to be the reason for the continuing decrease since mid-2016.

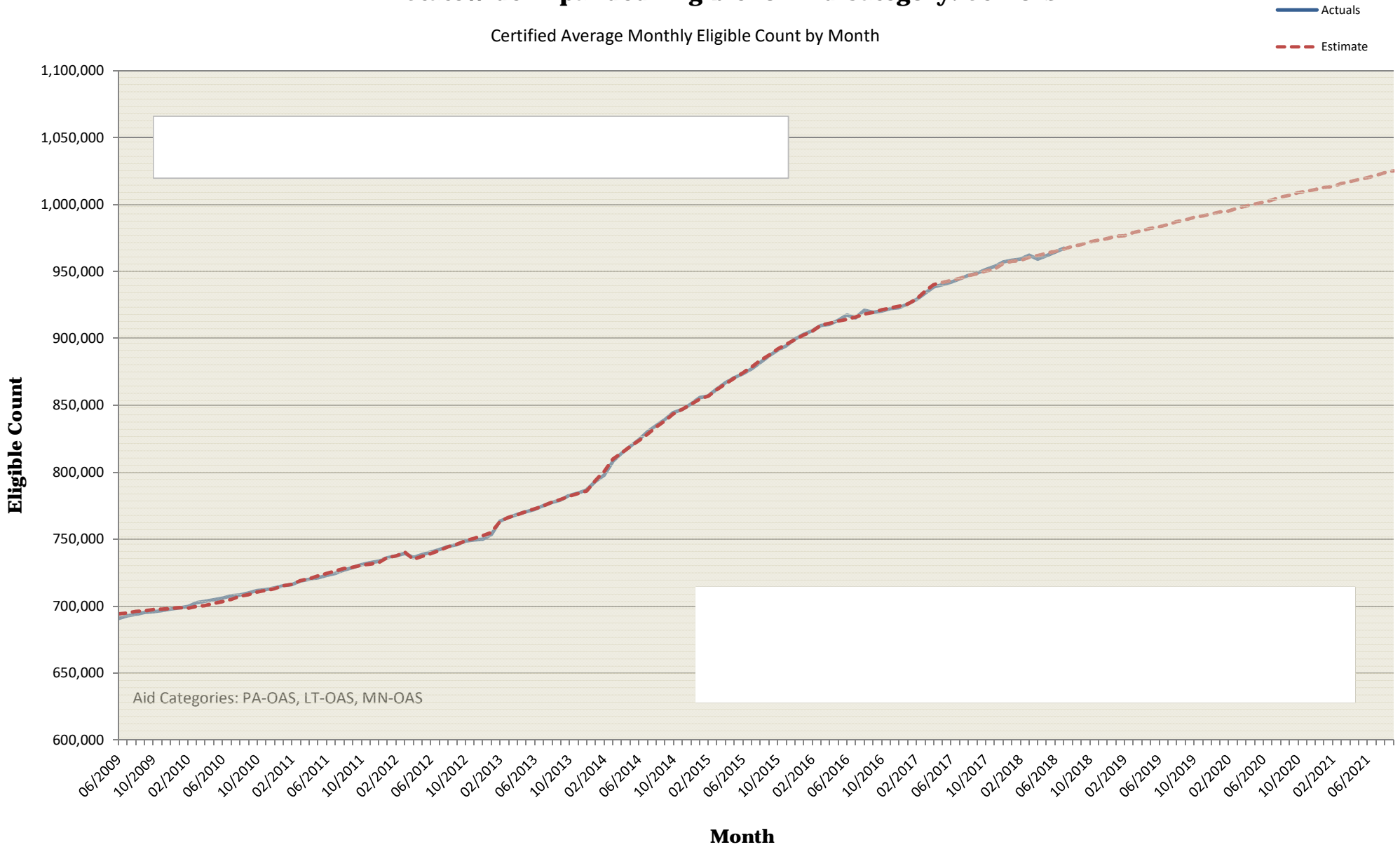
No growth is assumed for the estimated months, starting August 2018. With the vast changes occurring in Medi-Cal since 2007, the future impact of a recovering economy is uncertain.

Aid Categories: PA-AFDC, MN-AFDC, MIC, POV 250, POV 133, POV 100, POV 185.



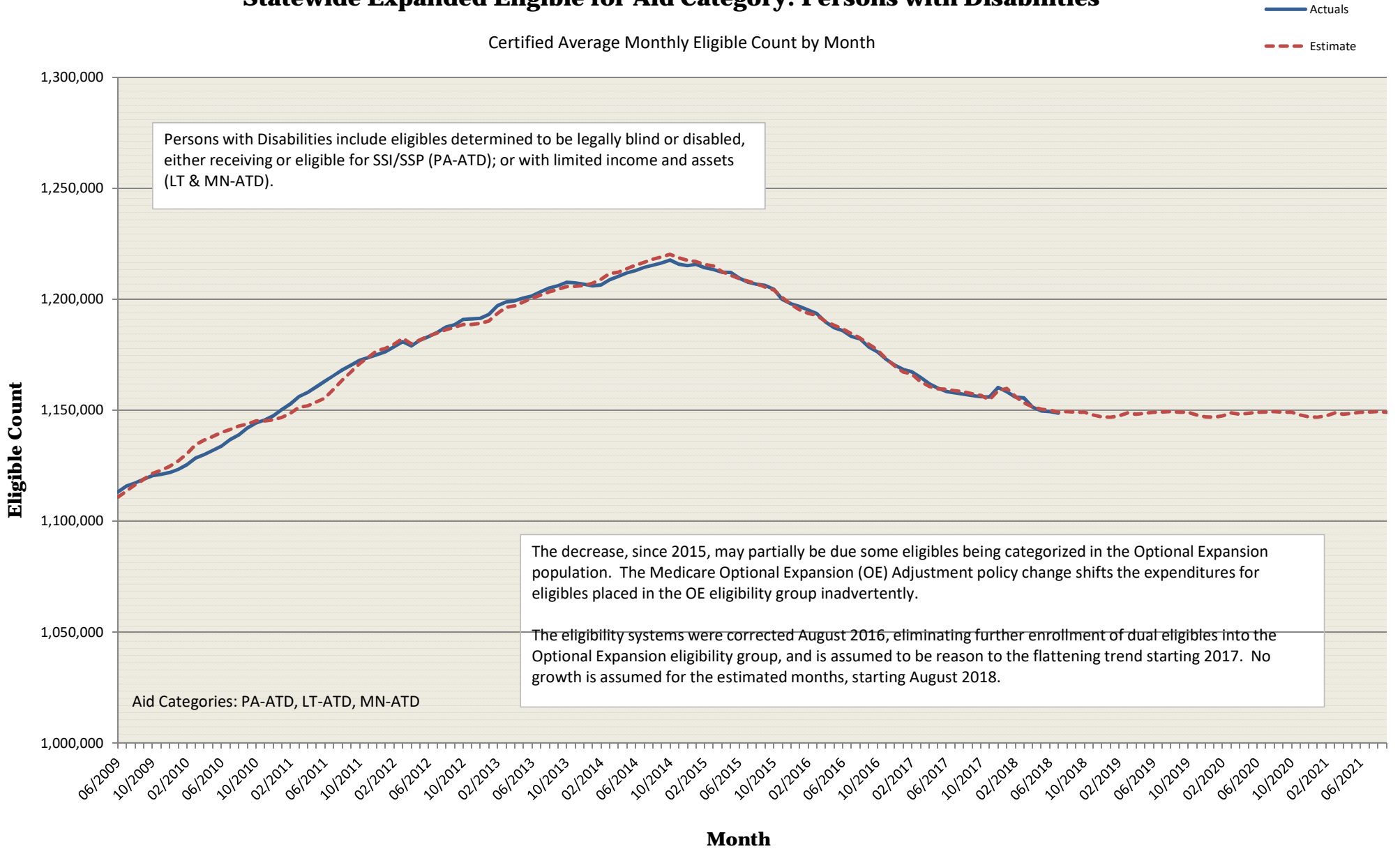
Statewide Expanded Eligible for Aid Category: Seniors

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible for Aid Category: Persons with Disabilities

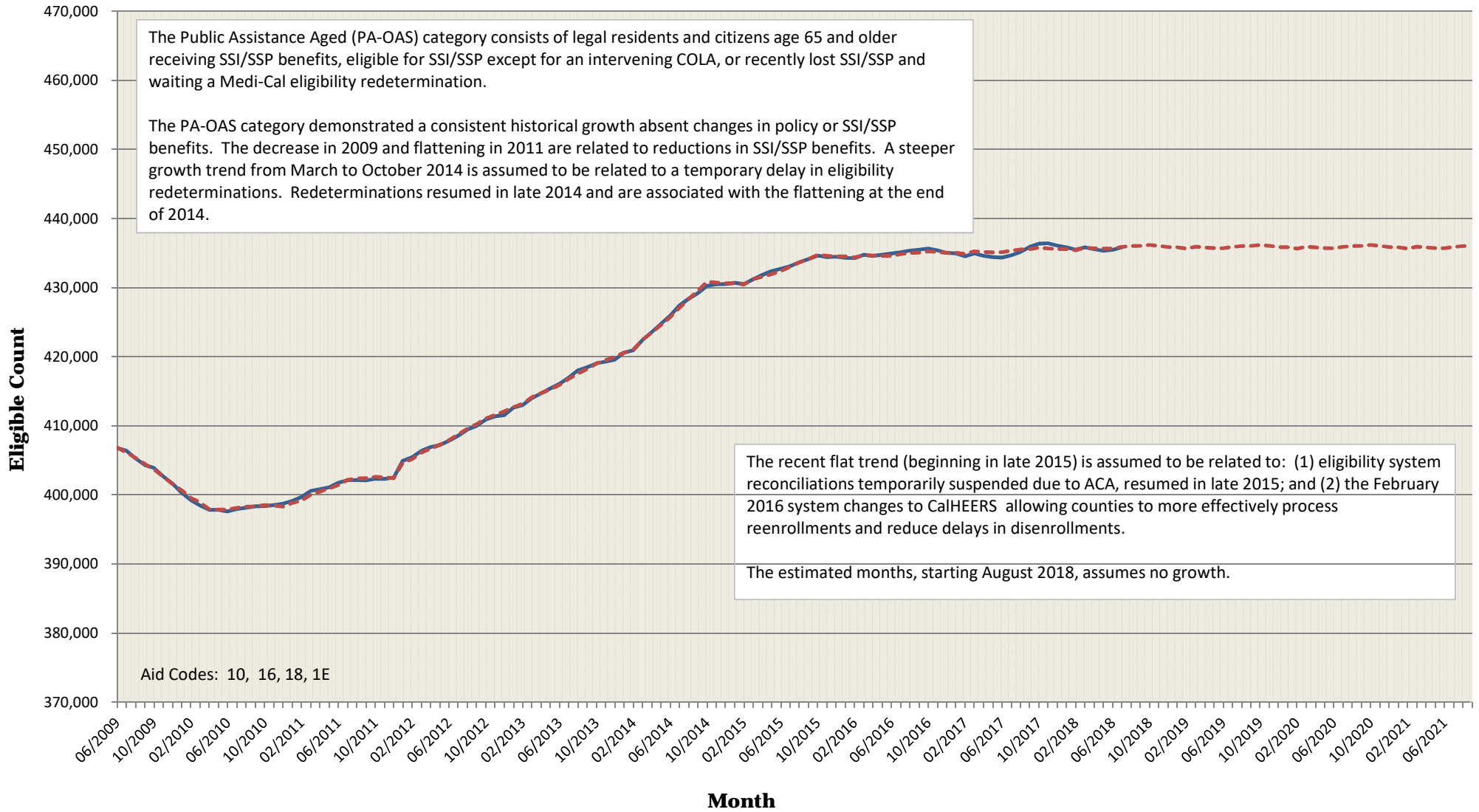
Certified Average Monthly Eligible Count by Month



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

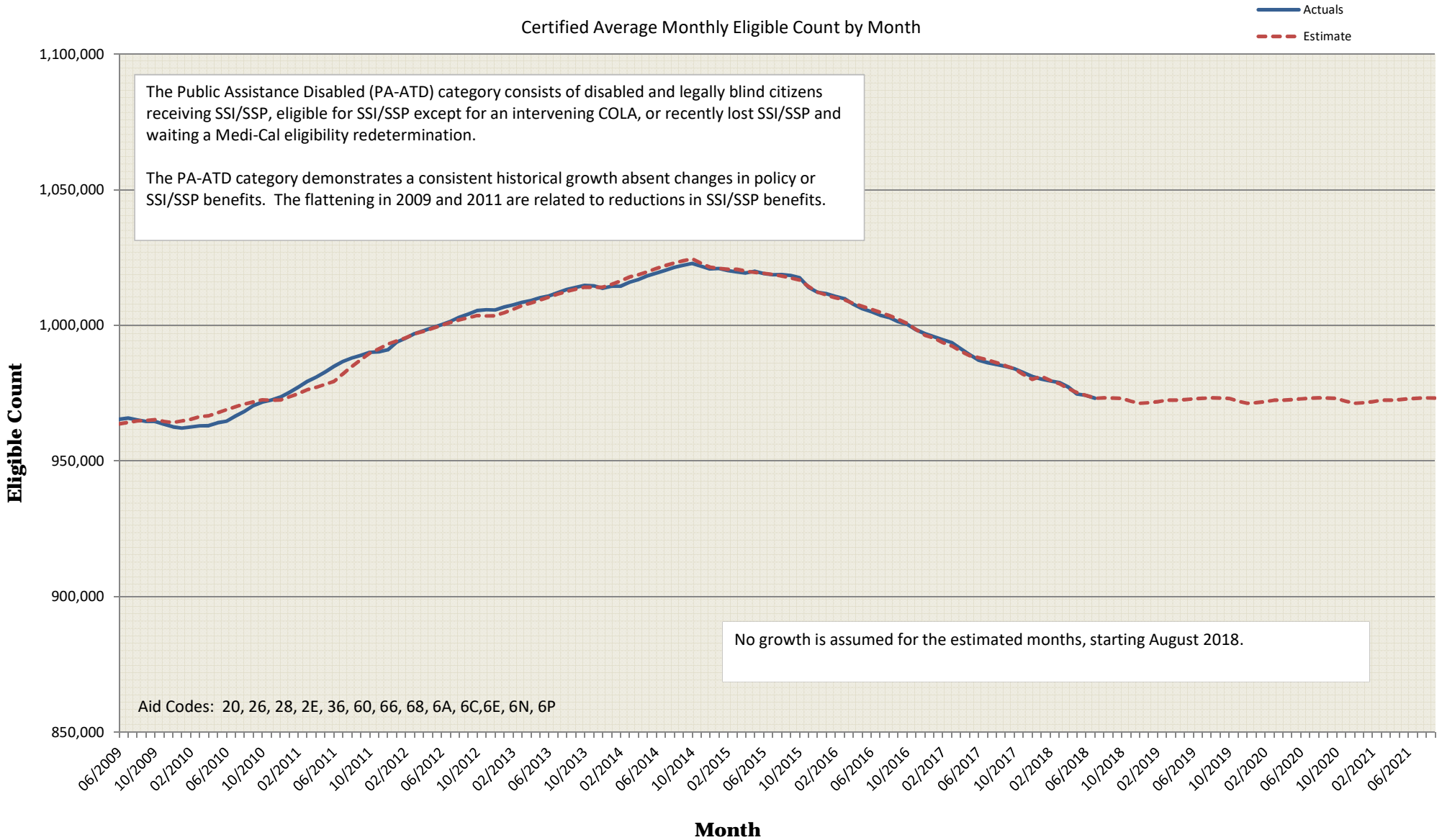
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate



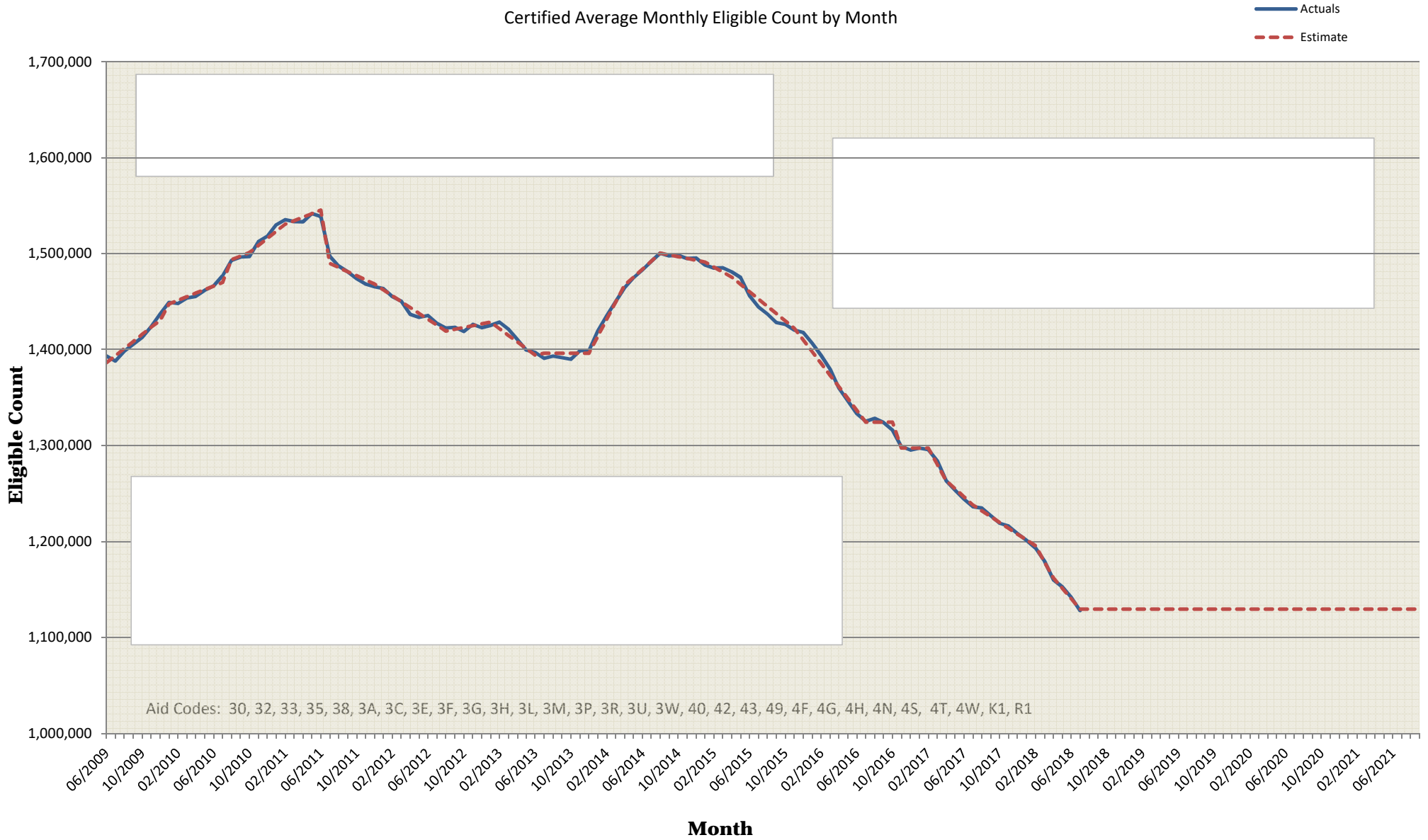
Statewide Expanded Eligible: Public Assistance Persons with Disabilities (PA-ATD)

Certified Average Monthly Eligible Count by Month



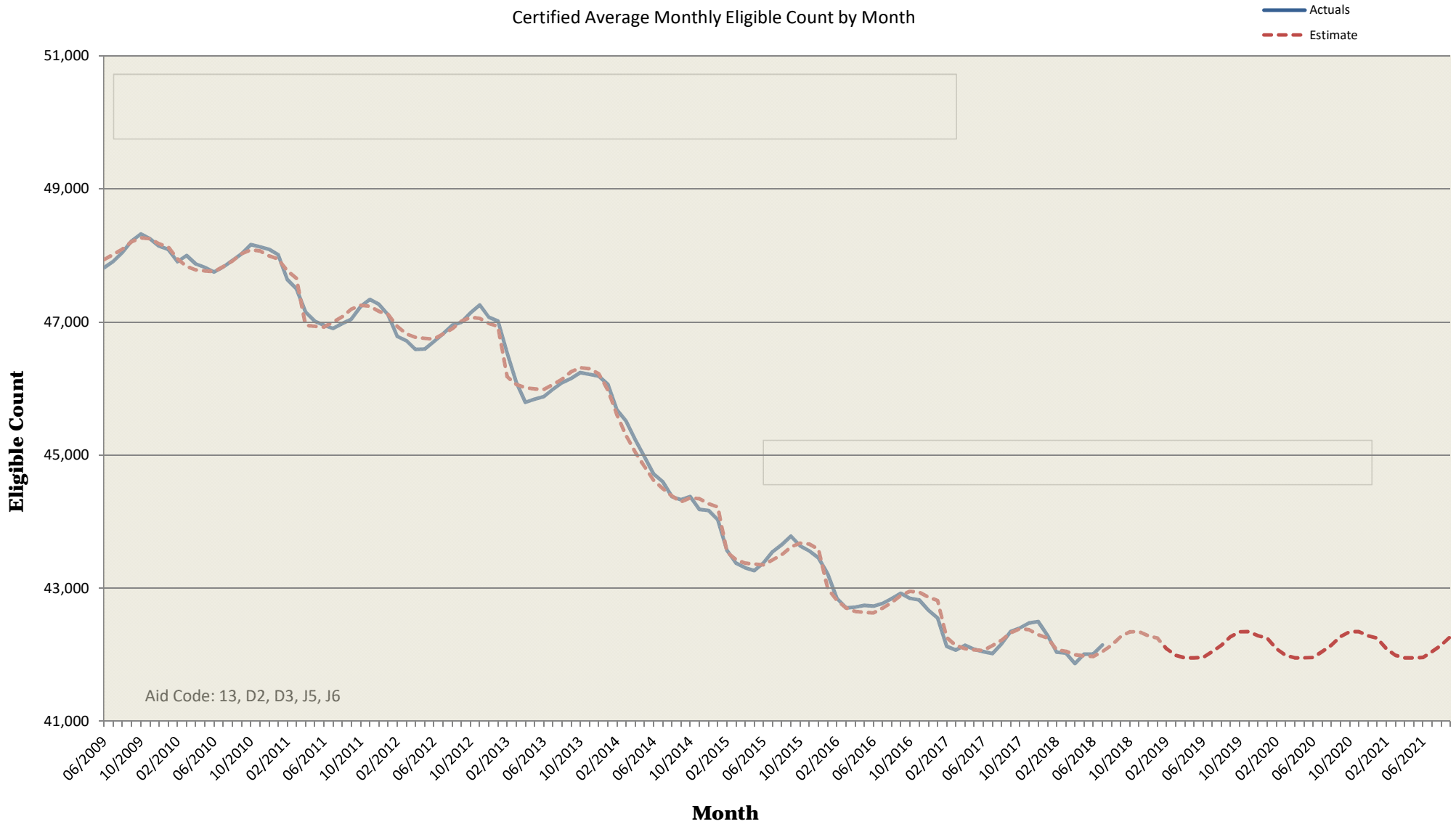
Statewide Expanded Eligible: Public Assistance Families (PA-AFDC)

Certified Average Monthly Eligible Count by Month



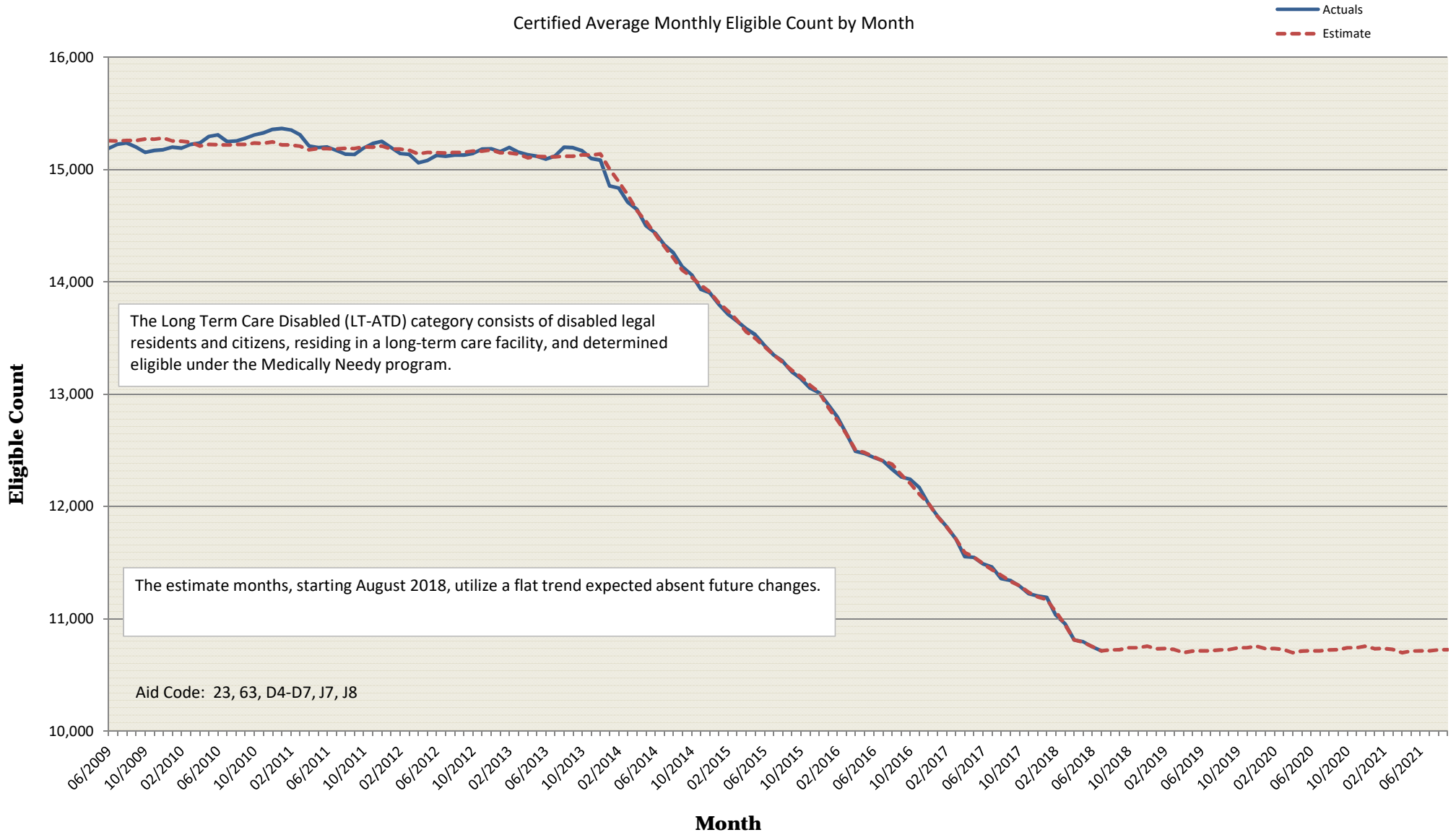
Statewide Expanded Eligible: Long Term Seniors (LT-OAS)

Certified Average Monthly Eligible Count by Month



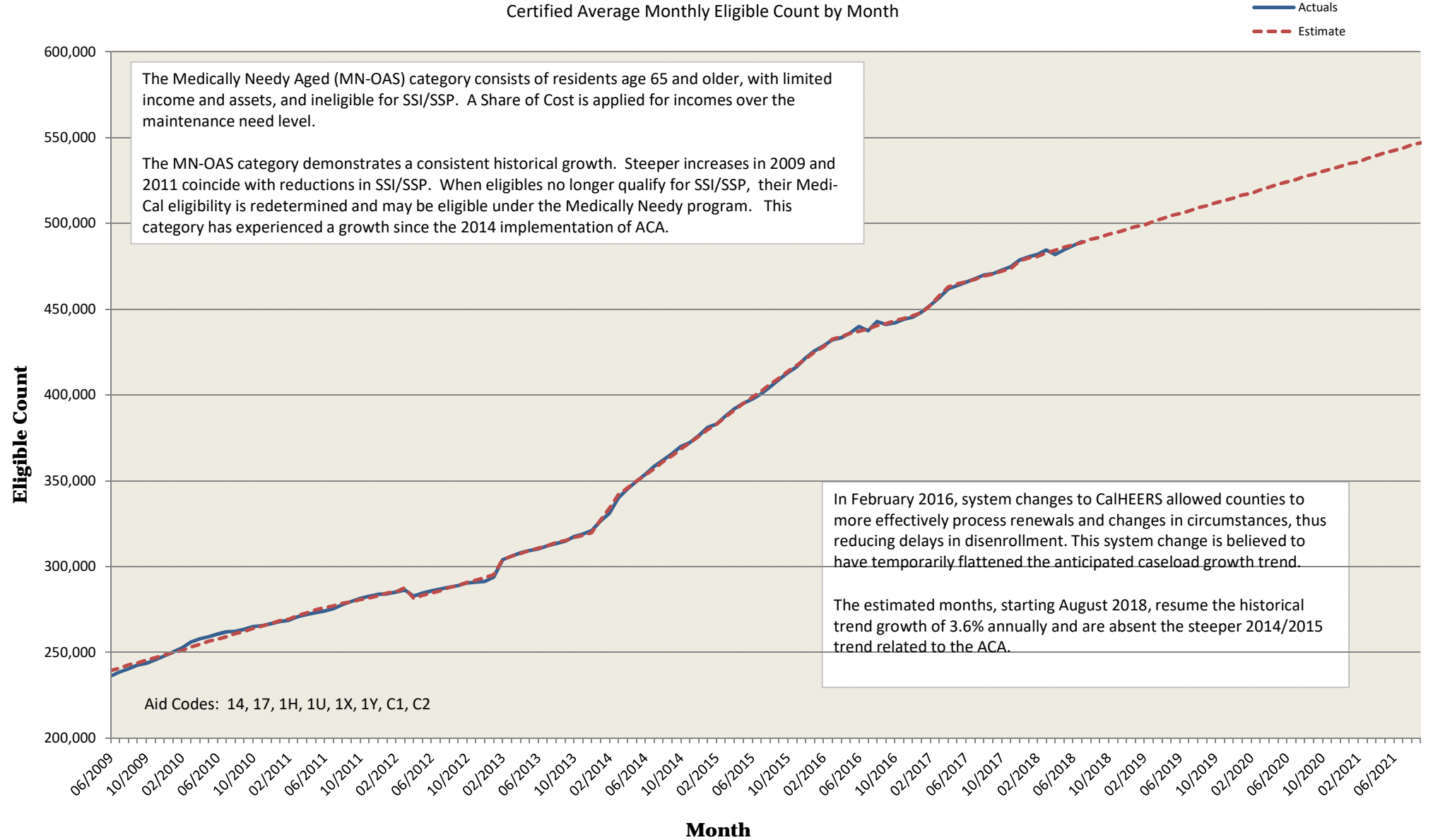
Statewide Expanded Eligible: Long Term Persons with Disabilities (LT-ATD)

Certified Average Monthly Eligible Count by Month



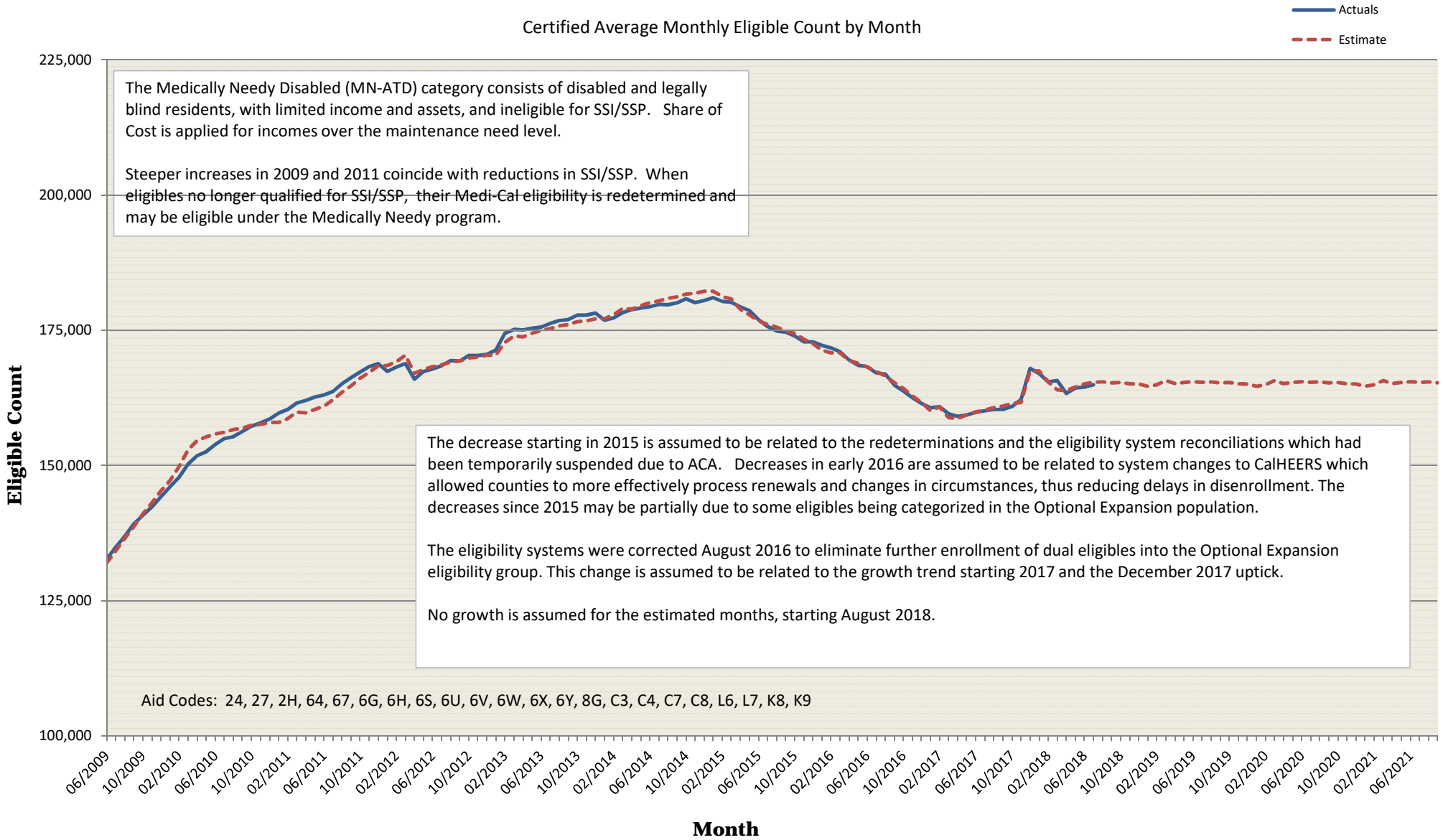
Statewide Expanded Eligible: Medically Needy Seniors (MN-OAS)

Certified Average Monthly Eligible Count by Month



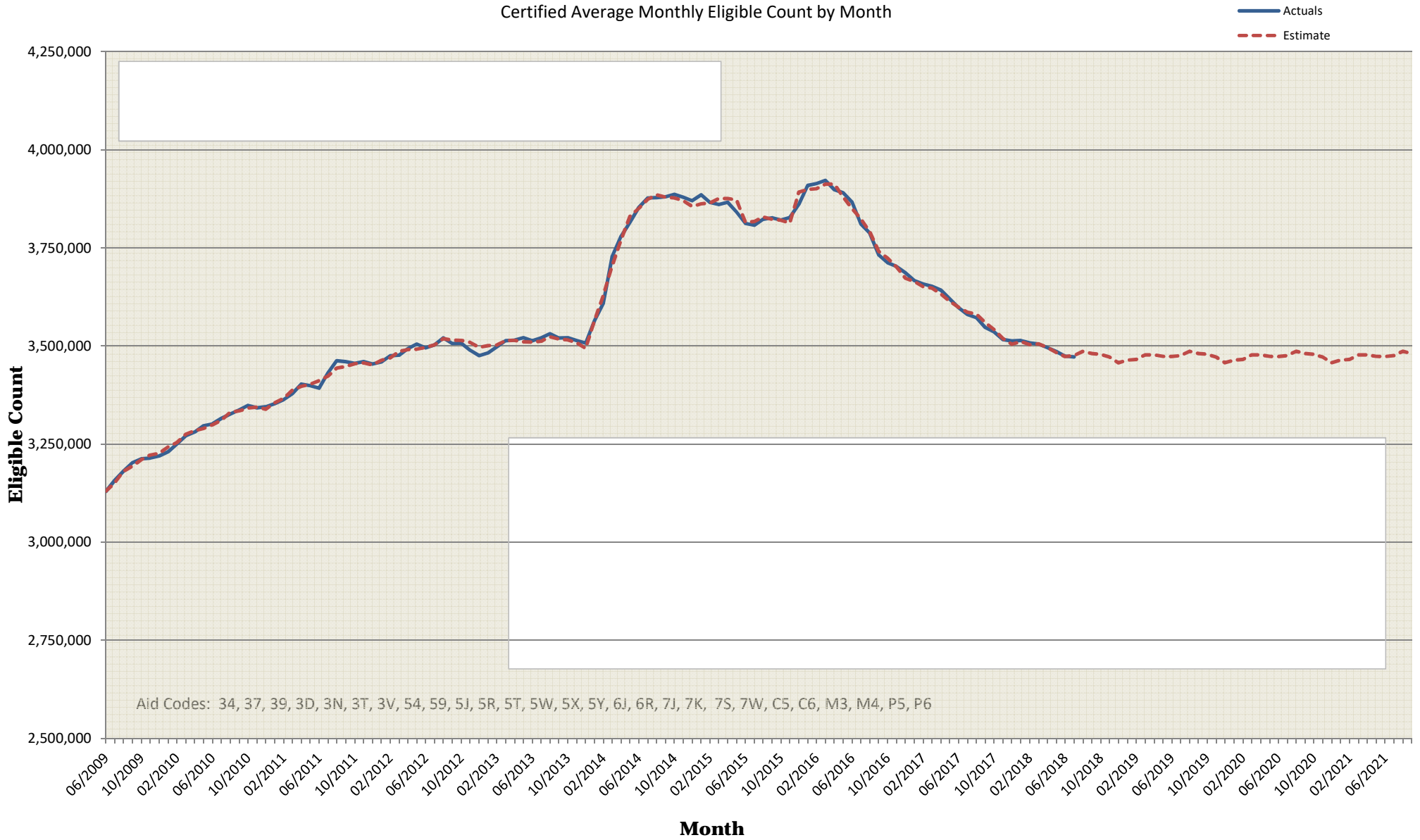
Statewide Expanded Eligible: Medically Needy Persons with Disabilities (MN-ATD)

Certified Average Monthly Eligible Count by Month



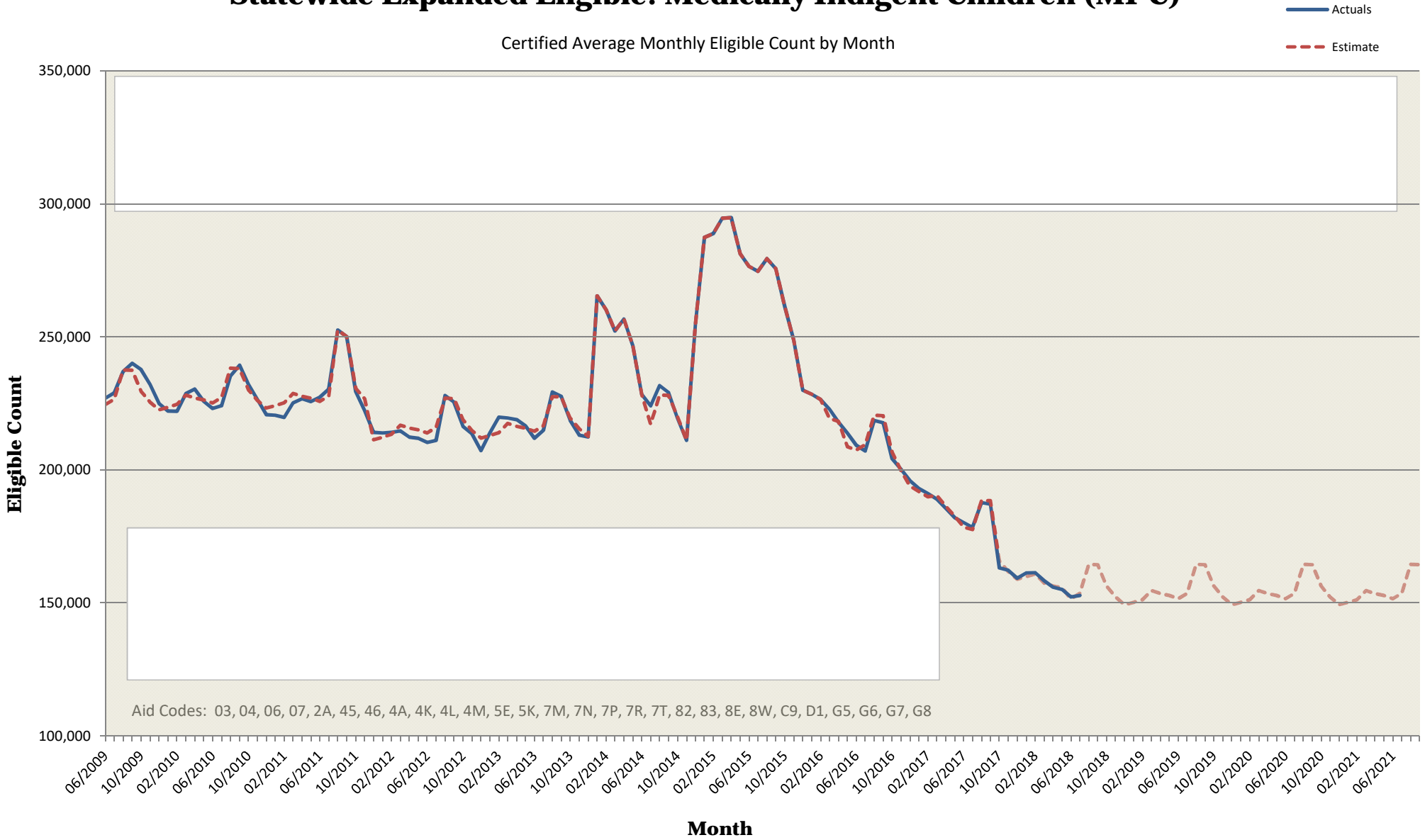
Statewide Expanded Eligible: Medically Needy Families (MN-AFDC)

Certified Average Monthly Eligible Count by Month



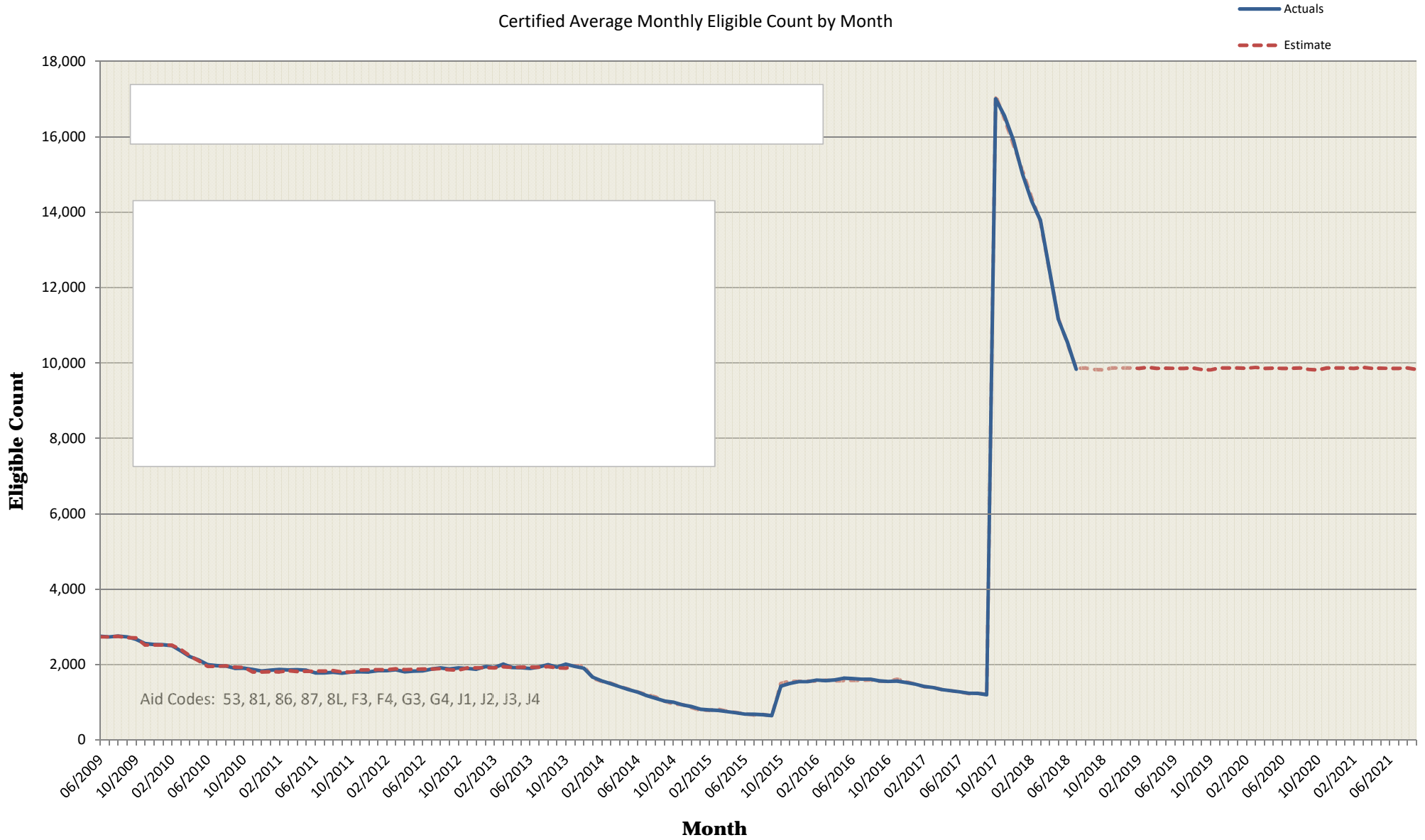
Statewide Expanded Eligible: Medically Indigent Children (MI-C)

Certified Average Monthly Eligible Count by Month



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

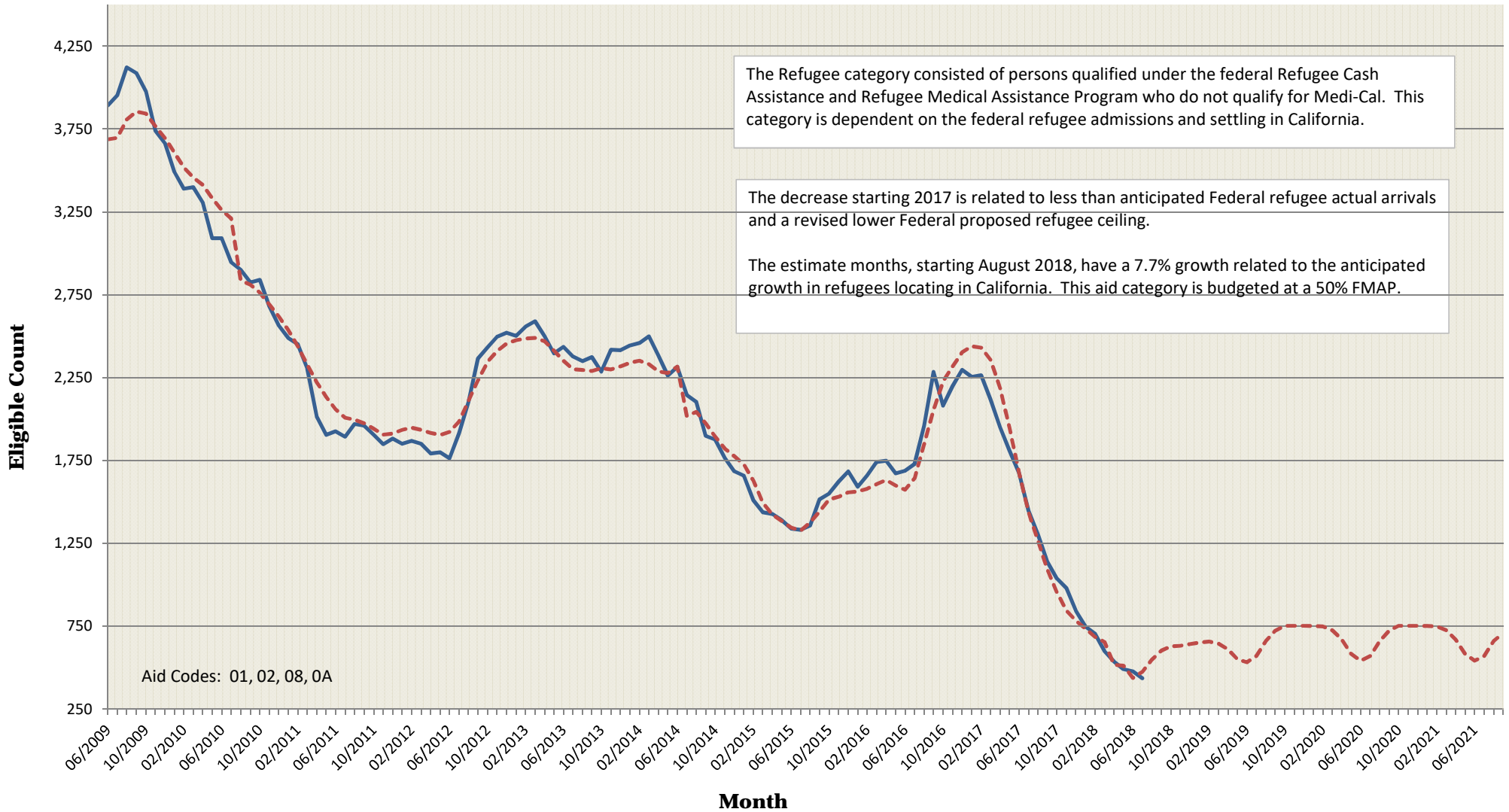
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Refugee

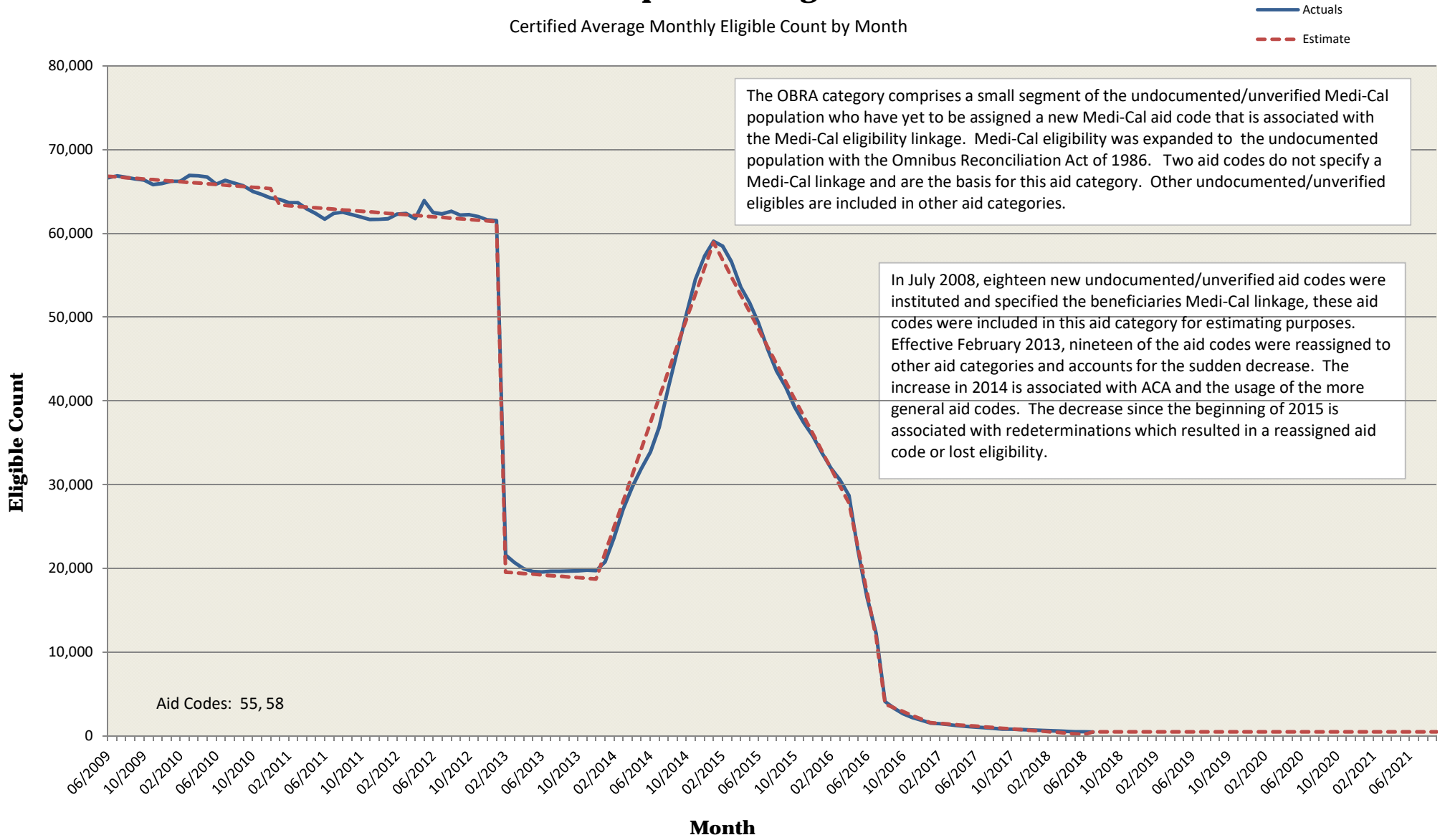
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate



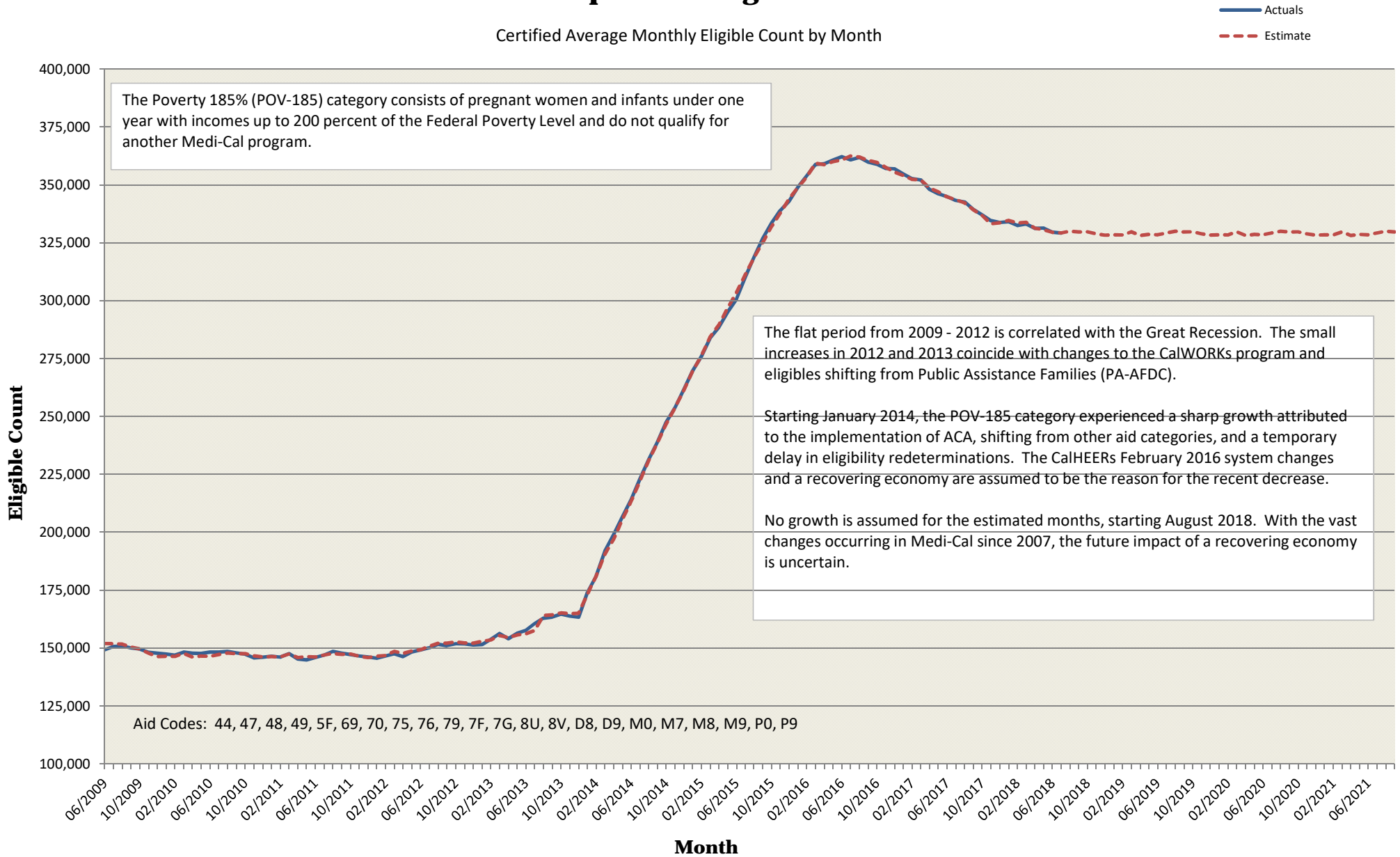
Statewide Expanded Eligible: OBRA

Certified Average Monthly Eligible Count by Month



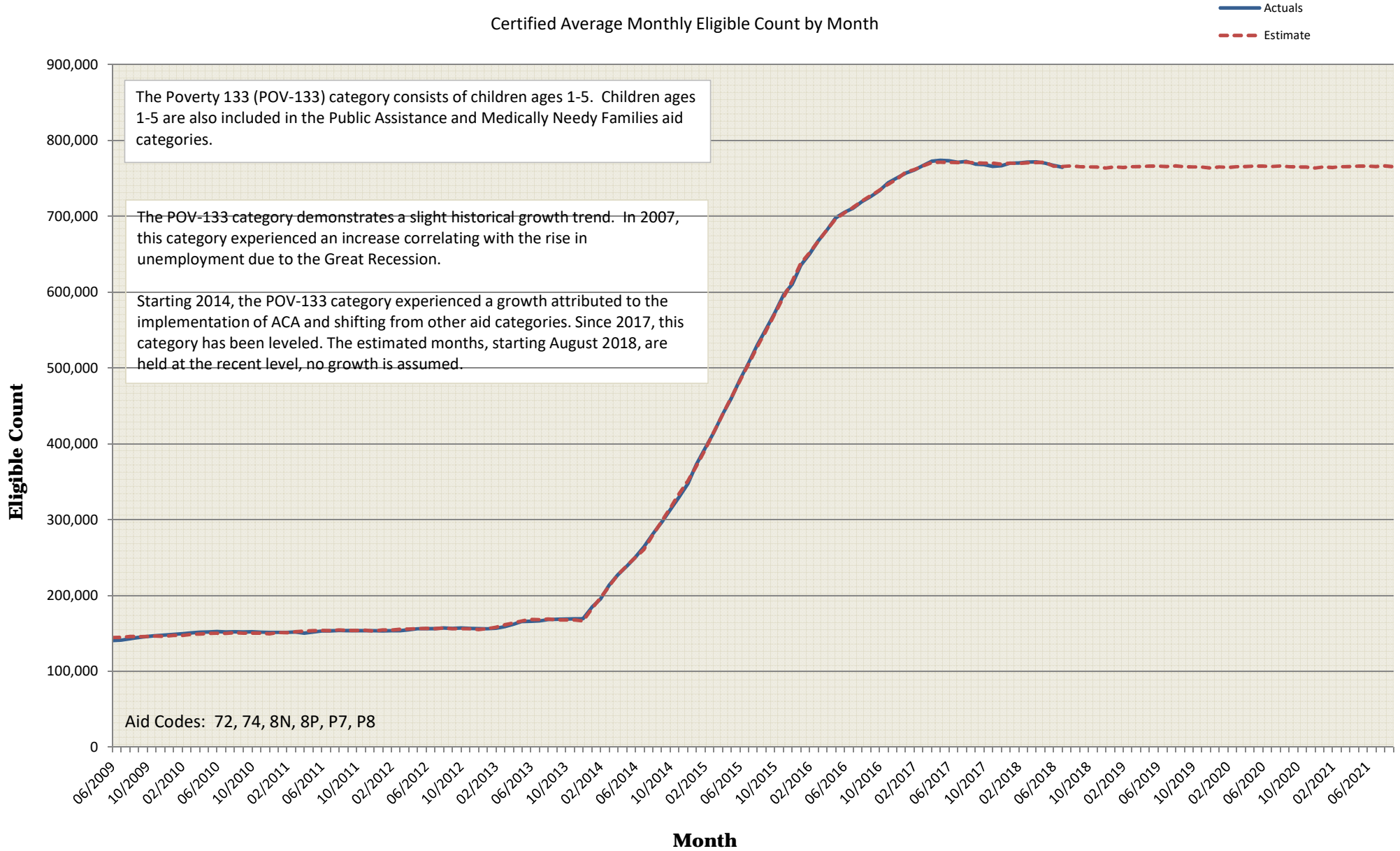
Statewide Expanded Eligible: POV-185

Certified Average Monthly Eligible Count by Month



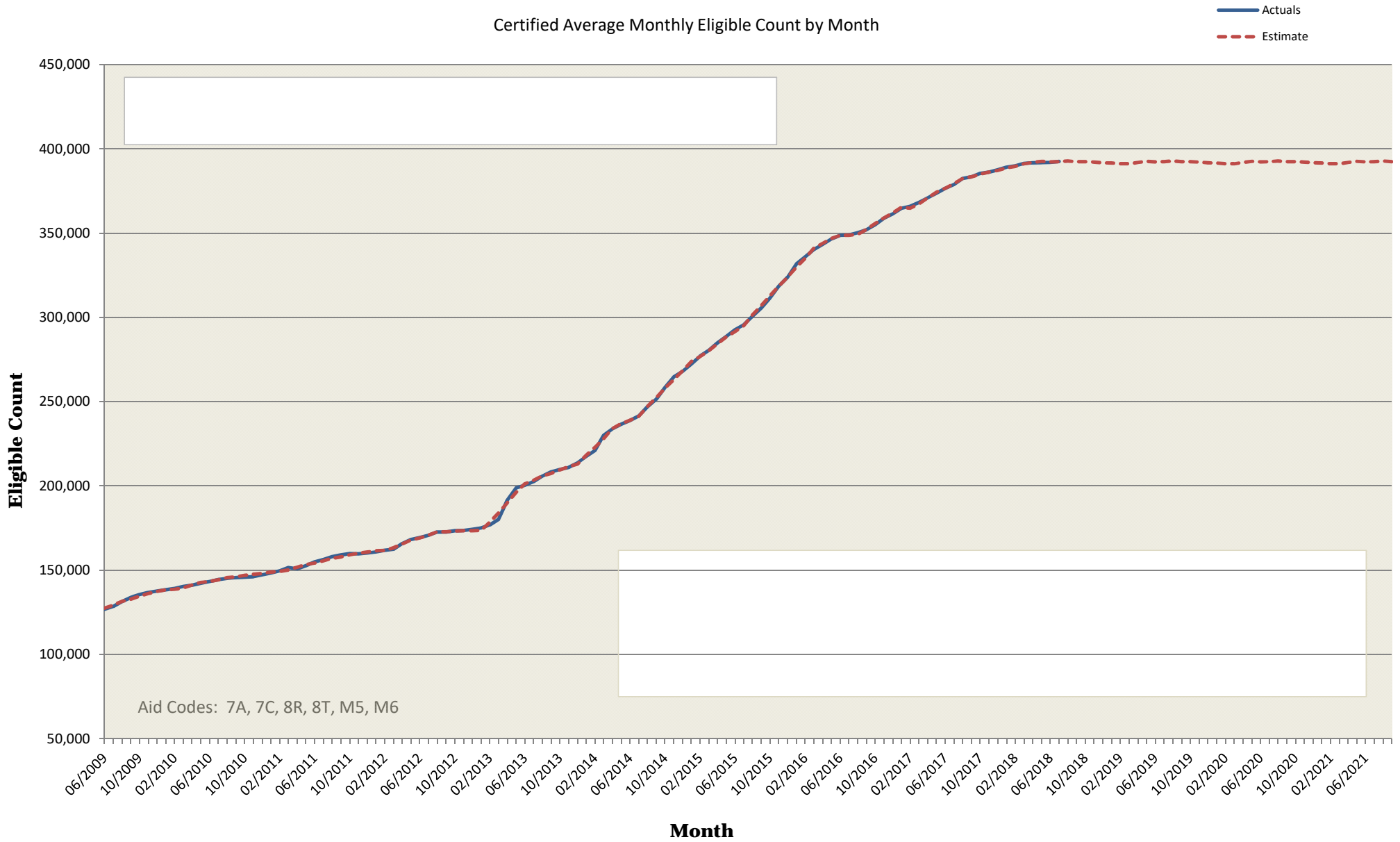
Statewide Expanded Eligible: POV-133

Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: POV-100

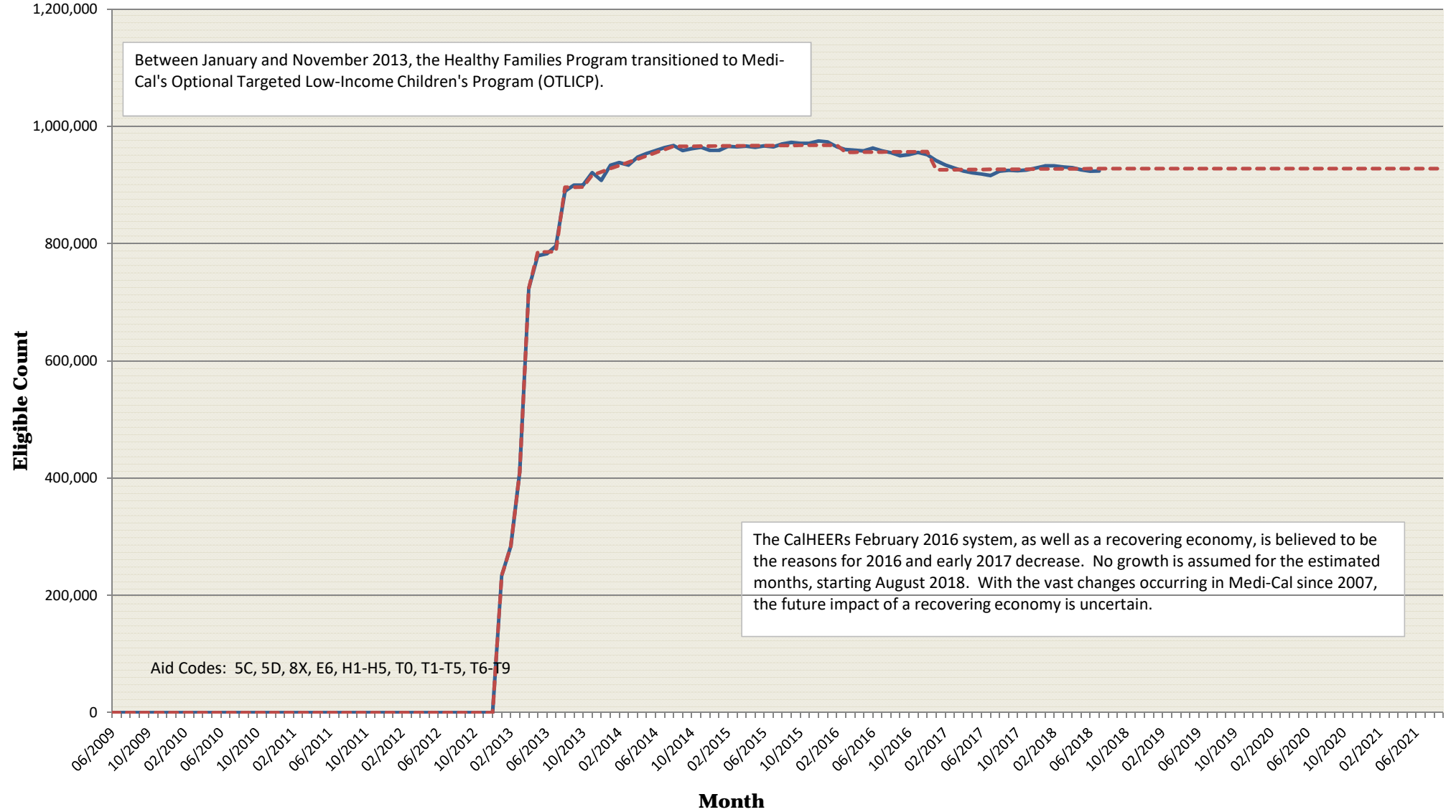
Certified Average Monthly Eligible Count by Month



Statewide Expanded Eligible: Optional Targeted Low-Income Children's Program (POV-250)

Certified Average Monthly Eligible Count by Month

— Actuals
- - - Estimate



Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

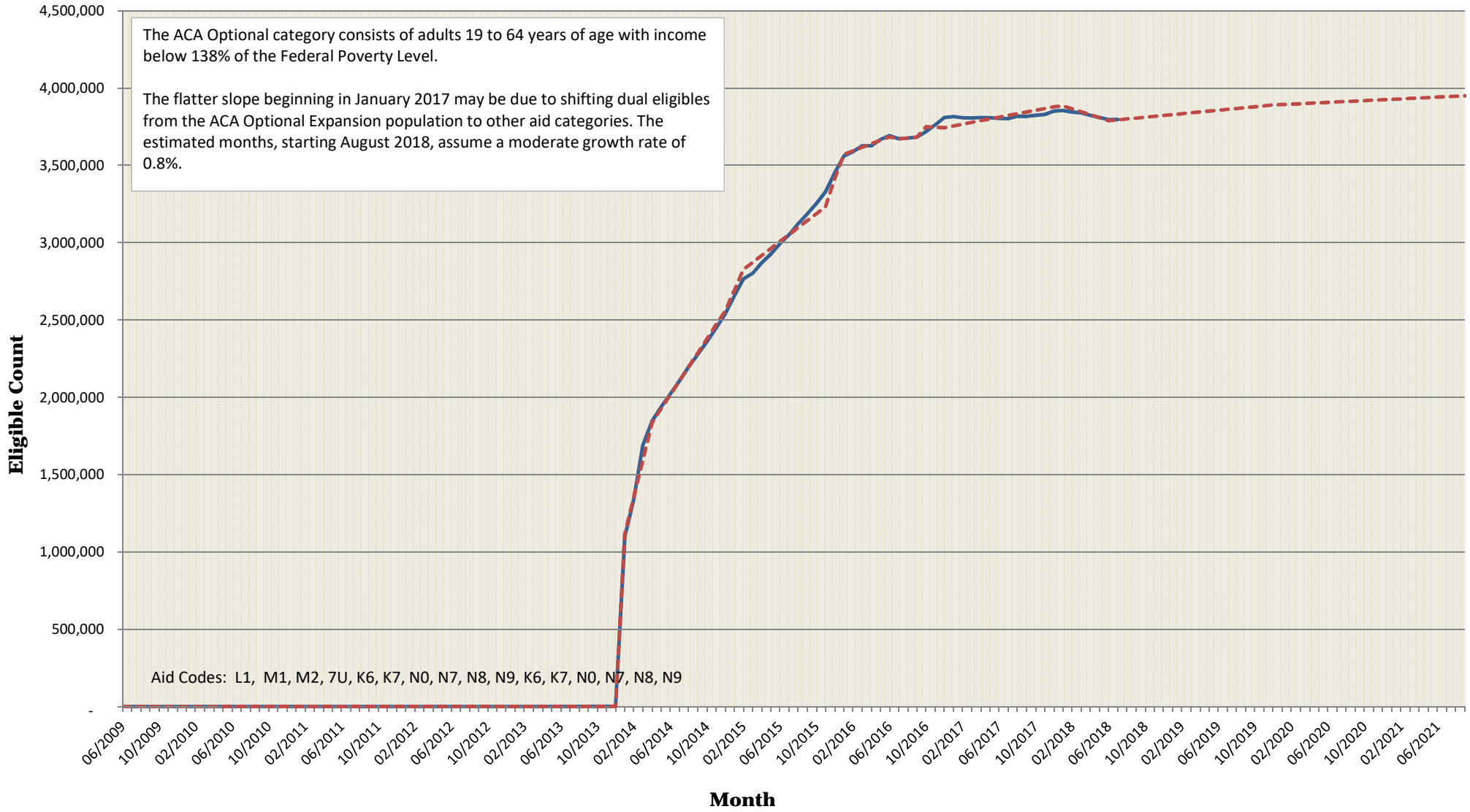
Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate

The ACA Optional category consists of adults 19 to 64 years of age with income below 138% of the Federal Poverty Level.

The flatter slope beginning in January 2017 may be due to shifting dual eligibles from the ACA Optional Expansion population to other aid categories. The estimated months, starting August 2018, assume a moderate growth rate of 0.8%.

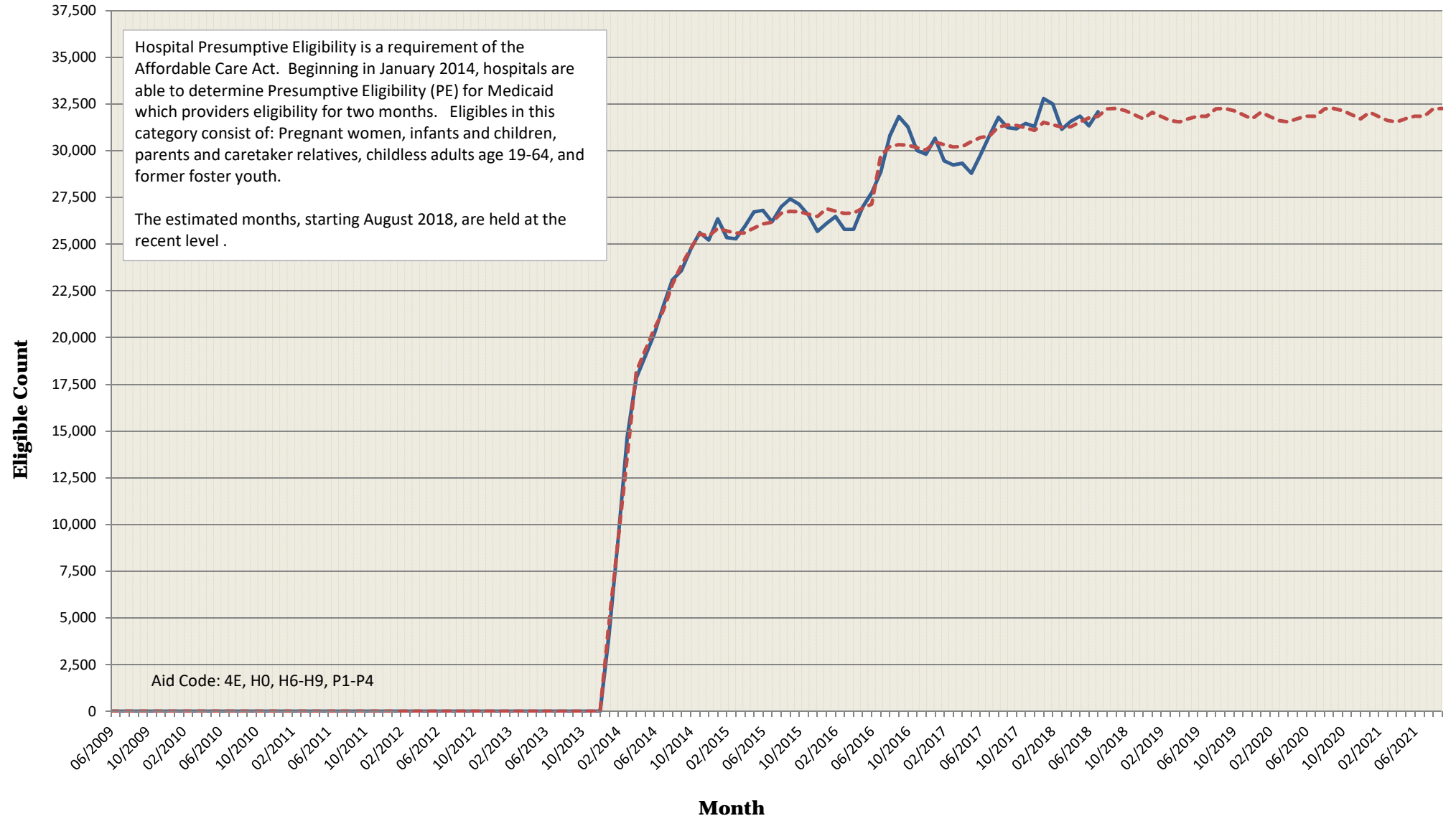
Aid Codes: L1, M1, M2, 7U, K6, K7, N0, N7, N8, N9, K6, K7, N0, N7, N8, N9



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

Certified Average Monthly Eligible Count by Month

— Actuals
 - - - Estimate



Medi-Cal Fee-For-Service Base Estimate

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

The Base Expenditure estimate consists of two main groups, (1) fee-for-service and (2) non-fee-for-service. The fee-for-service Base (FFS Base) Estimate is summarized in this section. The data used for these projections consist of 36-month claims paid through the main Medi-Cal claims processing system at the Fiscal Intermediary (FI).

The Non-Fee-for-Service (Non-FFS) Base Estimate consists of several Policy Changes and each is described and located in the Base Policy Change section.

FFS Base Estimate Service Categories

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

November 2018 FFS Base Estimate

Fiscal Year		November 2018 Estimate Total Expenditure	
PY	FY 2017-18	\$16,958,095,300 ^{1,2}	--
CY	FY 2018-19	\$17,466,996,700 ²	3.0%
BY	FY 2019-20	\$17,775,898,700	1.8%

Fiscal Year	FFS Base Expenditure		
	May 2018 Estimate	November 2018 Estimate	% Chng
FY 2017-18	\$17,058,966,900 ¹	\$16,958,095,300 ^{1,2}	-0.6%
FY 2018-19	\$17,738,522,300	\$17,466,996,700 ²	-1.5%

¹ Including adjustments of \$13.8 million related to Pharmacy and \$14.0 million related to Other Services.

² Including adjustments of \$5.3 million for FY 2017-18 and \$5.2 million for FY 2018-19, related to Other Medical. See these three Service Category write-ups for additional information.

Overall, the November 2018 FFS Base is estimated at \$17.5 billion and \$17.8 billion, respectively, for FY 2018-19 and FY 2019-20. Compared to the May 2018 Estimate, the FFS Base total expenditure is lower by 0.6% for FY 2017-18, and is estimated to decrease by 1.5% for FY 2018-19.

Several factors are contributing to these changes. The larger changes are discussed on the following page. Additional information is provided for each of the eleven (11) FFS Base service categories within this section.

Items Impacting FFS Base Estimate

Coordinated Care Initiative: With the Coordinated Care Initiative (CCI), beneficiaries moved to the Managed Care delivery system resulting in fewer Users in the FFS delivery system. The CCI was implemented in seven pilot counties with staggered implementation dates. The CCI impact on FFS Seniors and Persons with Disabilities (SPDs) users is seen through FY 2016-17.

Overall Caseload Decreases: Overall caseload continues to decrease. The Families and Children caseload has continued to decrease since 2016, and is lower than projected in the May 2018 Estimate. The Affordable Care Act (ACA) Optional Expansion caseload has been flattening since 2017, and is lower than projected in the May 2018 Estimate. A recovering economy is assumed to be the reason for the lower caseload.

Crossover Claims: A crossover claim is a claim for a recipient who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance. Historically, both Community Inpatient and County & Community Outpatient had been impacted by changes with the crossover claims.

Processing Days: Processing days reflect the number of days Medi-Cal adjudicates and pays providers. The number of processing days sometimes varies from year to year. PY has 251 processing days, equating to 51 checkwrite weeks. CY and BY, also, have 251 processing days equating to 51 checkwrite weeks.

FFS Claim Adjustments: Retroactive claim adjustments due to previously denied claims, payment reductions, rate changes, etc. occur often in the claims processing process. One-time retroactive claim adjustment payments temporarily change FFS users, utilization, and/or rate. FFS claim adjustments are excluded when projecting the FFS Base trends.

HIPPA Code Conversions: The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of standard service/procedure code sets for transactions. The Medi-Cal program implements code conversions to convert its interim (local) codes to national procedure codes in compliance with the HIPAA requirements. Providers are required to discontinue use of Healthcare Common Procedure Coding System (HCPCS) Level III Local codes and utilize HCPCS Level II national HIPAA compliance codes. Several FFS Base Service categories, including Medical Transportation, Home Health, Other Medical, and Other Services have showed unusual patterns in Utilization and/or Rate attributed to the code conversions. While the code conversion is not expected to have an impact of the overall cost of services, the new codes can cause temporary changes affecting the components for estimating. The code conversion changes are assumed to be offsetting between Utilization and Rate.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	2,058,050	3.54	\$216.50	\$766.44	\$4,732,103,100
2016-17 *	2	1,931,100	3.19	\$223.16	\$712.32	\$4,126,709,800
2016-17 *	3	1,929,790	3.29	\$226.09	\$744.25	\$4,308,731,400
2016-17 *	4	1,793,080	2.98	\$220.44	\$656.60	\$3,532,024,400
2016-17 *	TOTAL	1,928,000	3.26	\$221.39	\$721.80	\$16,699,568,700
2017-18 *	1	2,107,680	3.35	\$230.94	\$773.66	\$4,891,877,900
2017-18 *	2	1,910,640	3.12	\$230.61	\$720.54	\$4,130,113,200
2017-18 *	3	2,031,840	3.09	\$224.55	\$693.35	\$4,226,324,800
2017-18 *	4	1,816,470	2.94	\$229.64	\$674.71	\$3,676,758,300
2017-18 *	TOTAL	1,966,660	3.13	\$228.95	\$717.17	\$16,925,074,300
2018-19 **	1	2,065,830	3.35	\$239.27	\$802.49	\$4,973,384,500
2018-19 **	2	1,926,140	3.15	\$238.02	\$750.01	\$4,333,855,100
2018-19 **	3	1,921,360	3.14	\$239.93	\$753.02	\$4,340,463,000
2018-19 **	4	1,777,470	3.05	\$234.83	\$715.27	\$3,814,125,300
2018-19 **	TOTAL	1,922,700	3.18	\$238.14	\$756.83	\$17,461,827,900
2019-20 **	1	2,058,990	3.37	\$244.86	\$825.43	\$5,098,648,800
2019-20 **	2	1,914,620	3.18	\$241.61	\$767.30	\$4,407,240,100
2019-20 **	3	1,913,500	3.15	\$243.78	\$766.77	\$4,401,676,400
2019-20 **	4	1,772,250	3.05	\$238.60	\$727.57	\$3,868,333,400
2019-20 **	TOTAL	1,914,840	3.19	\$242.40	\$773.60	\$17,775,898,700

* ACTUAL

** ESTIMATED

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

Physicians Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

Background: Physicians include services billed by Physicians (M.D or D.O.) & Physician Group.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Unit)		Total Expenditure	
PY	FY 2017-18	356,620	--	2.27	--	\$74.53	--	\$725,104,800	--
CY	FY 2018-19	332,100	-6.9%	2.28	0.4%	\$74.96	0.6%	\$682,455,500	-5.9%
BY	FY 2019-20	331,870	-0.1%	2.29	0.4%	\$74.78	-0.2%	\$681,951,400	-0.1%

Users: Users are projected to decrease by 6.9% in CY due to: (1) retroactive payments for the primary care physician (PCP) service rates. Retroactive PCP were made in FY 2017-18, temporarily increasing the number of claims processed and user counts for Seniors and Persons with Disabilities populations. CY assumes a return to the historical levels absent of the PCP increases; and (2) Families and Children caseload decreases. Users are estimated to remain relatively unchanged in BY.

Utilization: The nearly 2.3 claims per user in PY is estimated to continue in CY and BY.

Rate: The Rate level is estimated to increase slightly from PY to CY due to: (1) FY 2017-18 fully incorporated Proposition 56 physician services supplemental payments, implemented January 2018, and (2) \$22 million in FY 2017-18 retroactive PCP payments. These increases were partially offset by: (3) a fully incorporated radiology rate reduction for 2015 Medicare rates, implemented May 2018. The net change in Rate between the three was still positive. The Rate level is estimated to remain relatively unchanged from CY to BY.

Total Expenditure: Total Expenditure is projected to decrease by 5.9% in CY, primarily due to lower User projections. BY projections are estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$703,732,000	\$725,104,800	3.0%
FY 2018-19	\$698,691,000	\$682,455,500	-2.3%

Compared to the May 2018 Estimate, the November 2018 Estimate is 3.0% higher for FY 2017-18 due to large retroactive PCP payments in February/March 2018. It is 2.3% lower in FY 2018-19 due to decreasing ACA Optional Expansion and Families and Children caseloads.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

PHYSICIANS

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	409,130	2.40	\$73.04	\$175.38	\$215,258,300
2016-17 *	2	347,860	2.31	\$74.00	\$171.19	\$178,654,500
2016-17 *	3	364,310	2.28	\$72.76	\$166.12	\$181,552,000
2016-17 *	4	309,240	2.22	\$72.37	\$160.58	\$148,974,300
2016-17 *	TOTAL	357,630	2.31	\$73.06	\$168.80	\$724,439,100
2017-18 *	1	370,290	2.41	\$73.71	\$177.39	\$197,053,500
2017-18 *	2	334,880	2.27	\$74.05	\$168.32	\$169,099,400
2017-18 *	3	417,130	2.21	\$76.94	\$170.20	\$212,989,000
2017-18 *	4	304,170	2.20	\$72.84	\$159.96	\$145,962,900
2017-18 *	TOTAL	356,620	2.27	\$74.53	\$169.44	\$725,104,800
2018-19 **	1	356,800	2.39	\$76.72	\$183.18	\$196,079,900
2018-19 **	2	327,480	2.27	\$76.03	\$172.74	\$169,707,200
2018-19 **	3	345,010	2.24	\$73.66	\$164.71	\$170,474,900
2018-19 **	4	299,110	2.23	\$73.02	\$162.92	\$146,193,500
2018-19 **	TOTAL	332,100	2.28	\$74.96	\$171.25	\$682,455,500
2019-20 **	1	358,820	2.39	\$75.98	\$181.55	\$195,429,700
2019-20 **	2	325,960	2.29	\$76.03	\$173.96	\$170,106,900
2019-20 **	3	344,080	2.24	\$73.64	\$164.79	\$170,102,700
2019-20 **	4	298,600	2.23	\$73.16	\$163.33	\$146,312,000
2019-20 **	TOTAL	331,870	2.29	\$74.78	\$171.24	\$681,951,400

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Medical Fee-for-Service Base Estimate

Analyst: Peter Bjorkman

Background: The Other Medical service category consists of clinics and specialist service providers. Payments to Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are approximately 84% of expenditures in this category. A full list of the provider types are listed in the Information Only Section.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2017-18	1,169,180	--	1.55	--	\$159.56	--	\$3,466,424,400*	--
CY	FY 2018-19	1,189,050	1.7%	1.56	0.6%	\$163.73	2.6%	\$3,643,544,900*	5.1%
BY	FY 2019-20	1,185,940	-0.3%	1.56	0.0%	\$163.40	-0.2%	\$3,623,199,000	-0.6%

* FY 2017-18 includes an adjustment of \$5.3 million for Clinical Laboratories. FY 2018-19 includes an adjustment of \$5.2 million for Clinical Laboratories.

Users: Users are estimated to increase by 1.7% in CY due to modest increases in FQHC users. Users are estimated to remain relatively unchanged in BY.

Utilization: Utilization is estimated to remain relatively unchanged in CY and BY.

Rate: Rates are estimated to increase by 2.6% in CY. The CY increase is due to the fully incorporated: (1) FY 2017-18 Los Angeles' Cost Based Reimbursement Clinics (CBRC) rate increase, implemented July 2017; (2) FY 2017-18 Medicare Economic Index (MEI) rate increase for FQHC/RHCs, implemented October 2017; and (3) Proposition 56 Physician Services supplemental payments, implemented January 2018. Rates are held level in BY as future rate increases are estimated through policy changes.

Total Expenditure: CY Expenditure is estimated to increase by 5.1% due to higher Users and Rates. BY Expenditure is estimated to remain relatively stable.

Reason for Change From Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$3,393,669,900	\$3,466,424,400*	2.1%
FY 2018-19	\$3,463,081,500	\$3,643,544,900*	5.2%

* FY 2017-18 includes an adjustment of \$5.3 million for Clinical Laboratories. FY 2018-19 includes an adjustment of \$5.2 million for Clinical Laboratories.

Compared to the May 2018 Estimate, the November 2018 Estimate is higher by 2.1% for FY 2017-18 due to modest increases in FQHC users; it is higher by 5.2% for FY 2018-19 for the same reason as in FY 2017-18, as well as the fully incorporated increases noted in Rate above.

Notes:

FFS Other Medical FY 2017-18 and FY 2018-19 rates both include one-time adjustments related to Clinical Laboratories AB 1494 10% retroactive recoupments and the July 2015, July 2016, and July 2017 rate change retroactive recoupments.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

OTHER MEDICAL

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	1,195,090	1.60	\$150.47	\$240.03	\$860,563,100
2016-17 *	2	1,133,620	1.55	\$157.42	\$243.50	\$828,112,900
2016-17 *	3	1,133,370	1.54	\$156.96	\$241.78	\$822,075,700
2016-17 *	4	1,049,940	1.48	\$156.44	\$231.55	\$729,339,100
2016-17 *	TOTAL	1,128,010	1.54	\$155.18	\$239.37	\$3,240,090,800
2017-18 *	1	1,289,670	1.60	\$159.18	\$255.22	\$987,436,800
2017-18 *	2	1,119,010	1.53	\$157.16	\$239.73	\$804,789,400
2017-18 *	3	1,187,540	1.55	\$159.69	\$246.94	\$879,740,800
2017-18 *	4	1,080,500	1.50	\$162.42	\$243.47	\$789,203,300
2017-18 *	TOTAL	1,169,180	1.55	\$159.56	\$246.69	\$3,461,170,400
2018-19 **	1	1,309,650	1.61	\$164.15	\$264.36	\$1,038,666,800
2018-19 **	2	1,208,570	1.55	\$164.93	\$255.35	\$925,821,000
2018-19 **	3	1,165,270	1.54	\$162.77	\$251.24	\$878,290,100
2018-19 **	4	1,072,710	1.52	\$162.89	\$247.22	\$795,598,200
2018-19 **	TOTAL	1,189,050	1.56	\$163.73	\$254.99	\$3,638,376,100
2019-20 **	1	1,312,140	1.61	\$163.51	\$263.17	\$1,035,967,700
2019-20 **	2	1,202,670	1.55	\$164.40	\$255.29	\$921,097,500
2019-20 **	3	1,160,320	1.54	\$162.76	\$251.18	\$874,361,500
2019-20 **	4	1,068,640	1.52	\$162.80	\$246.97	\$791,772,300
2019-20 **	TOTAL	1,185,940	1.56	\$163.40	\$254.59	\$3,623,199,000

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

County & Community Outpatient Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background: County and Community Outpatient providers are operated by county and community hospitals providing services that do not require an overnight stay.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2017-18	223,570	--	1.52	--	\$138.75	--	\$564,968,300	--
CY	FY 2018-19	211,970	-5.2%	1.52	0.0%	\$147.25	6.1%	\$568,609,100	0.6%
BY	FY 2019-20	212,120	0.1%	1.52	0.0%	\$146.71	-0.4%	\$568,197,200	-0.1%

Users: Users are estimated to decrease by 5.2% in CY, correlating to a lower caseload. Users are estimated to remain relatively unchanged in BY.

Utilization: Utilization is projected to remain stable at approximately 1.5 claims per user.

Rate: Rate is estimated to increase by 6.1% from PY to CY, due to the (1) full incorporation of Prop 56 Physician Services Supplemental Payments, implemented January 2018; (2) full incorporation of Genetic Disease Screening Program (GDSP) newborn screening rate year 2012 fee increase of \$9.95, implemented April 2017; (3) full incorporation of GDSP newborn screening rate year 2016 fee increase of \$17.55, implemented April 2017; and (4) partial incorporation of GDSP newborn screening rate year 2018 fee increase of \$12.00, implemented July 2018. These increases are partially offset by the reduction to radiology rates for 2015 Medicare Rates, implemented May 2018. Rate is projected to remain relatively unchanged in BY as future rate increases are estimated through policy changes.

Total Expenditure: Total Expenditure is estimated to increase by 0.6% in CY due to higher Rate partially offset by lower Users. BY Total Expenditure is estimated to remain relatively unchanged.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$561,337,400	\$564,968,300	0.6%
FY 2018-19	\$562,269,900	\$568,609,100	1.1%

Compared to the May 2018 Estimate, the November 2018 Estimate is higher by 0.6% and 1.1%, respectively, for FY 2017-18 and FY 2018-19. The estimated increases are due to the incorporation of rate increases discussed above.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

CO. & COMM. OUTPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	262,450	1.57	\$133.97	\$210.36	\$165,624,200
2016-17 *	2	218,000	1.51	\$132.16	\$199.50	\$130,470,900
2016-17 *	3	214,040	1.52	\$132.56	\$201.08	\$129,117,900
2016-17 *	4	196,450	1.47	\$135.65	\$199.43	\$117,534,600
2016-17 *	TOTAL	222,730	1.52	\$133.55	\$203.06	\$542,747,600
2017-18 *	1	260,500	1.58	\$136.08	\$215.58	\$168,473,600
2017-18 *	2	218,420	1.50	\$137.38	\$205.80	\$134,849,000
2017-18 *	3	214,570	1.50	\$145.52	\$217.85	\$140,230,100
2017-18 *	4	200,770	1.48	\$136.65	\$201.58	\$121,415,600
2017-18 *	TOTAL	223,570	1.52	\$138.75	\$210.59	\$564,968,300
2018-19 **	1	236,800	1.56	\$155.25	\$242.39	\$172,197,200
2018-19 **	2	210,120	1.50	\$146.84	\$220.76	\$139,161,300
2018-19 **	3	206,440	1.51	\$144.88	\$218.07	\$135,051,600
2018-19 **	4	194,500	1.50	\$140.05	\$209.42	\$122,199,000
2018-19 **	TOTAL	211,970	1.52	\$147.25	\$223.54	\$568,609,100
2019-20 **	1	239,510	1.57	\$152.41	\$238.63	\$171,460,300
2019-20 **	2	209,110	1.51	\$147.12	\$222.41	\$139,522,800
2019-20 **	3	205,780	1.51	\$144.78	\$217.98	\$134,574,000
2019-20 **	4	194,090	1.49	\$140.95	\$210.62	\$122,640,100
2019-20 **	TOTAL	212,120	1.52	\$146.71	\$223.22	\$568,197,200

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Pharmacy Fee-for-Service Base Estimate

Analyst: Toni Richardson

Background: Pharmacy services consists of the prescribed drugs, medical supplies, and durable medical equipment (DME) billed by pharmacies.

Fiscal Year		Users		Utilization (Prescriptions per User)		Rate (Cost per Prescription)		Total Expenditure	
PY	FY 2017-18	453,890	--	2.79	--	\$236.00	--	\$3,596,807,200*	--
CY	FY 2018-19	443,880	-2.2%	2.78	-0.4%	\$255.01	8.1%	\$3,780,879,900	5.1%
BY	FY 2019-20	442,500	-0.3%	2.80	0.7%	\$266.67	4.6%	\$3,957,837,700	4.7%

* Includes adjustment of \$13.8 million

Users: Users are estimated to decrease by 2.2% from PY to CY, correlating to lower caseload. From CY to BY users are estimated to remain relatively unchanged.

Utilization: The level of utilization experienced in PY is estimated to continue in CY and BY, around 2.8 prescriptions per user.

Rate: Rate is estimated to increase by 8.1% from PY to CY and by 4.6% from CY to BY. This growth is related to the historical growth experienced in prescription drugs.

Total Expenditure: Total expenditures are estimated to increase by 5.1% from PY to CY and by 4.7% from CY to BY, primarily due to historical growth experienced in pharmacy rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$3,584,470,000*	\$3,596,807,200*	0.3%
FY 2018-19	\$3,884,808,800	\$3,780,879,900	-2.7%

* Includes adjustment of \$13.8 million.

Compared to the May 2018 Estimate, the November 2018 Estimate is lower by 0.3% and 2.7%, respectively, for FY 2017-18 and FY 2018-19. The CY decrease is mainly due to lower Users, correlating to changes in caseload.

Notes:

FFS Pharmacy Base FY 2015-16 data included a one-time adjustment of -\$52.7 million related to Pharmacy recoupment of the 10% provider payment reduction. FFS Pharmacy Base FY 2017-18 data includes a one-time adjustment of -\$13.8 million related to the Durable Medical Equipment/ Medical Supplies (DME) recoupment of the 10% provider payment reduction.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

PHARMACY

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	517,860	3.01	\$196.24	\$591.39	\$918,761,500
2016-17 *	2	477,320	2.77	\$202.80	\$561.44	\$803,965,300
2016-17 *	3	476,450	2.78	\$209.02	\$580.26	\$829,394,700
2016-17 *	4	420,030	2.61	\$225.38	\$587.39	\$740,164,000
2016-17 *	TOTAL	472,910	2.80	\$207.08	\$580.14	\$3,292,285,500
2017-18 *	1	481,820	2.97	\$233.29	\$692.10	\$1,000,411,000
2017-18 *	2	456,550	2.76	\$231.87	\$639.23	\$875,521,700
2017-18 *	3	466,300	2.79	\$234.95	\$654.74	\$915,916,400
2017-18 *	4	410,900	2.61	\$245.73	\$641.84	\$791,198,100
2017-18 *	TOTAL	453,890	2.79	\$236.00	\$657.84	\$3,583,047,200
2018-19 **	1	476,960	2.95	\$256.81	\$757.83	\$1,084,369,200
2018-19 **	2	452,450	2.73	\$252.79	\$690.39	\$937,099,200
2018-19 **	3	444,540	2.76	\$253.53	\$700.39	\$934,055,700
2018-19 **	4	401,580	2.67	\$256.90	\$685.09	\$825,355,800
2018-19 **	TOTAL	443,880	2.78	\$255.01	\$709.81	\$3,780,879,900
2019-20 **	1	476,820	2.95	\$268.16	\$790.84	\$1,131,269,500
2019-20 **	2	450,490	2.76	\$264.80	\$731.49	\$988,591,300
2019-20 **	3	442,710	2.77	\$265.10	\$734.68	\$975,748,200
2019-20 **	4	399,960	2.67	\$268.71	\$718.59	\$862,228,700
2019-20 **	TOTAL	442,500	2.80	\$266.67	\$745.36	\$3,957,837,700

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of prescriptions

County Inpatient Fee-for-Service Base Estimate

Analyst: Daniel Pfeffer

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

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2017-18	4,360	--	5.21	--	\$2,827.01	--	\$771,245,900	--
CY	FY 2018-19	4,300	-1.4%	5.41	3.8%	\$2,967.09	5.0%	\$829,184,400	7.5%
BY	FY 2019-20	4,290	-0.2%	5.45	0.7%	\$2,972.06	0.2%	\$834,431,900	0.6%

Users: Users are estimated to decrease by 1.4% in CY, correlating to the lower caseload. Users are estimated to remain relatively unchanged in BY.

Utilization: Utilization or the number of days stay per user is estimated to increase by 3.8% in CY. PY Utilization was affected by 2017-18 DPH interim rate retroactive claim adjustments. The rate retro had negative unit adjustments, causing lower than average utilization for the adjustment months. Utilization is estimated to return to normal levels in CY. Utilization is estimated to remain stable in BY.

Rate: Rate is estimated to increase by 5.0% from PY to CY, mainly due to the FY 2017-18 DPH interim rate increase of 4.01% (for county hospitals), implemented September 15, 2017. PY incorporates a partial year impact of the rate increase, while CY incorporates a full year impact of the rate increase. The FY 2017-18 DPH interim rate increase is fully incorporated in the FFS County Inpatient base in the November 2018 Estimate. Rate is held level in BY as the FY 2018-19 DPH interim rate increase effective July 2018 is budgeted in the DPH Interim Rate Growth Policy Change.

Total Expenditure: Total expenditures are estimated to increase by 7.5% in CY due to estimated increases in Utilization and Rate, partially offset by a decrease in Users. Total expenditures are estimated to remain relatively unchanged in BY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$795,768,800	\$771,245,900	-3.1%
FY 2018-19	\$845,824,700	\$829,184,400	-2.0%

Compared to the May 2018 Estimate, the November 2018 Estimate is lower by 3.1% and 2.6%, respectively, for FY 2017-18 and FY 2018-19. The decreases are mainly due to lower Users, correlating to the changes in caseload.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

COUNTY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	5,410	5.35	\$2,523.13	\$13,499.51	\$219,191,500
2016-17 *	2	4,960	5.12	\$2,623.98	\$13,430.67	\$199,821,600
2016-17 *	3	4,850	5.42	\$2,795.26	\$15,159.56	\$220,708,100
2016-17 *	4	4,170	5.29	\$2,768.82	\$14,638.49	\$183,273,900
2016-17 *	TOTAL	4,850	5.30	\$2,670.54	\$14,142.27	\$822,995,000
2017-18 *	1	5,120	5.14	\$2,668.86	\$13,728.13	\$211,056,300
2017-18 *	2	4,080	5.10	\$2,831.25	\$14,430.74	\$176,545,700
2017-18 *	3	4,550	5.29	\$2,923.19	\$15,468.24	\$210,940,400
2017-18 *	4	3,700	5.33	\$2,916.55	\$15,542.08	\$172,703,600
2017-18 *	TOTAL	4,360	5.21	\$2,827.01	\$14,730.52	\$771,245,900
2018-19 **	1	4,910	5.30	\$2,917.71	\$15,472.90	\$228,144,500
2018-19 **	2	4,070	5.36	\$3,008.90	\$16,124.81	\$196,667,100
2018-19 **	3	4,400	5.55	\$2,964.85	\$16,456.14	\$217,214,600
2018-19 **	4	3,820	5.46	\$2,987.72	\$16,316.86	\$187,158,200
2018-19 **	TOTAL	4,300	5.41	\$2,967.09	\$16,065.98	\$829,184,400
2019-20 **	1	4,870	5.45	\$2,924.52	\$15,935.46	\$233,053,200
2019-20 **	2	4,070	5.35	\$3,021.29	\$16,151.35	\$196,987,300
2019-20 **	3	4,400	5.55	\$2,964.85	\$16,456.11	\$217,215,200
2019-20 **	4	3,820	5.46	\$2,989.73	\$16,318.50	\$187,176,200
2019-20 **	TOTAL	4,290	5.45	\$2,972.06	\$16,205.39	\$834,431,900

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Community Inpatient Fee-for-Service Base Estimate

Analyst: Daniel Pfeffer

Background: Community Inpatient provides acute inpatient services rendered by community-based hospitals. This service category consists of private hospitals, Non-Designated Public Hospitals (NDPHs), and Designated Public Hospitals (DPHs).

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2017-18	29,370	--	4.84	--	\$2,333.19	--	\$3,981,489,700	--
CY	FY 2018-19	27,910	-5.0%	5.05	4.3%	\$2,433.88	4.3%	\$4,116,501,700	3.4%
BY	FY 2019-20	28,340	1.5%	5.02	-0.6%	\$2,488.66	2.3%	\$4,251,695,100	3.3%

Users: The estimated User decrease of 5.0% for CY correlates to decreases in caseload. Users are projected to remain relatively stable in BY.

Utilization: Utilization is estimated to increase by 4.3% in CY. The high Utilization in CY nearly offsets the low Users in CY, and is likely reflective of a changing mix of users. Utilization is estimated to remain relatively unchanged in BY.

Rate: Rate is estimated to increase in CY and BY, following historical growth trends experienced in this service category.

Total Expenditure: Total expenditures are estimated to increase by 3.4% in CY and 3.3% in BY, mainly due to higher Rates.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$4,100,902,500	\$3,981,489,700	-2.9%
FY 2018-19	\$4,352,502,700	\$4,116,501,700	-5.4%

Compared to the May 2018 Estimate, the November 2018 Estimate is lower by 2.9% and 5.4%, respectively, for FY 2017-18 and FY 2018-19. The decreases are primarily due to lower Users, correlating to the changes in caseload.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

COMMUNITY INPATIENT

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	38,140	4.70	\$2,199.71	\$10,331.18	\$1,182,207,600
2016-17 *	2	31,440	4.66	\$2,232.91	\$10,411.74	\$981,941,500
2016-17 *	3	32,970	4.78	\$2,233.86	\$10,686.04	\$1,056,806,400
2016-17 *	4	26,450	4.43	\$2,345.62	\$10,395.70	\$824,930,100
2016-17 *	TOTAL	32,250	4.66	\$2,245.26	\$10,454.73	\$4,045,885,600
2017-18 *	1	35,410	4.76	\$2,285.34	\$10,884.19	\$1,156,368,800
2017-18 *	2	28,970	5.01	\$2,353.89	\$11,800.67	\$1,025,430,800
2017-18 *	3	27,660	4.85	\$2,362.20	\$11,446.34	\$949,874,100
2017-18 *	4	25,430	4.75	\$2,342.92	\$11,138.12	\$849,816,000
2017-18 *	TOTAL	29,370	4.84	\$2,333.19	\$11,297.51	\$3,981,489,700
2018-19 **	1	30,850	5.13	\$2,413.67	\$12,379.20	\$1,145,801,100
2018-19 **	2	27,430	5.07	\$2,425.38	\$12,285.10	\$1,011,116,500
2018-19 **	3	28,450	5.07	\$2,427.08	\$12,299.83	\$1,049,901,800
2018-19 **	4	24,890	4.92	\$2,477.69	\$12,181.32	\$909,682,300
2018-19 **	TOTAL	27,910	5.05	\$2,433.88	\$12,291.72	\$4,116,501,700
2019-20 **	1	32,570	5.04	\$2,470.96	\$12,444.84	\$1,216,105,400
2019-20 **	2	27,430	5.06	\$2,477.75	\$12,544.16	\$1,032,428,200
2019-20 **	3	28,450	5.07	\$2,482.00	\$12,578.13	\$1,073,659,600
2019-20 **	4	24,890	4.91	\$2,532.62	\$12,446.72	\$929,501,900
2019-20 **	TOTAL	28,340	5.02	\$2,488.66	\$12,502.75	\$4,251,695,100

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Nursing Facilities Fee-for-Service Base Estimate

Analyst: Devon Dyer

Background: Nursing Facilities consists of Nursing Facilities A, Freestanding Nursing Facilities B (AB 1629), Distinct Part Nursing Facilities B, Adult Subacute, Pediatric Subacute, and Rural Swing Beds.

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2017-18	28,380	--	32.07	--	\$226.75	--	\$2,476,416,600	--
CY	FY 2018-19	27,750	-2.2%	32.24	0.5%	\$227.10	0.2%	\$2,437,690,500	-1.6%
BY	FY 2019-20	27,780	0.1%	32.31	0.2%	\$227.68	0.3%	\$2,452,657,200	0.6%

Users: Users are projected to decrease in CY from PY as users in August 2017 are unusually high due to adjustments. Users are projected to remain relatively unchanged in BY from CY.

Utilization: Utilization is projected to remain relatively unchanged from FY 2017-18 through FY 2019-20.

Rate: Rate is estimated to remain relatively unchanged in CY as the AB 1629 Final rates and LTC Final rates for 2017-18 were only partially incorporated in the November 2018 FFS Nursing Facilities Base. AB 1629 Annual Rate Adjustment and LTC Rate Adjustment Policy Changes will continue to capture the impact of the final 2017-18 rate increases. Rate is projected to remain relatively unchanged in BY from CY, as Policy Changes are utilized to incorporate all future rate increases into the Estimate.

Total Expenditure: Total expenditures are estimated to decrease by 1.6% in CY, as users in August 2017 are unusually high possibly due to adjustments and more users are losing eligibility. Projected total expenditures remain relatively unchanged in BY from CY as policy changes incorporate future rate increases and anticipated retroactive payments into the Estimate.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$2,545,660,200	\$2,476,416,600	-2.7%
FY 2018-19	\$2,540,724,600	\$2,437,690,500	-4.1%

Compared to the May 2018 Estimate, the November 2018 Estimate is lower by 2.7% and 4.1%, respectively, for FY 2017-18 and FY 2018-19. The decreases are due to the continued decline of users, while utilization and the rate have remained relatively unchanged.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

NURSING FACILITIES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	34,840	36.25	\$209.59	\$7,597.23	\$794,077,400
2016-17 *	2	33,520	32.22	\$207.12	\$6,673.61	\$671,151,100
2016-17 *	3	31,940	32.63	\$233.99	\$7,635.67	\$731,550,300
2016-17 *	4	27,190	28.39	\$216.95	\$6,158.99	\$502,444,600
2016-17 *	TOTAL	31,870	32.61	\$216.43	\$7,057.24	\$2,699,223,400
2017-18 *	1	30,910	36.14	\$232.89	\$8,416.67	\$780,570,200
2017-18 *	2	28,910	31.86	\$222.46	\$7,086.75	\$614,683,600
2017-18 *	3	27,760	31.42	\$220.69	\$6,933.59	\$577,408,200
2017-18 *	4	25,930	28.15	\$230.01	\$6,474.91	\$503,754,500
2017-18 *	TOTAL	28,380	32.07	\$226.75	\$7,271.69	\$2,476,416,600
2018-19 **	1	28,890	35.87	\$227.21	\$8,150.18	\$706,354,400
2018-19 **	2	28,210	31.71	\$226.61	\$7,186.67	\$608,212,300
2018-19 **	3	27,660	32.01	\$227.19	\$7,272.61	\$603,539,900
2018-19 **	4	26,220	29.04	\$227.43	\$6,604.80	\$519,584,000
2018-19 **	TOTAL	27,750	32.24	\$227.10	\$7,321.41	\$2,437,690,500
2019-20 **	1	29,040	35.95	\$228.90	\$8,229.31	\$716,915,900
2019-20 **	2	28,210	31.91	\$226.68	\$7,232.25	\$612,069,600
2019-20 **	3	27,660	32.01	\$227.19	\$7,272.61	\$603,539,900
2019-20 **	4	26,220	29.03	\$227.78	\$6,611.76	\$520,131,800
2019-20 **	TOTAL	27,780	32.31	\$227.68	\$7,356.42	\$2,452,657,200

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

ICF-DD Fee-for-Service Base Estimate

Analyst: Toni Richardson

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

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
PY	FY 2017-18	4,870	--	31.74	--	\$220.01	--	\$408,037,800	--
CY	FY 2018-19	4,860	-0.2%	31.65	-0.3%	\$222.36	1.1%	\$410,114,300	0.5%
BY	FY 2019-20	4,880	0.4%	31.69	0.1%	\$222.16	-0.1%	\$412,267,500	0.5%

Users: Users are estimated to remain level from PY to CY and BY.

Utilization: The level of utilization experienced in PY is estimated to continue in CY and BY, around 31.7 days per user.

Rate: Rates are estimated to increase by 1.1% from PY to CY due to Proposition 56 ICF-DD supplemental payments and the ICF-DD FY 2017-18 rate increase. Prop 56 ICF-DD supplemental payments were implemented in April 2018 and is incorporated fully into the November 2018 FFS ICF-DD Base. The ICF-DD rate increase, effective on August 1, 2017, was installed on January 03, 2018 and is incorporated fully in the November 2018 FFS ICF-DD Base. BY is projected at levels consistent with CY, ICF-DD future rate increases are budgeted in the LTC Rate Adjustment policy change.

Total Expenditure: Total expenditures remain relatively unchanged in CY and BY from PY.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$385,079,100	\$408,037,800	6.0%
FY 2018-19	\$387,560,000	\$410,114,300	5.8%

Compared to the May 2018 Estimate, the November 2018 Estimate total expenditures have increased by 6.0% in FY 2017-18 and are estimated to increase by 5.8% in FY 2018-19. The increase in both years is due to Proposition 56 ICF-DD supplemental payments, and the ICF-DD rate increase for Rate Year 2017-18. Additionally, the increase in FY 2017-18 is also due to a retroactive rate adjustment installed in April 2018, for both the ICF-DD rate increase and the Prop 56 ICF-DD supplemental payments.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

ICF-DD

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	5,060	36.77	\$194.14	\$7,137.89	\$108,424,500
2016-17 *	2	4,970	31.46	\$211.91	\$6,666.82	\$99,495,700
2016-17 *	3	4,940	32.08	\$208.57	\$6,691.68	\$99,271,100
2016-17 *	4	4,790	26.82	\$210.13	\$5,635.68	\$80,973,400
2016-17 *	TOTAL	4,940	31.85	\$205.45	\$6,543.90	\$388,164,700
2017-18 *	1	4,970	36.20	\$209.44	\$7,581.57	\$113,094,300
2017-18 *	2	4,890	31.44	\$209.37	\$6,581.94	\$96,497,800
2017-18 *	3	4,870	32.58	\$209.82	\$6,835.67	\$99,944,300
2017-18 *	4	4,750	26.51	\$261.01	\$6,919.18	\$98,501,500
2017-18 *	TOTAL	4,870	31.74	\$220.01	\$6,982.76	\$408,037,800
2018-19 **	1	4,930	36.32	\$221.82	\$8,056.21	\$119,216,800
2018-19 **	2	4,870	31.30	\$222.47	\$6,963.55	\$101,813,200
2018-19 **	3	4,880	31.95	\$222.19	\$7,098.50	\$103,934,400
2018-19 **	4	4,740	26.83	\$223.20	\$5,987.80	\$85,150,000
2018-19 **	TOTAL	4,860	31.65	\$222.36	\$7,036.81	\$410,114,300
2019-20 **	1	4,950	36.44	\$221.76	\$8,080.07	\$120,065,700
2019-20 **	2	4,900	31.38	\$221.85	\$6,961.03	\$102,275,800
2019-20 **	3	4,900	31.94	\$222.13	\$7,095.71	\$104,402,600
2019-20 **	4	4,760	26.82	\$223.15	\$5,983.86	\$85,523,300
2019-20 **	TOTAL	4,880	31.69	\$222.16	\$7,040.34	\$412,267,500

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of days stay

Medical Transportation Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

Background: The Medical Transportation service category includes emergency and non-emergency Ground Medical Transportation and Air Ambulance Transportation.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2017-18	27,660	--	2.81	--	\$76.91	--	\$71,759,000	--
CY	FY 2018-19	25,930	-6.3%	2.88	2.5%	\$76.96	0.1%	\$68,870,300	-4.0%
BY	FY 2019-20	25,670	-1.0%	2.89	0.3%	\$76.16	-1.0%	\$67,825,200	-1.5%

Users: Users are estimated to decrease in CY by 6.3% correlating to a lower caseload. Users are projected to remain at a fairly stable level in BY.

Utilization: Utilization is estimated to remain fairly level in CY and in BY at approximately 2.9 claims per user.

Rate: Rate is estimated to remain level in CY and BY.

Total Expenditure: Total expenditure is estimated to decrease by 4% in CY primarily due to lower Users. BY total expenditure is projected to remain fairly level.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$69,463,100	\$71,759,000	3.3%
FY 2018-19	\$65,961,200	\$68,870,300	4.4%

Total expenditure is fairly consistent with the May 2018 Estimate, higher by \$2.3M, for FY 2017-18. Total expenditure is estimated fairly consistent with the May 2018 Estimate, higher by \$2.9M, for FY 2018-19.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MEDICAL TRANSPORTATION

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	25,120	3.07	\$88.25	\$270.95	\$20,418,600
2016-17 *	2	23,060	3.22	\$77.34	\$248.90	\$17,222,700
2016-17 *	3	22,020	3.34	\$76.06	\$253.79	\$16,762,400
2016-17 *	4	19,380	3.08	\$73.62	\$226.82	\$13,186,000
2016-17 *	TOTAL	22,390	3.18	\$79.18	\$251.51	\$67,589,800
2017-18 *	1	31,700	2.90	\$70.66	\$205.16	\$19,510,900
2017-18 *	2	25,390	2.93	\$86.18	\$252.58	\$19,235,800
2017-18 *	3	30,500	2.68	\$76.79	\$206.15	\$18,860,800
2017-18 *	4	23,040	2.72	\$75.23	\$204.73	\$14,151,500
2017-18 *	TOTAL	27,660	2.81	\$76.91	\$216.22	\$71,759,000
2018-19 **	1	29,270	2.96	\$78.63	\$232.50	\$20,414,500
2018-19 **	2	25,090	2.87	\$77.93	\$223.78	\$16,844,700
2018-19 **	3	26,450	2.87	\$75.74	\$217.02	\$17,219,800
2018-19 **	4	22,910	2.79	\$75.04	\$209.37	\$14,391,300
2018-19 **	TOTAL	25,930	2.88	\$76.96	\$221.33	\$68,870,300
2019-20 **	1	28,520	2.93	\$76.57	\$224.45	\$19,204,100
2019-20 **	2	24,940	2.92	\$77.42	\$225.91	\$16,899,700
2019-20 **	3	26,360	2.89	\$75.57	\$218.22	\$17,258,100
2019-20 **	4	22,860	2.81	\$74.91	\$210.86	\$14,463,300
2019-20 **	TOTAL	25,670	2.89	\$76.16	\$220.18	\$67,825,200

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Other Services Fee-for-Service Base Estimate

Analyst: Alvin Bautista

Background: Other Services includes Provider Types not included in other FFS service categories. Local Education Agency (LEA), Certified Hospice Services, Assistive Devices, and waiver services account for the majority of expenditures in this service category. A complete list of provider types can be found in the Information Only Section.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2017-18	191,700	--	3.18	--	\$92.50	--	\$690,161,000*	--
CY	FY 2018-19	207,600	8.3%	3.05	-4.1%	\$95.28	3.0%	\$724,282,300	4.9%
BY	FY 2019-20	206,990	-0.3%	3.04	-0.3%	\$95.73	0.5%	\$722,717,000	-0.2%

*Includes an adjustment of \$14.0 million.

Users: Users for LEA services were lower than average for several months in PY due to the Healthcare Common Procedure Coding System (HCPCS) code conversion for LEA services. Estimated Users are expected to continue at the normalized levels for CY and BY.

Utilization: Utilization was affected by the HCPCS code conversion for LEA services, as it was higher than average in PY. Estimated Utilization is expected to continue at the normalized levels for CY and BY.

Rate: Rate was affected by the HCPCS code conversion for LEA services, as it was lower than average in PY. CY & BY Rates are projected to return to the normalized level.

Total Expenditure: Total expenditure is estimated to return to the normalized levels for CY and BY, from the unusually low months occurred in PY.

Reason for Change from Prior Estimate:

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$712,121,100*	\$690,161,000*	-3.1%
FY 2018-19	\$732,362,600	\$724,282,300	-1.1%

* Includes an adjustment of \$14.0 million.

Compared to the May 2018 Estimate, the November 2018 Estimate is lower by 3.1% and by 1.1%, respectively, for FY 2017-18 and FY 2018-19. The November 2018 Estimate assumes the LEA services expenditures have returned to normalized levels for Users, Utilization, and Rate.

Notes:

FFS Other Services Base FY 2017-18 data includes a one-time adjustment of -\$14.0 million related to the Durable Medical Equipment/Medical Supplies (DME) recoupment of the 10% Provider Payment Reduction, thus reducing FY 2017-18 expenditures reflected on the next page. An adjustment of \$14.0 million is added to FY 2017-18 Total expenditures as noted above, as this amount is recouped through the Accounts Receivable process.

**QUARTERLY SUMMARY
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(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

OTHER SERVICES

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	204,600	3.29	\$91.20	\$299.94	\$184,097,800
2016-17 *	2	185,410	2.47	\$116.89	\$288.56	\$160,505,200
2016-17 *	3	188,970	3.47	\$85.81	\$297.39	\$168,598,400
2016-17 *	4	196,140	3.08	\$80.88	\$249.34	\$146,713,600
2016-17 *	TOTAL	193,780	3.08	\$92.03	\$283.79	\$659,915,000
2017-18 *	1	190,810	3.43	\$100.32	\$344.50	\$197,202,200
2017-18 *	2	195,290	2.97	\$93.93	\$278.56	\$163,198,200
2017-18 *	3	191,520	3.13	\$92.87	\$290.94	\$167,155,900
2017-18 *	4	189,180	3.18	\$82.24	\$261.83	\$148,597,700
2017-18 *	TOTAL	191,700	3.18	\$92.50	\$293.93	\$676,154,000
2018-19 **	1	204,680	3.32	\$100.19	\$332.46	\$204,149,500
2018-19 **	2	207,530	2.89	\$97.90	\$283.05	\$176,220,900
2018-19 **	3	213,220	2.88	\$97.58	\$280.67	\$179,530,200
2018-19 **	4	204,970	3.13	\$85.44	\$267.33	\$164,381,600
2018-19 **	TOTAL	207,600	3.05	\$95.28	\$290.74	\$724,282,300
2019-20 **	1	203,520	3.28	\$101.36	\$332.40	\$202,947,000
2019-20 **	2	206,740	2.89	\$98.38	\$283.83	\$176,037,800
2019-20 **	3	212,860	2.88	\$97.78	\$281.19	\$179,564,600
2019-20 **	4	204,830	3.13	\$85.42	\$267.17	\$164,167,600
2019-20 **	TOTAL	206,990	3.04	\$95.73	\$290.97	\$722,717,100

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

Home Health Fee-for-Service Base Estimate

Analyst: Felicia Oropeza

Background: Home Health provides services to assist in supporting a beneficiary in his/her home as an alternative to care in a licensed health care facility. Home Health services require a written treatment plan approved by a physician.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Claim)		Total Expenditure	
PY	FY 2017-18	4,150	--	5.03	--	\$820.97	--	\$205,680,500	--
CY	FY-2018-19	3,910	-5.8%	5.71	13.5%	\$765.54	-6.8%	\$204,863,900	-0.4%
BY	FY 2019-20	3,900	-0.3%	5.70	-0.2%	\$761.25	-0.6%	\$203,119,500	-0.9%

Users: Users are estimated to decrease in CY by 5.8% correlating to a lower Persons with Disabilities caseload. BY is estimated to remain consistent with CY.

Utilization: Utilization is estimated to increase in CY by 13.5% due to the Healthcare Common Procedure Coding System (HCPCS) code conversion for Home Health Agencies (HHA) claims. The methodology appears to have changed in how the claims are counted. BY is projected to be fairly consistent with CY. The high Utilization in CY partially offsets the low Rate in CY, as the code conversion is not expected to have an impact on the expenditure level.

Rate: Rate is estimated to decrease in CY by 6.8% due to the HCPCS code conversion for HHA claims. The methodology appears to have changed in how the claims are counted. BY is projected to be fairly consistent with CY. The low Rate in CY partially offsets the high Utilization in CY, as the code conversion is not expected to have an impact on the expenditure level.

Total Expenditure: Total expenditure is estimated to remain unchanged in CY and in BY due to nearly offsetting from Users, Utilization, and Rate. The code conversion is not expected to have an impact on the expenditure level.

Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M18	N18	% Chng
FY 2017-18	\$206,762,700	\$205,680,500	-0.5%
FY 2018-19	\$204,735,200	\$204,863,900	0.1%

Compared to the May 2018 Estimate, the November 2018 Estimate is remaining relatively level. The code conversion is not expected to have an impact on the November 2018 expenditures.

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

HOME HEALTH

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	4,640	3.67	\$1,243.75	\$4,559.59	\$63,478,600
2016-17 *	2	4,230	3.48	\$1,252.62	\$4,358.35	\$55,368,400
2016-17 *	3	4,270	3.34	\$1,235.84	\$4,126.87	\$52,894,100
2016-17 *	4	4,180	3.13	\$1,134.71	\$3,550.19	\$44,491,000
2016-17 *	TOTAL	4,330	3.41	\$1,219.93	\$4,160.31	\$216,232,100
2017-18 *	1	4,560	4.44	\$999.88	\$4,442.04	\$60,700,500
2017-18 *	2	3,960	5.47	\$774.44	\$4,235.78	\$50,261,800
2017-18 *	3	4,240	5.49	\$762.25	\$4,186.17	\$53,264,800
2017-18 *	4	3,840	4.78	\$753.06	\$3,596.20	\$41,453,400
2017-18 *	TOTAL	4,150	5.03	\$820.97	\$4,131.62	\$205,680,500
2018-19 **	1	4,090	6.03	\$783.75	\$4,725.84	\$57,990,600
2018-19 **	2	3,840	5.89	\$754.75	\$4,445.33	\$51,191,800
2018-19 **	3	3,930	5.66	\$767.64	\$4,346.26	\$51,250,100
2018-19 **	4	3,770	5.22	\$752.75	\$3,927.30	\$44,431,400
2018-19 **	TOTAL	3,910	5.71	\$765.54	\$4,368.84	\$204,863,900
2019-20 **	1	4,070	5.97	\$771.36	\$4,604.58	\$56,230,300
2019-20 **	2	3,840	5.91	\$752.02	\$4,448.04	\$51,223,100
2019-20 **	3	3,930	5.66	\$767.64	\$4,346.26	\$51,250,100
2019-20 **	4	3,770	5.22	\$752.18	\$3,925.94	\$44,416,100
2019-20 **	TOTAL	3,900	5.70	\$761.25	\$4,337.11	\$203,119,500

* ACTUAL

** ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

PA-OAS

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	67,560	4.09	\$155.63	\$635.94	\$128,884,500
2016-17 *	2	63,180	3.73	\$151.20	\$564.33	\$106,971,000
2016-17 *	3	64,940	3.66	\$157.88	\$578.35	\$112,675,800
2016-17 *	4	58,380	3.25	\$156.03	\$507.72	\$88,924,300
2016-17 *	TOTAL	63,520	3.70	\$155.17	\$573.95	\$437,455,600
2017-18 *	1	66,250	3.86	\$168.38	\$649.68	\$129,119,500
2017-18 *	2	59,690	3.55	\$162.09	\$575.76	\$103,104,200
2017-18 *	3	81,100	3.16	\$133.97	\$423.36	\$103,002,400
2017-18 *	4	56,650	3.31	\$160.49	\$531.54	\$90,337,400
2017-18 *	TOTAL	65,920	3.46	\$155.62	\$537.96	\$425,563,400
2018-19 **	1	63,530	3.87	\$168.72	\$652.97	\$124,456,700
2018-19 **	2	58,100	3.56	\$168.58	\$600.40	\$104,651,200
2018-19 **	3	61,080	3.62	\$158.66	\$574.86	\$105,343,700
2018-19 **	4	56,430	3.37	\$164.77	\$555.54	\$94,053,500
2018-19 **	TOTAL	59,790	3.61	\$165.24	\$597.26	\$428,505,100
2019-20 **	1	62,730	3.90	\$172.62	\$672.77	\$126,599,400
2019-20 **	2	56,800	3.62	\$170.06	\$615.00	\$104,792,000
2019-20 **	3	59,720	3.66	\$160.19	\$585.53	\$104,911,000
2019-20 **	4	55,050	3.40	\$166.56	\$566.97	\$93,639,700
2019-20 **	TOTAL	58,570	3.65	\$167.51	\$611.67	\$429,942,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

NEWLY

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	458,710	2.60	\$276.81	\$720.55	\$991,562,900
2016-17 *	2	434,680	2.46	\$279.09	\$687.72	\$896,810,400
2016-17 *	3	442,670	2.49	\$293.56	\$729.61	\$968,916,900
2016-17 *	4	416,440	2.34	\$291.22	\$680.43	\$850,073,100
2016-17 *	TOTAL	438,120	2.48	\$284.85	\$705.16	\$3,707,363,300
2017-18 *	1	509,600	2.61	\$286.94	\$749.42	\$1,145,714,800
2017-18 *	2	450,910	2.47	\$288.02	\$712.26	\$963,496,600
2017-18 *	3	473,090	2.49	\$288.09	\$716.10	\$1,016,338,200
2017-18 *	4	440,950	2.34	\$297.04	\$695.76	\$920,392,000
2017-18 *	TOTAL	468,640	2.48	\$289.73	\$719.45	\$4,045,941,600
2018-19 **	1	510,220	2.70	\$300.46	\$812.44	\$1,243,561,100
2018-19 **	2	467,010	2.59	\$302.38	\$783.56	\$1,097,785,700
2018-19 **	3	444,630	2.51	\$318.23	\$798.78	\$1,065,494,200
2018-19 **	4	416,390	2.46	\$315.20	\$774.39	\$967,339,300
2018-19 **	TOTAL	459,560	2.57	\$308.33	\$793.18	\$4,374,180,200
2019-20 **	1	501,080	2.73	\$311.06	\$849.32	\$1,276,726,300
2019-20 **	2	458,590	2.61	\$310.57	\$810.57	\$1,115,156,700
2019-20 **	3	437,340	2.52	\$326.73	\$821.76	\$1,078,170,000
2019-20 **	4	410,070	2.46	\$323.92	\$796.80	\$980,241,800
2019-20 **	TOTAL	451,770	2.59	\$317.40	\$820.90	\$4,450,294,700

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

PA-ATD

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	279,590	5.14	\$242.14	\$1,245.62	\$1,044,783,700
2016-17 *	2	263,540	4.35	\$257.29	\$1,119.72	\$885,264,100
2016-17 *	3	264,570	4.57	\$254.18	\$1,160.83	\$921,353,800
2016-17 *	4	248,490	4.06	\$258.62	\$1,049.03	\$782,024,300
2016-17 *	TOTAL	264,050	4.55	\$252.25	\$1,146.71	\$3,633,426,000
2017-18 *	1	275,880	4.80	\$266.42	\$1,278.78	\$1,058,357,400
2017-18 *	2	255,820	4.36	\$266.81	\$1,162.43	\$892,125,100
2017-18 *	3	277,860	4.25	\$257.70	\$1,096.18	\$913,761,400
2017-18 *	4	243,510	4.13	\$256.87	\$1,062.04	\$775,841,100
2017-18 *	TOTAL	263,270	4.39	\$262.21	\$1,152.22	\$3,640,084,900
2018-19 **	1	266,080	4.80	\$275.17	\$1,320.24	\$1,053,858,800
2018-19 **	2	256,060	4.26	\$268.99	\$1,144.59	\$879,242,500
2018-19 **	3	269,120	4.13	\$270.53	\$1,117.07	\$901,891,400
2018-19 **	4	242,490	4.14	\$266.72	\$1,103.33	\$802,644,600
2018-19 **	TOTAL	258,440	4.33	\$270.63	\$1,172.96	\$3,637,637,300
2019-20 **	1	263,830	4.83	\$279.07	\$1,347.04	\$1,066,170,200
2019-20 **	2	254,000	4.31	\$273.41	\$1,177.54	\$897,296,100
2019-20 **	3	267,620	4.14	\$274.84	\$1,138.19	\$913,796,300
2019-20 **	4	241,360	4.14	\$270.82	\$1,122.05	\$812,461,400
2019-20 **	TOTAL	256,700	4.36	\$274.80	\$1,197.79	\$3,689,724,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

PA-AFDC

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	169,940	2.38	\$185.74	\$442.00	\$225,338,700
2016-17 *	2	160,190	2.12	\$189.92	\$403.33	\$193,831,200
2016-17 *	3	158,630	2.28	\$191.79	\$436.66	\$207,797,200
2016-17 *	4	145,830	2.15	\$180.75	\$388.35	\$169,893,000
2016-17 *	TOTAL	158,650	2.24	\$187.18	\$418.57	\$796,860,100
2017-18 *	1	163,510	2.32	\$199.70	\$464.09	\$227,648,100
2017-18 *	2	152,840	2.19	\$200.04	\$437.33	\$200,528,300
2017-18 *	3	158,890	2.20	\$193.34	\$424.54	\$202,365,800
2017-18 *	4	140,560	2.13	\$188.50	\$400.89	\$169,050,300
2017-18 *	TOTAL	153,950	2.21	\$195.69	\$432.82	\$799,592,500
2018-19 **	1	157,400	2.32	\$210.17	\$487.06	\$229,996,700
2018-19 **	2	149,580	2.35	\$200.66	\$472.52	\$212,035,500
2018-19 **	3	152,580	2.33	\$200.63	\$468.41	\$214,403,700
2018-19 **	4	137,310	2.29	\$187.21	\$428.57	\$176,545,300
2018-19 **	TOTAL	149,220	2.32	\$200.11	\$465.19	\$832,981,200
2019-20 **	1	158,420	2.34	\$214.16	\$501.65	\$238,411,800
2019-20 **	2	148,890	2.37	\$206.66	\$489.57	\$218,681,300
2019-20 **	3	152,290	2.34	\$205.73	\$481.72	\$220,088,600
2019-20 **	4	137,310	2.29	\$191.80	\$439.92	\$181,213,000
2019-20 **	TOTAL	149,230	2.34	\$205.06	\$479.35	\$858,394,800

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

LT-OAS

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	21,250	33.15	\$183.31	\$6,075.95	\$387,354,000
2016-17 *	2	21,560	28.82	\$185.27	\$5,340.18	\$345,328,200
2016-17 *	3	20,680	29.47	\$205.53	\$6,056.60	\$375,708,900
2016-17 *	4	17,990	24.50	\$190.65	\$4,671.26	\$252,070,500
2016-17 *	TOTAL	20,370	29.16	\$190.88	\$5,566.24	\$1,360,461,600
2017-18 *	1	19,500	32.36	\$205.38	\$6,645.75	\$388,796,400
2017-18 *	2	18,450	28.63	\$195.97	\$5,611.10	\$310,512,900
2017-18 *	3	21,550	24.14	\$191.96	\$4,633.32	\$299,558,400
2017-18 *	4	17,160	24.93	\$206.68	\$5,153.32	\$265,215,600
2017-18 *	TOTAL	19,160	27.49	\$199.97	\$5,496.97	\$1,264,083,200
2018-19 **	1	18,470	32.64	\$202.37	\$6,604.88	\$366,008,300
2018-19 **	2	17,890	29.09	\$202.80	\$5,898.60	\$316,611,000
2018-19 **	3	17,750	29.61	\$203.20	\$6,016.87	\$320,476,300
2018-19 **	4	16,850	26.46	\$203.60	\$5,387.86	\$272,327,400
2018-19 **	TOTAL	17,740	29.52	\$202.94	\$5,990.77	\$1,275,423,000
2019-20 **	1	18,380	32.79	\$203.86	\$6,685.10	\$368,545,800
2019-20 **	2	17,850	29.35	\$202.39	\$5,939.55	\$318,084,200
2019-20 **	3	17,740	29.68	\$203.18	\$6,031.42	\$320,943,200
2019-20 **	4	16,830	26.52	\$203.59	\$5,398.27	\$272,627,600
2019-20 **	TOTAL	17,700	29.65	\$203.27	\$6,027.37	\$1,280,200,800

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

H-PE

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	43,440	3.73	\$251.58	\$937.58	\$122,193,400
2016-17 *	2	39,860	3.63	\$241.90	\$877.28	\$104,900,300
2016-17 *	3	40,300	3.55	\$263.45	\$936.27	\$113,203,000
2016-17 *	4	34,040	3.32	\$229.98	\$762.84	\$77,891,700
2016-17 *	TOTAL	39,410	3.57	\$247.78	\$884.27	\$418,188,400
2017-18 *	1	46,050	3.58	\$254.52	\$910.53	\$125,794,600
2017-18 *	2	40,840	3.49	\$248.69	\$868.89	\$106,456,000
2017-18 *	3	44,280	3.37	\$231.43	\$780.68	\$103,706,200
2017-18 *	4	40,260	3.15	\$252.98	\$797.99	\$96,371,400
2017-18 *	TOTAL	42,860	3.41	\$246.85	\$840.64	\$432,328,200
2018-19 **	1	46,500	3.61	\$254.33	\$918.85	\$128,174,500
2018-19 **	2	41,580	3.49	\$251.28	\$876.45	\$109,340,400
2018-19 **	3	43,390	3.42	\$257.94	\$881.22	\$114,716,100
2018-19 **	4	38,760	3.28	\$251.16	\$823.00	\$95,705,000
2018-19 **	TOTAL	42,560	3.46	\$253.81	\$877.08	\$447,936,000
2019-20 **	1	47,260	3.58	\$256.22	\$917.70	\$130,109,300
2019-20 **	2	41,580	3.50	\$251.38	\$878.71	\$109,617,200
2019-20 **	3	43,390	3.42	\$259.40	\$886.20	\$115,369,700
2019-20 **	4	38,760	3.28	\$252.58	\$827.56	\$96,234,000
2019-20 **	TOTAL	42,750	3.45	\$255.05	\$879.79	\$451,330,200

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

LT-ATD

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	7,010	32.71	\$206.19	\$6,745.46	\$141,944,700
2016-17 *	2	6,880	28.70	\$211.00	\$6,055.36	\$125,043,300
2016-17 *	3	6,720	29.22	\$224.84	\$6,570.96	\$132,542,800
2016-17 *	4	6,110	24.59	\$213.07	\$5,239.19	\$96,076,200
2016-17 *	TOTAL	6,680	28.94	\$213.49	\$6,179.48	\$495,606,900
2017-18 *	1	6,470	31.41	\$221.74	\$6,963.94	\$135,093,400
2017-18 *	2	5,870	27.53	\$218.97	\$6,029.23	\$106,222,900
2017-18 *	3	6,770	24.49	\$206.17	\$5,049.35	\$102,527,000
2017-18 *	4	5,480	23.96	\$239.02	\$5,726.84	\$94,080,500
2017-18 *	TOTAL	6,150	26.92	\$220.59	\$5,937.95	\$437,923,800
2018-19 **	1	5,710	32.60	\$225.17	\$7,339.90	\$125,740,700
2018-19 **	2	5,490	29.36	\$226.72	\$6,655.32	\$109,533,300
2018-19 **	3	5,600	29.21	\$224.95	\$6,571.51	\$110,421,700
2018-19 **	4	5,320	25.39	\$224.31	\$5,694.19	\$90,831,800
2018-19 **	TOTAL	5,530	29.20	\$225.32	\$6,579.77	\$436,527,500
2019-20 **	1	5,700	32.92	\$228.28	\$7,515.25	\$128,473,600
2019-20 **	2	5,470	29.64	\$226.49	\$6,713.57	\$110,135,200
2019-20 **	3	5,590	29.25	\$225.07	\$6,584.39	\$110,478,100
2019-20 **	4	5,320	25.37	\$224.94	\$5,707.51	\$91,070,600
2019-20 **	TOTAL	5,520	29.36	\$226.33	\$6,645.39	\$440,157,500

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

POV 250

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	100,620	2.24	\$187.70	\$419.50	\$126,631,400
2016-17 *	2	96,130	1.96	\$203.56	\$398.45	\$114,907,800
2016-17 *	3	96,250	2.27	\$178.48	\$405.41	\$117,065,300
2016-17 *	4	91,670	2.15	\$172.51	\$371.51	\$102,171,000
2016-17 *	TOTAL	96,170	2.16	\$185.25	\$399.28	\$460,775,600
2017-18 *	1	105,920	2.23	\$202.31	\$451.38	\$143,434,400
2017-18 *	2	99,890	2.11	\$194.75	\$410.93	\$123,140,400
2017-18 *	3	105,580	2.13	\$194.06	\$414.18	\$131,186,700
2017-18 *	4	96,790	2.09	\$182.63	\$381.22	\$110,698,100
2017-18 *	TOTAL	102,050	2.14	\$193.81	\$415.22	\$508,459,600
2018-19 **	1	109,240	2.21	\$208.91	\$460.90	\$151,046,200
2018-19 **	2	103,370	2.10	\$203.09	\$427.29	\$132,509,800
2018-19 **	3	106,150	2.13	\$198.07	\$422.53	\$134,549,800
2018-19 **	4	98,630	2.20	\$181.56	\$398.77	\$117,994,100
2018-19 **	TOTAL	104,350	2.16	\$198.21	\$428.14	\$536,100,000
2019-20 **	1	109,630	2.21	\$212.33	\$469.64	\$154,454,200
2019-20 **	2	103,370	2.11	\$205.27	\$433.98	\$134,583,200
2019-20 **	3	106,150	2.14	\$200.67	\$429.38	\$136,731,600
2019-20 **	4	98,630	2.20	\$184.75	\$407.08	\$120,453,000
2019-20 **	TOTAL	104,440	2.17	\$201.08	\$435.82	\$546,222,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MN-OAS

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	78,290	4.67	\$181.35	\$847.22	\$198,980,600
2016-17 *	2	72,860	4.16	\$178.32	\$742.18	\$162,216,000
2016-17 *	3	73,400	4.05	\$189.91	\$768.58	\$169,251,200
2016-17 *	4	68,780	3.69	\$186.47	\$687.76	\$141,901,400
2016-17 *	TOTAL	73,330	4.16	\$183.75	\$764.06	\$672,349,200
2017-18 *	1	82,510	4.14	\$194.21	\$804.59	\$199,169,600
2017-18 *	2	72,410	3.82	\$187.22	\$714.83	\$155,288,600
2017-18 *	3	82,800	3.58	\$179.61	\$643.58	\$159,859,300
2017-18 *	4	70,810	3.50	\$189.29	\$662.13	\$140,649,600
2017-18 *	TOTAL	77,130	3.77	\$187.77	\$707.62	\$654,967,100
2018-19 **	1	83,110	3.86	\$195.27	\$753.08	\$187,756,900
2018-19 **	2	76,880	3.59	\$193.85	\$695.02	\$160,300,900
2018-19 **	3	79,740	3.56	\$192.59	\$686.19	\$164,158,800
2018-19 **	4	74,900	3.45	\$190.13	\$656.64	\$147,550,800
2018-19 **	TOTAL	78,660	3.62	\$193.09	\$698.98	\$659,767,300
2019-20 **	1	86,930	3.82	\$196.17	\$748.95	\$195,312,100
2019-20 **	2	80,610	3.53	\$190.93	\$674.21	\$163,050,300
2019-20 **	3	83,510	3.49	\$190.45	\$664.43	\$166,453,700
2019-20 **	4	78,720	3.37	\$187.55	\$632.62	\$149,401,800
2019-20 **	TOTAL	82,440	3.56	\$191.53	\$681.51	\$674,217,900

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MN-ATD

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	44,540	4.99	\$198.44	\$989.56	\$132,220,800
2016-17 *	2	41,240	4.19	\$197.50	\$828.28	\$102,485,100
2016-17 *	3	41,260	4.46	\$186.58	\$831.94	\$102,970,600
2016-17 *	4	37,800	4.04	\$175.50	\$708.58	\$80,345,600
2016-17 *	TOTAL	41,210	4.44	\$190.45	\$845.33	\$418,022,100
2017-18 *	1	42,770	4.55	\$182.61	\$830.44	\$106,554,000
2017-18 *	2	37,760	4.27	\$175.22	\$747.36	\$84,659,000
2017-18 *	3	43,950	4.09	\$163.20	\$668.05	\$88,089,200
2017-18 *	4	36,800	4.09	\$170.49	\$697.21	\$76,962,500
2017-18 *	TOTAL	40,320	4.25	\$173.12	\$736.33	\$356,264,700
2018-19 **	1	40,290	4.60	\$178.82	\$822.30	\$99,401,700
2018-19 **	2	37,620	4.10	\$176.58	\$723.69	\$81,684,400
2018-19 **	3	39,330	4.04	\$177.65	\$717.00	\$84,609,400
2018-19 **	4	36,850	4.13	\$168.13	\$694.33	\$76,749,900
2018-19 **	TOTAL	38,520	4.22	\$175.50	\$740.75	\$342,445,400
2019-20 **	1	40,730	4.54	\$183.20	\$831.09	\$101,552,300
2019-20 **	2	37,580	4.14	\$176.63	\$731.38	\$82,457,900
2019-20 **	3	39,330	4.04	\$178.80	\$723.19	\$85,320,600
2019-20 **	4	36,860	4.14	\$169.05	\$699.04	\$77,298,900
2019-20 **	TOTAL	38,620	4.22	\$177.25	\$747.87	\$346,629,800

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MN-AFDC

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	464,540	2.62	\$189.42	\$496.66	\$692,158,400
2016-17 *	2	426,370	2.35	\$198.82	\$466.85	\$597,152,600
2016-17 *	3	414,020	2.44	\$192.98	\$471.00	\$585,001,700
2016-17 *	4	391,410	2.28	\$182.65	\$416.86	\$489,496,800
2016-17 *	TOTAL	424,090	2.43	\$191.11	\$464.49	\$2,363,809,500
2017-18 *	1	455,320	2.51	\$202.04	\$508.00	\$693,914,000
2017-18 *	2	413,420	2.36	\$201.27	\$474.90	\$589,002,200
2017-18 *	3	425,890	2.36	\$199.30	\$470.05	\$600,576,800
2017-18 *	4	392,770	2.24	\$192.62	\$431.39	\$508,311,300
2017-18 *	TOTAL	421,850	2.37	\$199.09	\$472.48	\$2,391,804,300
2018-19 **	1	442,560	2.57	\$203.82	\$523.60	\$695,172,500
2018-19 **	2	412,450	2.43	\$203.23	\$493.17	\$610,227,600
2018-19 **	3	405,600	2.41	\$203.88	\$490.64	\$597,009,000
2018-19 **	4	385,050	2.32	\$194.86	\$452.92	\$523,192,500
2018-19 **	TOTAL	411,410	2.44	\$201.69	\$491.31	\$2,425,601,600
2019-20 **	1	444,550	2.58	\$208.37	\$536.70	\$715,770,500
2019-20 **	2	411,490	2.44	\$205.41	\$500.58	\$617,949,000
2019-20 **	3	405,230	2.41	\$206.53	\$497.26	\$604,515,900
2019-20 **	4	385,030	2.32	\$197.18	\$458.07	\$529,110,100
2019-20 **	TOTAL	411,570	2.44	\$204.69	\$499.57	\$2,467,345,400

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MI-C

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	64,200	2.79	\$149.93	\$418.82	\$80,670,600
2016-17 *	2	61,080	2.61	\$150.78	\$392.96	\$72,008,800
2016-17 *	3	56,780	2.75	\$153.12	\$420.55	\$71,631,200
2016-17 *	4	48,960	2.59	\$157.54	\$407.37	\$59,829,400
2016-17 *	TOTAL	57,750	2.69	\$152.50	\$409.98	\$284,140,000
2017-18 *	1	60,760	2.75	\$151.68	\$417.63	\$76,124,500
2017-18 *	2	58,210	2.58	\$151.63	\$391.53	\$68,373,900
2017-18 *	3	56,120	2.70	\$157.88	\$426.72	\$71,846,900
2017-18 *	4	48,290	2.57	\$155.67	\$400.84	\$58,070,600
2017-18 *	TOTAL	55,850	2.66	\$154.09	\$409.48	\$274,416,000
2018-19 **	1	58,930	2.69	\$163.64	\$439.76	\$77,743,400
2018-19 **	2	56,410	2.56	\$161.91	\$414.85	\$70,201,500
2018-19 **	3	53,670	2.68	\$173.21	\$463.94	\$74,700,300
2018-19 **	4	47,450	2.59	\$164.37	\$426.23	\$60,672,900
2018-19 **	TOTAL	54,110	2.63	\$165.77	\$436.30	\$283,318,000
2019-20 **	1	58,600	2.71	\$174.88	\$473.08	\$83,164,200
2019-20 **	2	56,110	2.59	\$168.06	\$435.56	\$73,317,000
2019-20 **	3	53,520	2.69	\$180.87	\$486.71	\$78,141,000
2019-20 **	4	47,380	2.60	\$171.60	\$446.58	\$63,474,000
2019-20 **	TOTAL	53,900	2.65	\$173.95	\$460.87	\$298,096,200

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

MI-A

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	470	26.15	\$198.06	\$5,179.71	\$7,303,400
2016-17 *	2	490	23.26	\$208.47	\$4,848.17	\$7,170,400
2016-17 *	3	460	20.75	\$228.13	\$4,733.51	\$6,518,000
2016-17 *	4	420	21.50	\$196.85	\$4,231.95	\$5,294,200
2016-17 *	TOTAL	460	22.97	\$207.41	\$4,764.56	\$26,286,100
2017-18 *	1	450	26.62	\$221.87	\$5,905.38	\$7,889,600
2017-18 *	2	1,360	10.06	\$178.56	\$1,795.52	\$7,334,700
2017-18 *	3	1,930	8.14	\$186.62	\$1,518.36	\$8,804,900
2017-18 *	4	1,550	7.35	\$214.17	\$1,574.30	\$7,326,800
2017-18 *	TOTAL	1,320	9.96	\$198.42	\$1,975.31	\$31,356,000
2018-19 **	1	1,600	9.45	\$215.38	\$2,034.31	\$9,772,200
2018-19 **	2	1,560	8.45	\$212.30	\$1,794.28	\$8,398,400
2018-19 **	3	1,550	8.62	\$200.58	\$1,728.58	\$8,058,000
2018-19 **	4	1,490	7.70	\$223.20	\$1,719.48	\$7,676,900
2018-19 **	TOTAL	1,550	8.57	\$212.58	\$1,821.83	\$33,905,500
2019-20 **	1	1,580	9.76	\$230.89	\$2,252.67	\$10,645,200
2019-20 **	2	1,560	8.51	\$212.79	\$1,810.91	\$8,476,300
2019-20 **	3	1,550	8.62	\$201.93	\$1,740.25	\$8,112,400
2019-20 **	4	1,490	7.70	\$225.62	\$1,737.38	\$7,756,800
2019-20 **	TOTAL	1,540	8.66	\$218.02	\$1,888.07	\$34,990,700

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

REFUGEE

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	510	2.83	\$136.40	\$386.60	\$589,900
2016-17 *	2	550	2.72	\$129.62	\$352.16	\$582,100
2016-17 *	3	610	2.39	\$140.26	\$335.43	\$610,800
2016-17 *	4	520	2.39	\$135.11	\$322.80	\$499,400
2016-17 *	TOTAL	550	2.58	\$135.31	\$348.60	\$2,282,300
2017-18 *	1	640	2.31	\$104.95	\$242.31	\$467,700
2017-18 *	2	340	2.36	\$120.40	\$284.70	\$290,400
2017-18 *	3	260	2.30	\$109.24	\$251.33	\$198,000
2017-18 *	4	200	2.39	\$115.81	\$276.35	\$161,700
2017-18 *	TOTAL	360	2.33	\$110.92	\$258.56	\$1,117,800
2018-19 **	1	220	1.97	\$161.16	\$318.07	\$209,100
2018-19 **	2	210	1.86	\$137.14	\$254.53	\$159,000
2018-19 **	3	270	1.63	\$144.11	\$235.39	\$193,600
2018-19 **	4	250	2.43	\$132.89	\$322.52	\$243,500
2018-19 **	TOTAL	240	1.97	\$142.95	\$281.58	\$805,200
2019-20 **	1	320	2.08	\$143.11	\$297.20	\$286,100
2019-20 **	2	280	1.97	\$138.15	\$271.95	\$229,300
2019-20 **	3	340	1.73	\$140.53	\$243.35	\$244,600
2019-20 **	4	290	2.38	\$130.69	\$311.02	\$274,500
2019-20 **	TOTAL	310	2.03	\$137.93	\$280.08	\$1,034,500

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

OBRA

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	3,190	4.11	\$243.54	\$1,000.14	\$9,569,300
2016-17 *	2	1,150	4.10	\$317.54	\$1,303.18	\$4,485,600
2016-17 *	3	640	6.12	\$227.44	\$1,391.81	\$2,677,800
2016-17 *	4	450	6.20	\$219.87	\$1,363.92	\$1,837,200
2016-17 *	TOTAL	1,360	4.52	\$252.48	\$1,140.59	\$18,569,900
2017-18 *	1	440	9.09	\$241.07	\$2,190.45	\$2,893,600
2017-18 *	2	240	14.47	\$313.23	\$4,532.94	\$3,286,400
2017-18 *	3	160	18.01	\$263.67	\$4,749.83	\$2,341,700
2017-18 *	4	120	16.06	\$283.97	\$4,561.40	\$1,664,900
2017-18 *	TOTAL	240	12.82	\$273.55	\$3,507.76	\$10,186,500
2018-19 **	1	120	23.57	\$251.08	\$5,918.88	\$2,132,200
2018-19 **	2	110	25.28	\$270.29	\$6,833.89	\$2,208,600
2018-19 **	3	100	26.80	\$264.89	\$7,099.45	\$2,172,900
2018-19 **	4	100	22.11	\$249.09	\$5,506.25	\$1,621,600
2018-19 **	TOTAL	110	24.44	\$259.28	\$6,335.97	\$8,135,300
2019-20 **	1	100	28.81	\$256.82	\$7,400.00	\$2,160,800
2019-20 **	2	100	27.85	\$271.74	\$7,568.81	\$2,210,000
2019-20 **	3	100	28.11	\$264.87	\$7,445.23	\$2,174,000
2019-20 **	4	100	22.41	\$248.81	\$5,575.99	\$1,628,200
2019-20 **	TOTAL	100	26.80	\$261.13	\$6,997.51	\$8,172,900

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

POV 185

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	140,710	2.94	\$260.60	\$767.11	\$323,817,500
2016-17 *	2	126,600	2.84	\$275.02	\$780.65	\$296,492,300
2016-17 *	3	126,500	2.93	\$273.78	\$802.80	\$304,653,400
2016-17 *	4	108,620	2.67	\$260.18	\$695.69	\$226,689,900
2016-17 *	TOTAL	125,610	2.86	\$267.53	\$764.07	\$1,151,653,100
2017-18 *	1	136,910	2.94	\$252.81	\$743.19	\$305,242,900
2017-18 *	2	115,840	2.82	\$293.76	\$827.94	\$287,719,000
2017-18 *	3	115,020	2.91	\$280.51	\$816.39	\$281,706,400
2017-18 *	4	100,530	2.71	\$284.04	\$770.40	\$232,356,800
2017-18 *	TOTAL	117,070	2.85	\$276.12	\$787.97	\$1,107,025,100
2018-19 **	1	117,820	3.00	\$292.19	\$877.61	\$310,211,100
2018-19 **	2	106,460	2.90	\$309.18	\$895.09	\$285,884,200
2018-19 **	3	107,600	2.98	\$304.61	\$908.52	\$293,274,300
2018-19 **	4	96,590	2.77	\$302.80	\$838.05	\$242,830,800
2018-19 **	TOTAL	107,120	2.92	\$301.83	\$880.80	\$1,132,200,400
2019-20 **	1	117,330	3.02	\$306.64	\$927.22	\$326,375,600
2019-20 **	2	106,120	2.92	\$314.29	\$919.08	\$292,584,900
2019-20 **	3	107,470	3.00	\$312.12	\$935.09	\$301,483,200
2019-20 **	4	96,560	2.78	\$310.17	\$862.49	\$249,838,800
2019-20 **	TOTAL	106,870	2.94	\$310.69	\$912.56	\$1,170,282,600

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

POV 133

AVERAGE MONTHLY

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNIT PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2016-17 *	1	76,280	1.95	\$169.63	\$331.48	\$75,854,100
2016-17 *	2	77,570	1.77	\$175.84	\$311.20	\$72,421,100
2016-17 *	3	83,630	1.99	\$157.62	\$314.26	\$78,845,300
2016-17 *	4	80,440	1.91	\$155.90	\$297.67	\$71,837,800
2016-17 *	TOTAL	79,480	1.91	\$164.26	\$313.45	\$298,958,200
2017-18 *	1	91,170	1.95	\$175.74	\$343.31	\$93,901,800
2017-18 *	2	85,390	1.91	\$170.65	\$325.82	\$83,467,300
2017-18 *	3	93,210	1.92	\$173.28	\$333.22	\$93,177,200
2017-18 *	4	83,710	1.87	\$180.00	\$335.84	\$84,335,300
2017-18 *	TOTAL	88,370	1.91	\$174.85	\$334.66	\$354,881,600
2018-19 **	1	96,580	2.00	\$189.31	\$377.89	\$109,485,400
2018-19 **	2	92,360	1.94	\$186.83	\$362.19	\$100,357,900
2018-19 **	3	92,420	1.93	\$185.84	\$358.50	\$99,398,500
2018-19 **	4	83,810	1.99	\$180.98	\$359.82	\$90,470,800
2018-19 **	TOTAL	91,290	1.96	\$185.89	\$364.87	\$399,712,600
2019-20 **	1	95,800	2.00	\$197.76	\$396.28	\$113,890,400
2019-20 **	2	91,750	1.95	\$194.48	\$379.56	\$104,469,000
2019-20 **	3	92,150	1.94	\$193.43	\$374.83	\$103,625,100
2019-20 **	4	83,760	2.00	\$187.93	\$375.11	\$94,252,400
2019-20 **	TOTAL	90,860	1.97	\$193.57	\$381.74	\$416,237,000

* ACTUAL

** ESTIMATED

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

**QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND NOVEMBER 2018 BASE ESTIMATES)**

POV 100

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2016-17 *	1	37,200	2.07	\$182.89	\$378.57	\$42,245,200
2016-17 *	2	37,170	1.82	\$190.65	\$346.50	\$38,639,300
2016-17 *	3	37,740	2.05	\$161.08	\$329.50	\$37,307,500
2016-17 *	4	36,750	1.96	\$162.61	\$319.01	\$35,168,700
2016-17 *	TOTAL	37,210	1.97	\$173.97	\$343.42	\$153,360,800
2017-18 *	1	43,530	2.03	\$195.14	\$396.39	\$51,761,700
2017-18 *	2	41,360	1.93	\$188.37	\$363.54	\$45,105,400
2017-18 *	3	43,360	1.94	\$187.48	\$363.41	\$47,278,300
2017-18 *	4	40,340	1.93	\$192.32	\$371.28	\$44,932,500
2017-18 *	TOTAL	42,150	1.96	\$190.89	\$373.84	\$189,077,900
2018-19 **	1	47,450	2.06	\$200.49	\$412.08	\$58,657,000
2018-19 **	2	43,000	2.04	\$200.45	\$408.71	\$52,723,300
2018-19 **	3	40,750	2.04	\$199.35	\$405.69	\$49,591,200
2018-19 **	4	38,800	2.11	\$186.12	\$392.40	\$45,674,700
2018-19 **	TOTAL	42,500	2.06	\$196.85	\$405.20	\$206,646,200
2019-20 **	1	46,050	2.08	\$208.32	\$434.35	\$60,000,900
2019-20 **	2	42,470	2.05	\$207.24	\$425.01	\$54,150,600
2019-20 **	3	40,470	2.04	\$205.98	\$421.04	\$51,117,400
2019-20 **	4	38,720	2.11	\$192.97	\$407.64	\$47,356,800
2019-20 **	TOTAL	41,930	2.07	\$203.88	\$422.60	\$212,625,700

* ACTUAL

** ESTIMATED

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

Medi-Cal Base Policy Changes

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

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

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

Base Policy Change Service Categories:

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

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2018-19

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$60,773,000	\$44,754,000	\$0	\$16,019,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$23,184,000	\$20,401,920	\$2,782,080	\$0
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,417,000	\$3,006,960	\$410,040	\$0
ELIGIBILITY SUBTOTAL		\$87,374,000	\$68,162,880	\$3,192,120	\$16,019,000
<u>DRUG MEDI-CAL</u>					
56	NARCOTIC TREATMENT PROGRAM	\$128,223,000	\$122,888,710	\$5,334,290	\$0
57	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$15,021,000	\$14,310,420	\$710,580	\$0
58	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$6,775,000	\$4,813,480	\$1,961,520	\$0
59	RESIDENTIAL TREATMENT SERVICES	\$823,000	\$808,180	\$14,820	\$0
DRUG MEDI-CAL SUBTOTAL		\$150,842,000	\$142,820,790	\$8,021,210	\$0
<u>MENTAL HEALTH</u>					
61	SMHS FOR ADULTS	\$1,579,681,000	\$1,455,716,810	\$49,828,190	\$74,136,000
62	SMHS FOR CHILDREN	\$1,325,898,000	\$1,244,199,530	\$39,842,470	\$41,856,000
MENTAL HEALTH SUBTOTAL		\$2,905,579,000	\$2,699,916,340	\$89,670,660	\$115,992,000
<u>MANAGED CARE</u>					
85	TWO PLAN MODEL	\$19,819,226,000	\$13,605,990,350	\$6,213,235,650	\$0
86	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,117,145,000	\$5,616,692,330	\$2,500,452,670	\$0
87	GEOGRAPHIC MANAGED CARE	\$3,600,376,000	\$2,479,310,580	\$1,121,065,420	\$0
91	REGIONAL MODEL	\$1,195,578,000	\$822,832,060	\$372,745,940	\$0
94	PACE (Other M/C)	\$547,615,000	\$271,370,000	\$276,245,000	\$0
95	DENTAL MANAGED CARE (Other M/C)	\$80,927,000	\$50,307,990	\$30,619,010	\$0
96	SENIOR CARE ACTION NETWORK (Other M/C)	\$40,304,000	\$20,152,000	\$20,152,000	\$0
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,536,000	\$6,268,000	\$6,268,000	\$0
101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,149,000	\$1,074,500	\$1,074,500	\$0
MANAGED CARE SUBTOTAL		\$33,415,856,000	\$22,873,997,810	\$10,541,858,190	\$0
<u>OTHER</u>					
162	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,296,170,000	\$1,546,190,500	\$1,749,979,500	\$0
163	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,149,500,000	\$0	\$2,149,500,000	\$0
164	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,688,030,000	\$1,688,030,000	\$0	\$0
165	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$1,906,526,000	\$1,906,526,000	\$0	\$0
166	DENTAL SERVICES	\$485,929,000	\$285,754,490	\$200,174,510	\$0
168	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$267,117,000	\$267,117,000	\$0	\$0

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2018-19**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<u>OTHER</u>				
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$99,725,000	\$99,725,000	\$0	\$0
173	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$45,138,000	\$23,186,500	\$21,951,500	\$0
175	LAWSUITS/CLAIMS	\$33,122,000	\$16,561,000	\$16,561,000	\$0
176	MEDI-CAL TCM PROGRAM	\$30,915,000	\$30,686,000	\$229,000	\$0
183	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,667,000	\$1,667,000	\$0	\$0
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,072,000	\$536,000	\$536,000	\$0
186	EPSDT SCREENS	\$747,000	\$389,840	\$357,160	\$0
196	BASE RECOVERIES	(\$381,841,000)	(\$214,674,000)	(\$167,167,000)	\$0
	OTHER SUBTOTAL	\$9,623,817,000	\$5,651,695,330	\$3,972,121,670	\$0
	GRAND TOTAL	\$46,183,468,000	\$31,436,593,150	\$14,614,863,850	\$132,011,000

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2019-20

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>ELIGIBILITY</u>					
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$59,676,000	\$39,940,000	\$0	\$19,736,000
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$13,009,000	\$10,301,600	\$2,707,400	\$0
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,417,000	\$2,712,220	\$704,780	\$0
	ELIGIBILITY SUBTOTAL	\$76,102,000	\$52,953,820	\$3,412,180	\$19,736,000
<u>DRUG MEDI-CAL</u>					
56	NARCOTIC TREATMENT PROGRAM	\$128,610,000	\$121,595,120	\$7,014,880	\$0
57	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$15,364,000	\$14,407,070	\$956,930	\$0
58	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$6,961,000	\$4,872,600	\$2,088,400	\$0
59	RESIDENTIAL TREATMENT SERVICES	\$851,000	\$830,940	\$20,060	\$0
	DRUG MEDI-CAL SUBTOTAL	\$151,786,000	\$141,705,720	\$10,080,280	\$0
<u>MENTAL HEALTH</u>					
61	SMHS FOR ADULTS	\$1,754,479,000	\$1,606,727,620	\$73,352,380	\$74,399,000
62	SMHS FOR CHILDREN	\$1,381,782,000	\$1,292,899,650	\$43,035,350	\$45,847,000
	MENTAL HEALTH SUBTOTAL	\$3,136,261,000	\$2,899,627,270	\$116,387,730	\$120,246,000
<u>MANAGED CARE</u>					
85	TWO PLAN MODEL	\$20,230,736,000	\$13,733,403,950	\$6,497,332,050	\$0
86	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,138,153,000	\$5,555,557,050	\$2,582,595,950	\$0
87	GEOGRAPHIC MANAGED CARE	\$3,614,500,000	\$2,454,707,560	\$1,159,792,440	\$0
91	REGIONAL MODEL	\$1,206,867,000	\$817,771,800	\$389,095,200	\$0
94	PACE (Other M/C)	\$574,133,000	\$287,066,500	\$287,066,500	\$0
95	DENTAL MANAGED CARE (Other M/C)	\$67,273,000	\$41,311,040	\$25,961,960	\$0
96	SENIOR CARE ACTION NETWORK (Other M/C)	\$51,557,000	\$25,778,500	\$25,778,500	\$0
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$15,701,000	\$7,850,500	\$7,850,500	\$0
101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,009,000	\$504,500	\$504,500	\$0
	MANAGED CARE SUBTOTAL	\$33,899,929,000	\$22,923,951,390	\$10,975,977,610	\$0
<u>OTHER</u>					
162	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,451,743,000	\$1,619,870,500	\$1,831,872,500	\$0
163	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,264,888,000	\$0	\$2,264,888,000	\$0
164	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,841,100,000	\$1,841,100,000	\$0	\$0
165	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$1,985,334,000	\$1,985,334,000	\$0	\$0
166	DENTAL SERVICES	\$993,312,000	\$615,544,300	\$377,767,700	\$0
168	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$240,500,000	\$240,500,000	\$0	\$0

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2019-20**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<u>OTHER</u>				
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$65,300,000	\$65,300,000	\$0	\$0
173	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$47,402,000	\$24,612,000	\$22,790,000	\$0
175	LAWSUITS/CLAIMS	\$32,350,000	\$16,175,000	\$16,175,000	\$0
176	MEDI-CAL TCM PROGRAM	\$34,224,000	\$34,224,000	\$0	\$0
183	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$1,028,000	\$0	\$0
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,126,000	\$563,000	\$563,000	\$0
186	EPSDT SCREENS	\$717,000	\$369,520	\$347,480	\$0
196	BASE RECOVERIES	(\$370,639,000)	(\$208,376,000)	(\$162,263,000)	\$0
	OTHER SUBTOTAL	\$10,588,385,000	\$6,236,244,320	\$4,352,140,680	\$0
	GRAND TOTAL	\$47,852,463,000	\$32,254,482,520	\$15,457,998,480	\$139,982,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>								
4	3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$47,497,000	\$0	\$60,773,000	\$0	\$13,276,000	\$0
5	5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$7,401,000	\$888,120	\$23,184,000	\$2,782,080	\$15,783,000	\$1,893,960
6	6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,412,000	\$409,440	\$3,417,000	\$410,040	\$5,000	\$600
ELIGIBILITY SUBTOTAL			\$58,310,000	\$1,297,560	\$87,374,000	\$3,192,120	\$29,064,000	\$1,894,560
<u>DRUG MEDI-CAL</u>								
57	56	NARCOTIC TREATMENT PROGRAM	\$176,249,000	\$8,119,530	\$128,223,000	\$5,334,290	(\$48,026,000)	(\$2,785,240)
58	57	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$22,788,000	\$955,990	\$15,021,000	\$710,580	(\$7,767,000)	(\$245,410)
60	58	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$8,444,000	\$1,311,590	\$6,775,000	\$1,961,520	(\$1,669,000)	\$649,930
62	59	RESIDENTIAL TREATMENT SERVICES	\$1,282,000	\$53,640	\$823,000	\$14,820	(\$459,000)	(\$38,820)
DRUG MEDI-CAL SUBTOTAL			\$208,763,000	\$10,440,750	\$150,842,000	\$8,021,210	(\$57,921,000)	(\$2,419,540)
<u>MENTAL HEALTH</u>								
63	61	SMHS FOR ADULTS	\$1,560,148,000	\$49,335,620	\$1,579,681,000	\$49,828,190	\$19,533,000	\$492,570
64	62	SMHS FOR CHILDREN	\$1,310,501,000	\$3,172,360	\$1,325,898,000	\$39,842,470	\$15,397,000	\$36,670,110
MENTAL HEALTH SUBTOTAL			\$2,870,649,000	\$52,507,980	\$2,905,579,000	\$89,670,660	\$34,930,000	\$37,162,680
<u>MANAGED CARE</u>								
87	85	TWO PLAN MODEL	\$20,309,108,000	\$6,415,941,270	\$19,819,226,000	\$6,213,235,650	(\$489,882,000)	(\$202,705,620)
88	86	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,190,098,000	\$2,516,398,960	\$8,117,145,000	\$2,500,452,670	(\$72,953,000)	(\$15,946,290)
89	87	GEOGRAPHIC MANAGED CARE	\$3,648,659,000	\$1,143,355,070	\$3,600,376,000	\$1,121,065,420	(\$48,283,000)	(\$22,289,650)
94	91	REGIONAL MODEL	\$1,212,883,000	\$379,661,330	\$1,195,578,000	\$372,745,940	(\$17,305,000)	(\$6,915,390)
95	94	PACE (Other M/C)	\$509,658,000	\$257,829,000	\$547,615,000	\$276,245,000	\$37,957,000	\$18,416,000
97	95	DENTAL MANAGED CARE (Other M/C)	\$123,429,000	\$45,874,990	\$80,927,000	\$30,619,010	(\$42,502,000)	(\$15,255,980)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE								
98	96	SENIOR CARE ACTION NETWORK (Other M/C)	\$41,482,000	\$20,741,000	\$40,304,000	\$20,152,000	(\$1,178,000)	(\$589,000)
100	97	AIDS HEALTHCARE CENTERS (Other M/C)	\$17,325,000	\$8,662,500	\$12,536,000	\$6,268,000	(\$4,789,000)	(\$2,394,500)
102	101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,131,000	\$565,500	\$2,149,000	\$1,074,500	\$1,018,000	\$509,000
MANAGED CARE SUBTOTAL			\$34,053,773,000	\$10,789,029,620	\$33,415,856,000	\$10,541,858,190	(\$637,917,000)	(\$247,171,430)
OTHER								
165	162	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,333,500,000	\$1,775,783,500	\$3,296,170,000	\$1,749,979,500	(\$37,330,000)	(\$25,804,000)
166	163	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,157,906,000	\$2,157,906,000	\$2,149,500,000	\$2,149,500,000	(\$8,406,000)	(\$8,406,000)
168	164	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,895,965,000	\$0	\$1,688,030,000	\$0	(\$207,935,000)	\$0
167	165	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$1,836,141,000	\$0	\$1,906,526,000	\$0	\$70,385,000	\$0
169	166	DENTAL SERVICES	\$1,074,108,000	\$413,429,250	\$485,929,000	\$200,174,510	(\$588,179,000)	(\$213,254,740)
173	168	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$209,741,000	\$0	\$267,117,000	\$0	\$57,376,000	\$0
172	169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$155,445,000	\$0	\$99,725,000	\$0	(\$55,720,000)	\$0
175	173	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$45,515,000	\$22,055,500	\$45,138,000	\$21,951,500	(\$377,000)	(\$104,000)
208	175	LAWSUITS/CLAIMS	\$32,865,000	\$16,432,500	\$33,122,000	\$16,561,000	\$257,000	\$128,500
176	176	MEDI-CAL TCM PROGRAM	\$35,254,000	\$0	\$30,915,000	\$229,000	(\$4,339,000)	\$229,000
187	183	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$0	\$1,667,000	\$0	\$639,000	\$0
188	185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,090,000	\$545,000	\$1,072,000	\$536,000	(\$18,000)	(\$9,000)
177	186	EPSDT SCREENS	\$4,956,000	\$2,381,480	\$747,000	\$357,160	(\$4,209,000)	(\$2,024,320)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
203	196	BASE RECOVERIES	(\$349,320,000)	(\$152,929,000)	(\$381,841,000)	(\$167,167,000)	(\$32,521,000)	(\$14,238,000)
		OTHER SUBTOTAL	\$10,434,194,000	\$4,235,604,230	\$9,623,817,000	\$3,972,121,670	(\$810,377,000)	(\$263,482,560)
		GRAND TOTAL	\$47,625,689,000	\$15,088,880,140	\$46,183,468,000	\$14,614,863,850	(\$1,442,221,000)	(\$474,016,290)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>ELIGIBILITY</u>							
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	\$60,773,000	\$0	\$59,676,000	\$0	(\$1,097,000)	\$0
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$23,184,000	\$2,782,080	\$13,009,000	\$2,707,400	(\$10,175,000)	(\$74,680)
6	MEDI-CAL ACCESS INFANT PROGRAM 266- 322% FPL	\$3,417,000	\$410,040	\$3,417,000	\$704,780	\$0	\$294,740
	ELIGIBILITY SUBTOTAL	\$87,374,000	\$3,192,120	\$76,102,000	\$3,412,180	(\$11,272,000)	\$220,060
<u>DRUG MEDI-CAL</u>							
56	NARCOTIC TREATMENT PROGRAM	\$128,223,000	\$5,334,290	\$128,610,000	\$7,014,880	\$387,000	\$1,680,590
57	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$15,021,000	\$710,580	\$15,364,000	\$956,930	\$343,000	\$246,350
58	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$6,775,000	\$1,961,520	\$6,961,000	\$2,088,400	\$186,000	\$126,880
59	RESIDENTIAL TREATMENT SERVICES	\$823,000	\$14,820	\$851,000	\$20,060	\$28,000	\$5,240
	DRUG MEDI-CAL SUBTOTAL	\$150,842,000	\$8,021,210	\$151,786,000	\$10,080,280	\$944,000	\$2,059,060
<u>MENTAL HEALTH</u>							
61	SMHS FOR ADULTS	\$1,579,681,000	\$49,828,190	\$1,754,479,000	\$73,352,380	\$174,798,000	\$23,524,190
62	SMHS FOR CHILDREN	\$1,325,898,000	\$39,842,470	\$1,381,782,000	\$43,035,350	\$55,884,000	\$3,192,880
	MENTAL HEALTH SUBTOTAL	\$2,905,579,000	\$89,670,660	\$3,136,261,000	\$116,387,730	\$230,682,000	\$26,717,070
<u>MANAGED CARE</u>							
85	TWO PLAN MODEL	\$19,819,226,000	\$6,213,235,650	\$20,230,736,000	\$6,497,332,050	\$411,510,000	\$284,096,400
86	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,117,145,000	\$2,500,452,670	\$8,138,153,000	\$2,582,595,950	\$21,008,000	\$82,143,280
87	GEOGRAPHIC MANAGED CARE	\$3,600,376,000	\$1,121,065,420	\$3,614,500,000	\$1,159,792,440	\$14,124,000	\$38,727,020
91	REGIONAL MODEL	\$1,195,578,000	\$372,745,940	\$1,206,867,000	\$389,095,200	\$11,289,000	\$16,349,260
94	PACE (Other M/C)	\$547,615,000	\$276,245,000	\$574,133,000	\$287,066,500	\$26,518,000	\$10,821,500
95	DENTAL MANAGED CARE (Other M/C)	\$80,927,000	\$30,619,010	\$67,273,000	\$25,961,960	(\$13,654,000)	(\$4,657,040)
96	SENIOR CARE ACTION NETWORK (Other M/C)	\$40,304,000	\$20,152,000	\$51,557,000	\$25,778,500	\$11,253,000	\$5,626,500

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
MANAGED CARE							
97	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,536,000	\$6,268,000	\$15,701,000	\$7,850,500	\$3,165,000	\$1,582,500
101	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,149,000	\$1,074,500	\$1,009,000	\$504,500	(\$1,140,000)	(\$570,000)
	MANAGED CARE SUBTOTAL	\$33,415,856,000	\$10,541,858,190	\$33,899,929,000	\$10,975,977,610	\$484,073,000	\$434,119,420
OTHER							
162	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,296,170,000	\$1,749,979,500	\$3,451,743,000	\$1,831,872,500	\$155,573,000	\$81,893,000
163	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,149,500,000	\$2,149,500,000	\$2,264,888,000	\$2,264,888,000	\$115,388,000	\$115,388,000
164	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,688,030,000	\$0	\$1,841,100,000	\$0	\$153,070,000	\$0
165	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,906,526,000	\$0	\$1,985,334,000	\$0	\$78,808,000	\$0
166	DENTAL SERVICES	\$485,929,000	\$200,174,510	\$993,312,000	\$377,767,700	\$507,383,000	\$177,593,180
168	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$267,117,000	\$0	\$240,500,000	\$0	(\$26,617,000)	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$99,725,000	\$0	\$65,300,000	\$0	(\$34,425,000)	\$0
173	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$45,138,000	\$21,951,500	\$47,402,000	\$22,790,000	\$2,264,000	\$838,500
175	LAWSUITS/CLAIMS	\$33,122,000	\$16,561,000	\$32,350,000	\$16,175,000	(\$772,000)	(\$386,000)
176	MEDI-CAL TCM PROGRAM	\$30,915,000	\$229,000	\$34,224,000	\$0	\$3,309,000	(\$229,000)
183	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,667,000	\$0	\$1,028,000	\$0	(\$639,000)	\$0
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,072,000	\$536,000	\$1,126,000	\$563,000	\$54,000	\$27,000
186	EPSDT SCREENS	\$747,000	\$357,160	\$717,000	\$347,480	(\$30,000)	(\$9,680)
196	BASE RECOVERIES	(\$381,841,000)	(\$167,167,000)	(\$370,639,000)	(\$162,263,000)	\$11,202,000	\$4,904,000
	OTHER SUBTOTAL	\$9,623,817,000	\$3,972,121,670	\$10,588,385,000	\$4,352,140,680	\$964,568,000	\$380,019,010
	GRAND TOTAL	\$46,183,468,000	\$14,614,863,850	\$47,852,463,000	\$15,457,998,480	\$1,668,995,000	\$843,134,630

MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>ELIGIBILITY</u>
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
6	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
	<u>DRUG MEDI-CAL</u>
56	NARCOTIC TREATMENT PROGRAM
57	OUTPATIENT DRUG FREE TREATMENT SERVICES
58	INTENSIVE OUTPATIENT TREATMENT SERVICES
59	RESIDENTIAL TREATMENT SERVICES
	<u>MENTAL HEALTH</u>
61	SMHS FOR ADULTS
62	SMHS FOR CHILDREN
	<u>MANAGED CARE</u>
85	TWO PLAN MODEL
86	COUNTY ORGANIZED HEALTH SYSTEMS
87	GEOGRAPHIC MANAGED CARE
91	REGIONAL MODEL
94	PACE (OTHER M/C)
95	DENTAL MANAGED CARE (OTHER M/C)
96	SENIOR CARE ACTION NETWORK (OTHER M/C)
97	AIDS HEALTHCARE CENTERS (OTHER M/C)
101	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)
	<u>OTHER</u>
162	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
163	MEDICARE PAYMENTS - PART D PHASED-DOWN
164	PERSONAL CARE SERVICES (MISC. SVCS.)
165	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
166	DENTAL SERVICES
168	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
173	WAIVER PERSONAL CARE SERVICES (MISC. SVCS.)
175	LAWSUITS/CLAIMS
176	MEDI-CAL TCM PROGRAM
183	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)
185	HIPP PREMIUM PAYOUTS (MISC. SVCS.)

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

<u>POLICY CHANGE NUMBER</u>	<u>POLICY CHANGE TITLE</u>
	<u>OTHER</u>
186	EPSDT SCREENS
196	BASE RECOVERIES

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2014
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1837

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$60,773,000	\$59,676,000
- STATE FUNDS	\$16,019,000	\$19,736,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$60,773,000	\$59,676,000
STATE FUNDS	\$16,019,000	\$19,736,000
FEDERAL FUNDS	\$44,754,000	\$39,940,000

DESCRIPTION

Purpose:

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

Authority:

AB 99 (Chapter 278, Statutes of 1991)
 SB 800 (Chapter 448, Statutes of 2013)
 SPA CA 18-0028

Interdependent Policy Changes:

Not Applicable

Background:

MCAP covers pregnant women in families with incomes between 213-322% of the FPL. These pregnant and post-partum women are subject to premiums fixed at 1.5% of their adjusted annual income. The Department integrated eligibility rules for MCAP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015. The Department maintained a health plan delivery system for MCAP that was separate from the Medi-Cal delivery system until September 30, 2016. The Department will make final reconciliation payments to health plans under the erstwhile delivery system in FY 2018-19.

Effective October 1, 2016, the Department enrolled new MCAP mothers in the Fee-for-Service (FFS) delivery system. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) CA 18-0028, authorizing the Department to enroll MCAP mothers in the Medi-Cal managed care (MMC) plans, beginning July 1, 2017. All MCAP mothers will remain in the delivery system in which they enrolled until the end of the post-partum period to maintain continuity of care.

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL**BASE POLICY CHANGE NUMBER: 3****Reason for Change:**

The overall net increase from the prior estimate, for FY 2018-19, is due to: updated enrollment data that shows a slight increase in caseload; per member per month (PMPM) and per member per delivery (PMPD) rates increases based on updated expenditures from FY 2017-18; and a decrease in premium contributions, based on updated premium data.

The decrease from FY 2018-19 to FY 2019-20, in the current estimate, resulted from a slight decrease in estimated caseload and deliveries. Additionally, the federal matching rate for Title XXI decreases from 88% to 76.5% beginning October 1, 2019.

Methodology:

1. Based on actual enrollment data from September 2012 through July 2018, the Department estimates the following:

Program Forecast	FY 2018-19	FY 2019-20
Average Monthly Caseload	4,491	4,488
Average Deliveries	599	588
Per Member Per Month (PMPM)	\$ 264.31	\$ 264.31
Supplemental Capitation Payment	\$ 6,986.06	\$ 6,986.06

2. Approximately 7% of new enrollees are initially enrolled in FFS. These enrollees are estimated to be reclassified to Managed Care within two months.
3. MCAP subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total \$2,060,000 in FY 2018-19, and FY 2019-20.
4. The Department assumes 10% of monthly subscribers have a maternity only deductible exceeding \$500 and are ineligible for FFP.
5. The Department anticipates potential risk-sharing agreement payments of \$90,000 due to reconciliation payments in FY 2018-19.
6. The total estimated costs for MCAP mothers in FY 2018-19, and FY 2019-20 are:

(Dollars in Thousands)

FY 2018-19	TF	SF	FF
88% Title XXI FFP / 12% Perinatal Insurance Fund	\$ 52,963	\$ 6,355	\$ 46,608
100% Perinatal Insurance Fund	\$ 9,870	\$ 9,870	\$ -
Premium Payments	\$ (2,060)	\$ (206)	\$ (1,854)
Total	\$ 60,773	\$ 16,019	\$ 44,754

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 3

FY 2019-20	TF	SF	FF
88% Title XXI FFP / 12% Perinatal Insurance Fund	\$ 17,330	\$ 2,080	\$ 15,250
76.5% Title XXI FFP / 23.5% Perinatal Insurance Fund	\$ 34,698	\$ 8,154	\$ 26,544
100% Perinatal Insurance Fund	\$ 9,708	\$ 9,708	\$ -
Premium Payments	\$ (2,060)	\$ (206)	\$ (1,854)
Total	\$ 59,676	\$ 19,736	\$ 39,940

Funding:

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 7/2014
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1823

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$23,184,000	\$13,009,000
- STATE FUNDS	\$2,782,080	\$2,707,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,184,000	\$13,009,000
STATE FUNDS	\$2,782,080	\$2,707,400
FEDERAL FUNDS	\$20,401,920	\$10,301,600

DESCRIPTION

Purpose:

This policy change estimates the costs for the County Health Initiative Matching (CHIM) fund for the County Children's Health Initiative Program (CCHIP).

Authority:

AB 495 (Chapter 648, Statutes of 2001)
 SB 800 (Chapter 448, Statutes of 2013)
 SB 857 (Chapter 31, Statutes of 2014)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

CCHIP integration into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) was completed on March 7, 2016.

COUNTY HEALTH INITIATIVE MATCHING (CHIM)**BASE POLICY CHANGE NUMBER: 5****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is an increase due to shifting prior year funds from FY 2017-18 to FY 2018-19. Additionally, Santa Clara CCHIP received approval to start submitting claims for the April 2016 claim period, and forward. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to prior year funds being paid in FY 2018-19.

Methodology:

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

FY 2018-19	TF	GF	FF
FY 2015-16	\$361,000	\$43,000	\$318,000
Benefits Title XXI 88/12 GF	\$325,000	\$39,000	\$286,000
Admin Title XXI 88/12 GF	\$36,000	\$4,000	\$32,000
FY 2016-17	\$5,403,000	\$649,000	\$4,754,000
Benefits Title XXI 88/12 GF	\$4,863,000	\$584,000	\$4,279,000
Admin Title XXI 88/12 GF	\$540,000	\$65,000	\$475,000
FY 2017-18	\$8,965,000	\$1,076,000	\$7,889,000
Benefits Title XXI 88/12 GF	\$8,068,000	\$968,000	\$7,100,000
Admin Title XXI 88/12 GF	\$897,000	\$108,000	\$789,000
FY 2018-19	\$8,455,000	\$1,015,000	\$7,440,000
Benefits Title XXI 88/12 GF	\$7,609,000	\$913,000	\$6,696,000
Admin Title XXI 88/12 GF	\$846,000	\$102,000	\$744,000
Total FY 2018-19	\$23,184,000	\$2,783,000	\$20,401,000

FY 2019-20	TF	GF	FF
FY 2018-19	\$3,041,000	\$364,000	\$2,677,000
Benefits Title XXI 88/12 GF	\$2,737,000	\$328,000	\$2,409,000
Admin Title XXI 88/12 GF	\$304,000	\$36,000	\$268,000
FY 2019-20	\$9,968,000	\$2,342,000	\$7,626,000
Benefits Title XXI 76.5/23.5 GF	\$8,971,000	\$2,108,000	\$6,863,000
Admin Title XXI 76.5/23.5 GF	\$997,000	\$234,000	\$763,000
Total FY 2019-20	\$13,009,000	\$2,706,000	\$10,303,000

*Totals may differ due to rounding.

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

BASE POLICY CHANGE NUMBER: 5

Funding:

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

76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 11/2013
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1797

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,417,000	\$3,417,000
- STATE FUNDS	\$410,040	\$704,780
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,417,000	\$3,417,000
STATE FUNDS	\$410,040	\$704,780
FEDERAL FUNDS	\$3,006,960	\$2,712,220

DESCRIPTION

Purpose:

This policy change estimates the fee-for-service (FFS) benefit cost, Medi-Cal managed care carve-out costs, and premium payments for the Medi-Cal Access Infant Program (MCAIP) infants with family incomes between 266-322% of the federal poverty level (FPL).

Authority:

AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

Effective November 1, 2013, MCAIP infants transitioned into the Medi-Cal delivery system through a phase-in methodology. MCAIP infants began enrollment into Medi-Cal Managed Care in July 2014.

The Department integrated eligibility rules for MCAIP into the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in October 2015, with additional updates to occur in June 2019. Similar to subscribers enrolled in the Optional Targeted Low Income Children's Program (OTLICP) with family incomes at or above 160% of the FPL, subscribers enrolled in MCAIP are subject to premiums.

Reason for Change:

The slight change from the prior estimate, for FY 2018-19, resulted from a higher percentage of eligibles enrolling in FFS, and updated eligible data, that was lower, compared to the prior estimate. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

BASE POLICY CHANGE NUMBER: 6

Methodology:

1. The Department estimates the following average monthly infants with family income between 266% and 322% FPL will enroll in FY 2018-19 and FY 2019-20:

Delivery System	FY 2018-19	FY 2019-20
FFS	207	207
Medi-Cal Managed Care	609	609
Total Monthly Enrollment	816	816

2. The Department estimates the weighted average PMPM cost in FY 2018-19 and FY 2019-20 is \$792.84 for FFS infants and \$215.65 for Medi-Cal Managed Care infants.
3. MCAIP subscribers are subject to monthly premiums. Premiums are estimated to total \$127,000 in FY 2018-19 and FY 2019-20.
4. The Federal Financial Participation (FFP) for Title XXI funding will decrease from 88% to 76.5% on October 1, 2019, and decrease again to 65% on October 1, 2020.
5. The total estimated costs for MCAIP infants in FY 2018-19 and FY 2019-20 are:
(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Benefits	\$ 3,544	\$ 425	\$ 3,119
Premiums	\$ (127)	\$ (15)	\$ (112)
Net	\$ 3,417	\$ 410	\$ 3,007

FY 2019-20	TF	GF	FF
Benefits	\$ 3,544	\$ 731	\$ 2,813
Premiums	\$ (127)	\$ (26)	\$ (101)
Net	\$ 3,417	\$ 705	\$ 2,712

Funding:

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

76.5% Title XXI FFP/23.5% GF (4260-113-0890/0001)

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 7/2012
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 1728

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$128,223,000	\$128,610,000
- STATE FUNDS	\$5,334,290	\$7,014,880
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$128,223,000	\$128,610,000
STATE FUNDS	\$5,334,290	\$7,014,880
FEDERAL FUNDS	\$122,888,710	\$121,595,120

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Drug Medi-Cal Organized Delivery System Waiver

Background:

The NTP provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions. These services are provided by certified providers under contract with the counties or the State.

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (NTP, Intensive Outpatient Treatment), Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

NARCOTIC TREATMENT PROGRAM**BASE POLICY CHANGE NUMBER: 56**

County participation in the waiver is voluntary. NTP services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due expenditures shifting to the DMC-ODS waiver. FY 2018-19 to FY 2019-20 expenditures remain fairly stable.

Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2015-July 2018) and trending the Users, Units/User, and Rate.

FY 2018-19				FY 2019-20			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

Regular

All Others	1,602	69.5	\$13.72	\$91,689,000	1,595	69.7	\$13.72	\$91,540,000
ACA Optional	7,512	66.0	\$13.77	\$81,956,000	7,510	66.4	\$13.77	\$82,419,000
Regular Subtotal				\$173,645,000				\$173,959,000

Perinatal

All Others	36	91.6	\$15.22	\$606,000	25	92.2	\$15.22	\$607,000
ACA Optional	14	44.2	\$14.81	\$109,000	14	44.3	\$14.81	\$110,000
Perinatal Subtotal				\$715,000				\$717,000

Total				\$174,360,000				\$174,676,000
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- Rates include Final RY 2017-18 rate increases. RY 2018-19 rate increases are not included in this policy change. RY 2018-19 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.
- Funding for the services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88% until September 30, 2019 and 76.5% October 2019 through September 2020. Funding for the ACA Optional beneficiaries 94% FF / 6% GF in 2018, 93% FF / 7% GF in 2019, and 90% FF / 10% GF 2020 and thereafter. Total estimated reimbursements for NTP services are (County Funds are not included in the Total Funds below):

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 56

FY 2018-19	TF	GF	FF	County
50% Title XIX / 50% GF	\$46,134,000	\$0	\$46,134,000	\$46,134,000
ACA 93% FFP / 7% GF (2019)	\$41,033,000	\$2,872,000	\$38,161,000	\$0
ACA 94% FFP / 6% GF (2018)	\$41,033,000	\$2,462,000	\$38,571,000	\$0
88% Title XXI / 12% GF	\$23,000	\$0	\$23,000	\$3,000
Total	\$128,223,000	\$5,334,000	\$122,889,000	\$46,137,000

FY 2019-20	TF	GF	FF	County
50% Title XIX / 50% GF	\$46,061,000	\$0	\$46,061,000	\$46,060,000
ACA 90% FFP/10% GF (2020)	\$41,264,000	\$4,126,000	\$37,138,000	\$0
ACA 93% FFP/7% GF (2019)	\$41,264,000	\$2,888,000	\$38,376,000	\$0
76.5% Title XXI / 23.5% GF (9/2019)	\$16,000	\$0	\$16,000	\$5,000
88% Title XXI / 12% GF	\$5,000	\$0	\$5,000	\$2,000
Total	\$128,610,000	\$7,014,000	\$121,594,000	\$46,067,000

Funding:

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

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

76.5% Title XXI FF / 33.5% GF (4260-113-0001/0890)

94% ACA Title XIX FF / 6% GF (4260-101-001/0890)

93% ACA Title XIX FF / 7% GF (4260-101-001/0890)

90% ACA Title XIX FF / 10% GF (4260-101-001/0890)

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 57
IMPLEMENTATION DATE: 7/2012
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 1727

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$15,021,000	\$15,364,000
- STATE FUNDS	\$710,580	\$956,930
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,021,000	\$15,364,000
STATE FUNDS	\$710,580	\$956,930
FEDERAL FUNDS	\$14,310,420	\$14,407,070

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Drug Medi-Cal Organized Delivery System Waiver

Background:

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

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

These services are provided by certified providers under contract with the counties or with the State.

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 57

extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. ODF services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due expenditures shifting to the DMC-ODS waiver. FY 2018-19 to FY 2019-20 expenditures remain fairly stable.

Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2015-July 2018) and trending the Users, Units/User, and Rate.

FY 2018-19				FY 2019-20			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

Regular

All Others	450	7.8	\$35.70	\$7,478,000	457	7.8	\$35.68	\$7,603,000
ACA Optional	2,713	9.1	\$36.78	\$10,893,000	2,787	9.1	\$36.80	\$11,220,000
Regular Total				\$18,371,000				\$18,823,000

Perinatal

All Others	14	18.4	\$47.80	\$302,000	14	18.3	\$47.89	\$304,000
ACA Optional	9	9.3	\$39.76	\$39,000	8	9.7	\$39.89	\$38,000
Perinatal Total				\$341,000				\$342,000

Total				\$18,712,000				\$19,165,000
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- Rates include Final RY 2017-18 rate increases. RY 2018-19 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.
- Funding for the services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88% until September 30, 2019 and 76.5% October 2019 through September 2020. Funding for the ACA Optional beneficiaries 94% FF / 6% GF in 2018, 93% FF / 7% GF in 2019, and 90% FF / 10% GF 2020 and thereafter. Total estimated reimbursements for ODF services are (County Funds are not included in the Total Funds below):

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 57

FY 2018-19	TF	GF	FF	County
50% Title XIX / 50% GF	\$3,630,000	\$0	\$3,630,000	\$3,629,000
ACA 93% FFP / 7% GF (2019)	\$5,466,000	\$383,000	\$5,083,000	\$0
ACA 94% FFP / 6% GF (2018)	\$5,466,000	\$328,000	\$5,138,000	\$0
88% Title XXI / 12% GF	\$459,000	\$0	\$459,000	\$63,000
Total	\$15,021,000	\$711,000	\$14,310,000	\$3,692,000

FY 2019-20	TF	GF	FF	County
50% Title XIX / 50% GF	\$3,693,000	\$0	\$3,693,000	\$3,693,000
ACA 90% FFP/10% GF (2020)	\$5,629,000	\$563,000	\$5,066,000	\$0
ACA 93% FFP/7% GF (2019)	\$5,629,000	\$394,000	\$5,235,000	\$0
76.5% Title XXI / 23.5% GF (9/2019)	\$299,000	\$0	\$299,000	\$92,000
88% Title XXI / 12% GF	\$114,000	\$0	\$114,000	\$16,000
Total	\$15,364,000	\$957,000	\$14,407,000	\$3,801,000

Funding:

50% Title XIX FF (4260-101-0890) / 50% CF
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
76.5% Title XXI FF / 33.5% GF (4260-113-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58
IMPLEMENTATION DATE: 7/2012
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 1726

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$6,775,000	\$6,961,000
- STATE FUNDS	\$1,961,520	\$2,088,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,775,000	\$6,961,000
STATE FUNDS	\$1,961,520	\$2,088,400
FEDERAL FUNDS	\$4,813,480	\$4,872,600

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Drug Medi-Cal Organized Delivery System Waiver

Background:

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

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

These services are provided by certified providers under contract with the counties or with the State.

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30, 2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. IOT services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due expenditures shifting to the DMC-ODS waiver. FY 2018-19 to FY 2019-20 expenditures remain fairly stable.

Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2015-July 2018) and trending the Users, Units/User, and Rate.

FY 2018-19				FY 2019-20			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

Regular

All Others	78	13.4	\$58.51	\$3,665,000	81	13.4	\$58.50	\$3,783,000
ACA Optional	311	11.9	\$58.55	\$2,612,000	322	11.8	\$58.54	\$2,666,000
Regular Total				\$6,277,000				\$6,449,000

Perinatal

All Others	17	23.4	\$83.43	\$803,000	18	22.7	\$83.43	\$832,000
ACA Optional	6	15.2	\$84.42	\$96,000	6	15.2	\$84.42	\$97,000
Perinatal Total				\$899,000				\$929,000

Total				\$7,176,000				\$7,378,000
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- Rates include Final RY 2017-18 rate increases. RY 2018-19 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.
- Funding for the services is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 88% until September 30, 2019 and 76.5% October 2019 through September 2020. Funding for the ACA Optional beneficiaries 94% FF / 6% GF in 2018, 93% FF / 7% GF in 2019, and 90% FF / 10% GF 2020 and thereafter. Total estimated reimbursements for IOT services are (County Funds are not included in Total Funds):

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 58

FY 2018-19	TF	GF	FF	County
50% Title XIX / 50% GF	\$3,942,000	\$1,770,000	\$2,171,000	\$401,000
ACA 93% FFP / 7% GF (2019)	\$1,354,000	\$95,000	\$1,259,000	\$0
ACA 94% FFP / 6% GF (2018)	\$1,354,000	\$81,000	\$1,273,000	\$0
88% Title XXI / 12% GF	\$125,000	\$15,000	\$110,000	\$0
Total	\$6,774,000	\$1,961,000	\$4,813,000	\$401,000

FY 2019-20	TF	GF	FF	County
50% Title XIX / 50% GF	\$4,070,000	\$1,827,000	\$2,243,000	\$416,000
ACA 90% FFP/10% GF (2020)	\$1,381,000	\$138,000	\$1,243,000	\$0
ACA 93% FFP/7% GF (2019)	\$1,381,000	\$97,000	\$1,284,000	\$0
76.5% Title XXI / 23.5% GF (9/2019)	\$97,000	\$23,000	\$74,000	\$0
88% Title XXI / 12% GF	\$32,000	\$4,000	\$28,000	\$0
Total	\$6,961,000	\$2,089,000	\$4,872,000	\$416,000

Funding:

50% Title XIX FF (4260-101-0890) / 50% CF
50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
76.5% Title XXI FF / 33.5% GF (4260-113-0001/0890)
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 59
IMPLEMENTATION DATE: 7/2012
ANALYST: Devon Dyer
FISCAL REFERENCE NUMBER: 1725

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$823,000	\$851,000
- STATE FUNDS	\$14,820	\$20,060
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$823,000	\$851,000
STATE FUNDS	\$14,820	\$20,060
FEDERAL FUNDS	\$808,180	\$830,940

DESCRIPTION

Purpose:

This policy change estimates the Drug Medi-Cal (DMC) Residential Treatment Services (RTS) expenditures.

Authority:

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

Interdependent Policy Changes:

Drug Medi-Cal Organized Delivery System Waiver

Background:

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

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

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

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

The responsibility for Drug Medi-Cal services was realigned to the counties as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, new state requirements enacted after September 30,

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 59

2012, increase the costs beyond the 2011 Realignment programs or levels of service, shall apply to the extent that the state provides funding for the increase.

On August 13, 2015, the Department received approval from the Centers for Medicare and Medicaid Services to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder. DMC-ODS waiver services will include the existing treatment modalities (Narcotic Treatment Program, IOT, Outpatient Drug Free, and Perinatal Residential Treatment Services), and additional new and expanded services.

County participation in the waiver is voluntary. Residential services expenditures for participating counties will be shifted to the Drug Medi-Cal Organized Delivery System Waiver policy change as implementation occurs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due expenditures shifting to the DMC-ODS waiver. FY 2018-19 to FY 2019-20 expenditures remain fairly stable.

Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2015-July 2018) and trending the Users, Units/User, and Rate.

FY 2018-19				FY 2019-20				
Average Monthly				Average Monthly				
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total	
Perinatal								
All Others	17	32.8	\$87.19	\$1,188,000	18	33.0	\$87.17	\$1,231,000
ACA Optional	9	23.1	\$87.11	\$228,000	10	23.5	\$87.08	\$236,000
Total			\$1,416,000				\$1,467,000	

- Funding for RTS perinatal service is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Funding for the ACA Optional beneficiaries 94% FF / 6% GF in 2018, 93% FF / 7% GF in 2019, and 90% FF / 10% GF 2020 and thereafter. Total estimate reimbursements for Residential services are County Funds are not included in the Total Funds below):

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 59

FY 2018-19	TF	GF	FF	County
50% Title XIX / 50% GF	\$594,000	\$0	\$594,000	\$594,000
ACA 93% FFP / 7% GF (2019)	\$114,000	\$8,000	\$106,000	\$0
ACA 94% FFP / 6% GF (2018)	\$114,000	\$7,000	\$107,000	\$0
Total	\$822,000	\$15,000	\$807,000	\$594,000

FY 2019-20	TF	GF	FF	County
50% Title XIX / 50% GF	\$615,000	\$0	\$615,000	\$615,000
ACA 90% FFP/10% GF (2020)	\$118,000	\$12,000	\$106,000	\$0
ACA 93% FFP/7% GF (2019)	\$118,000	\$8,000	\$110,000	\$0
Total	\$851,000	\$20,000	\$831,000	\$615,000

Funding:

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

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

94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)

93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)

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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1780

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,579,681,000	\$1,754,479,000
- STATE FUNDS	\$123,964,190	\$147,751,380
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,579,681,000	\$1,754,479,000
STATE FUNDS	\$123,964,190	\$147,751,380
FEDERAL FUNDS	\$1,455,716,810	\$1,606,727,620

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 reimbursement through claims to the State. MHPs are responsible for most of 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: 61

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 2018-19, is a net increase due to:

- Updated estimated Affordable Care Act (ACA) utilization and costs for SD/MC and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through June 2018, and
- Updated SD/MC and FFS Inpatient payment lags based on updated paid claims data.

The change between FY 2018-19 and FY 2019-20, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2019-20, based on projections and updated payment lags for SD/MC and FFS inpatient claims.

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 June 30, 2018, with dates of service from June 2012 through March 2018. The FFS data is current as of June 30, 2018, with dates of service from April 2012 through January 2018.
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: 61**

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 2018-19 Utilization	FY 2019-20 Utilization
SD/MC	213,885	210,725
SD/MC ACA	168,855	196,612
FFS	13,181	13,191
FFS ACA	18,236	20,808
Total	414,157	441,336

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 2016-17	\$1,913,875	\$1,656,640	\$257,235
FY 2017-18	\$2,089,882	\$1,804,152	\$285,730
FY 2018-19	\$2,287,336	\$1,974,784	\$312,552
FY 2019-20	\$2,484,789	\$2,145,415	\$339,374

6. On a cash basis for FY 2018-19, the Department will be paying 1% of FY 2016-17 claims, 64% of FY 2017-18 claims, and 35% of FY 2018-19 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2016-17 claims, 25% of FY 2017-18 claims, and 74% of FY 2018-19 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2016-17	\$19,139	\$16,567	\$2,572
FY 2017-18	\$1,226,090	\$1,154,658	\$71,432
FY 2018-19	\$927,222	\$695,193	\$232,029
Total FY 2018-19	\$2,172,451	\$1,866,418	\$306,033

7. On a cash basis for FY 2019-20, the Department will be paying 1% of FY 2017-18 claims, 64% of FY 2018-19 claims, and 35% of FY 2019-20 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2017-18 claims, 25% of FY 2018-19 claims, and 74% of FY 2019-20 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	\$20,899	\$18,042	\$2,857
FY 2018-19	\$1,342,000	\$1,263,862	\$78,138
FY 2019-20	\$1,007,203	\$755,262	\$251,941
Total FY 2019-20	\$2,370,102	\$2,037,166	\$332,936

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 61

8. The chart below shows the FY 2018-19 and FY 2019-20 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, 93% FF and 7% GF until December 31, 2019, and 90% FF and 10% GF beginning January 2020;
- GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars in Thousands)

Fiscal Year	TF	FF	ACA FF	ACA GF	GF Reimbursement	County
FY 2018-19	\$2,172,451	\$666,906	\$788,811	\$49,828	\$74,136	\$592,770
FY 2019-20	\$2,370,102	\$690,021	\$916,707	\$73,352	\$74,399	\$615,623

Funding:

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

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)

93% Title XIX FF / 7% GF (4260-101-0001/0890)

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 62
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1779

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,325,898,000	\$1,381,782,000
- STATE FUNDS	\$81,698,470	\$88,882,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,325,898,000	\$1,381,782,000
STATE FUNDS	\$81,698,470	\$88,882,350
FEDERAL FUNDS	\$1,244,199,530	\$1,292,899,650

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking reimbursement through claims to the State. MHPs are responsible for most of 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.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 62

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

The following Medi-Cal SMHS are available for children:

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

*Children - Age 18 through 20

Reason for Change:

The change from the prior estimate, FY 2018-19, is a net increase due to:

- Updated estimated Affordable Care Act (ACA) utilization and costs for SD/MC and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through June 30, 2018,
- Updated SD/MC and FFS Inpatient payment lags based on updated paid claims data, and
- Including the estimated funding for full scope undocumented children at 100% General Fund (GF).

The change between FY 2018-19 and FY 2019-20, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2019-20 based on projections and updated payment lags for SD/MC and FFS Inpatient claims.

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 June 30, 2018, with dates of service from June 2012 through March 2018. The FFS data is current as of June 30, 2018, with dates of service from April 2012 through January 2018.
2. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent 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 CHILDREN

BASE POLICY CHANGE NUMBER: 62

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

Children	FY 2018-19 Utilization	FY 2019-20 Utilization
SD/MC	293,283	301,410
SD/MC ACA	10,108	11,770
FFS	13,780	14,381
FFS ACA	1,998	2,317
Total	319,169	329,878

4. 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 2016-17	\$1,967,535	\$1,873,067	\$94,468
FY 2017-18	\$2,158,524	\$2,051,865	\$106,659
FY 2018-19	\$2,278,791	\$2,163,745	\$115,046
FY 2019-20	\$2,399,058	\$2,275,626	\$123,432

5. On a cash basis for FY 2018-19, the Department will be paying 1% of FY 2016-17 claims, 64% of FY 2017-18 claims, and 35% of FY 2018-19 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2016-17 claims, 25% of FY 2017-18 claims, and 74% of FY 2018-19 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2016-17	\$19,676	\$18,731	\$945
FY 2017-18	\$1,335,429	\$1,309,017	\$26,412
FY 2018-19	\$847,121	\$761,715	\$85,406
Total FY 2018-19	\$2,202,226	\$2,089,463	\$112,763

6. On a cash basis for FY 2019-20, the Department will be paying 1% of FY 2017-18 claims, 64% of FY 2018-19 claims, and 35% of FY 2019-20 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2017-18 claims, 25% of FY 2018-19 claims, and 74% of FY 2019-20 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2017-18	\$21,586	\$20,519	\$1,067
FY 2018-19	\$1,408,882	\$1,380,393	\$28,489
FY 2019-20	\$892,733	\$801,101	\$91,632
Total FY 2019-20	\$2,323,201	\$2,202,013	\$121,188

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 62

7. On a cash basis, the Department estimates SD/MC costs of \$36,439,000 in FY 2018-19 and \$38,019,000 in FY 2019-20, for full scope undocumented children funded with 100% GF.
8. The chart below shows the FY 2018-19 and FY 2019-20 estimate with the following funding adjustments:
- Individuals under age 19, who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship, full scope Medi-Cal benefits effective May 1, 2016, and reimbursed with 100% GF.
 - Medi-Cal claims are eligible for 50% federal reimbursement,
 - MCHIP claims are eligible for 88% federal reimbursement (through September 30, 2019) and 76.5% federal reimbursement (beginning October 1, 2019),
 - ACA is funded by 100% federal funds (FF) until December 31, 2016, 95% FF / 5% GF until December 31, 2017, 94% FF / 6% GF until December 31, 2018, 93% FF / 7% GF until December 31, 2019, and 90% FF / 10% GF beginning January 1, 2020, 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)

Fiscal Year	TF	GF	FF	MCHIP	ACA FF	ACA GF	GF Reimb.	CF
FY 2018-19	\$2,202,226	\$36,439	\$875,189	\$315,301	\$53,709	\$3,404	\$41,856	\$876,328
FY 2019-20	\$2,323,201	\$38,019	\$901,876	\$328,618	\$62,406	\$5,016	\$45,847	\$941,419

Funding:

100% GF (4260-101-0001)

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)

93% Title XIX FF / 7% GF (4260-101-0001/0890)

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

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 56

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$19,819,226,000	\$20,230,736,000
- STATE FUNDS	\$6,213,235,650	\$6,497,332,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$19,819,226,000	\$20,230,736,000
STATE FUNDS	\$6,213,235,650	\$6,497,332,050
FEDERAL FUNDS	\$13,605,990,350	\$13,733,403,950

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:

Capitated Rate Adjustment for FY 2019-20

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.

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.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 85

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to lower than previously expected eligible months.

The change from FY 2018-19 to FY 2019-20, is an increase in the current estimate due to higher eligible months.

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. FY 2018-19 draft weighted rates have been updated from the previous estimate. FY 2018-19 draft weighted rates are budgeted in FY 2019-20.
3. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$210,600,000 for FY 2018-19 and \$210,600,000 for FY 2019-20 were included in the rates.
4. The savings from AB 97 are included in the rates. Savings of \$241,000,000 for FY 2018-19 and \$241,000,000 for FY 2019-20 were included in the rates.
5. Services provided through the LA Mobile Vision Pilot Project are no longer included in the base rates, as of July 1, 2018.
6. Acupuncture services are included in the rates as of July 1, 2016.
7. Indian Health Services supplemental payments are budgeted in the base PCs.
8. Non-Medical Transportation (NMT) for covered Managed Care services are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.
9. The County Health Initiative Matching (CHIM) Program is expected to be transitioned to Medi-Cal Managed Care for Santa Clara and San Francisco counties no sooner than January 1, 2019. The costs associated with CHIM are not currently reflected in this PC.
10. Services covered through the Pediatric Palliative Care Waiver will be transitioned to Medi-Cal Managed Care no sooner than January 1, 2019. The anticipated costs associated with this transition are reflected in the FY 2018-19 base rates.
11. 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.
12. The Department receives federal reimbursement of 90% for family planning services.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 85

13. 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. This FMAP split will become 76.5/23.5 on October 1, 2019.
14. Of the nonfederal share for this policy change in FY 2018-19, \$217.7 million in new growth as compared to the 2016 Budget Act will be funded with Proposition 56 revenue.
15. Two Plan Model costs on an accrual basis are:

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Alameda	3,886,192	\$1,017,942
Contra Costa	2,523,439	\$676,583
Kern	3,988,708	\$884,012
Los Angeles	36,982,568	\$8,786,189
Riverside	8,350,281	\$1,947,242
San Bernardino	8,364,552	\$1,959,258
San Francisco	1,799,686	\$577,132
San Joaquin	2,884,494	\$650,224
Santa Clara	3,880,937	\$870,820
Stanislaus	2,370,802	\$596,200
Tulare	2,498,714	\$448,175
Fresno	4,911,838	\$1,115,745
Kings	580,271	\$119,161
Madera	678,778	\$128,684
Total	83,701,261	\$19,777,367
Hepatitis C Adjustment		\$244,974
Total FY 2018-19		\$20,022,341

(Dollars in Thousands)

Included in the Above Dollars	FY 2018-19
Mental Health	\$210,600
AB 97	(\$241,000)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 85

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Alameda	3,918,741	\$1,030,207
Contra Costa	2,545,459	\$685,906
Kern	4,020,638	\$895,061
Los Angeles	37,317,778	\$8,893,532
Riverside	8,413,332	\$1,969,241
San Bernardino	8,432,736	\$1,982,271
San Francisco	1,827,229	\$587,708
San Joaquin	2,902,569	\$656,612
Santa Clara	3,917,975	\$881,822
Stanislaus	2,394,582	\$604,991
Tulare	2,515,698	\$452,402
Fresno	4,968,612	\$1,136,087
Kings	584,353	\$120,410
Madera	681,624	\$129,555
Total	84,441,324	\$20,025,805
Hepatitis C Adjustment		\$219,538
Total FY 2019-20		\$20,245,343

(Dollars in Thousands)

Included in the Above Dollars	FY 2019-20
Mental Health	\$210,600
AB 97	(\$241,000)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 85

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

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	SF
Title XIX 50/50	\$10,731,071	\$5,365,536	\$5,365,536	\$0
State GF	\$32,754	\$32,754	\$0	\$0
ACA 94/6 GF	\$4,491,452	\$269,487	\$4,221,965	\$0
ACA 93/7 GF	\$3,292,149	\$230,450	\$3,061,699	\$0
Family Planning 90/10 GF	\$130,926	\$13,093	\$117,833	\$0
Title XXI 88/12 GF	\$701,650	\$84,198	\$617,452	\$0
Healthcare Treatment Fund	\$217,718	\$0	\$0	\$217,718
Title XIX 100%	\$221,506	\$0	\$221,506	\$0
Total	\$19,819,226	\$5,995,518	\$13,605,991	\$217,718

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX 50/50	\$11,295,715	\$5,647,858	\$5,647,858
State GF	\$32,626	\$32,626	\$0
ACA 93/7 GF	\$4,698,244	\$328,877	\$4,369,367
ACA 90/10 GF	\$3,366,512	\$336,651	\$3,029,861
Family Planning 90/10 GF	\$130,696	\$13,070	\$117,626
Title XXI 88/12 GF	\$234,316	\$28,118	\$206,198
Title XXI 76.5/23.5 GF	\$468,650	\$110,132	\$358,518
Title XIX 100%	\$3,977	\$0	\$3,977
Total	\$20,230,736	\$6,497,332	\$13,733,405

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 12/1987
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 57

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$8,117,145,000	\$8,138,153,000
- STATE FUNDS	\$2,500,452,670	\$2,582,595,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,117,145,000	\$8,138,153,000
STATE FUNDS	\$2,500,452,670	\$2,582,595,950
FEDERAL FUNDS	\$5,616,692,330	\$5,555,557,050

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:

Capitated Rate Adjustment for FY 2019-20

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.

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.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 86

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to lower than previously expected eligible months.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to higher eligible months.

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. 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).
3. FY 2018-19 draft weighted rates have been updated from the previous estimate. Draft FY 2018-19 weighted rates are budgeted for FY 2019-20.
4. 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.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$133,875,000 for FY 2018-19 and FY 2019-20 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$67,273,000 for FY 2018-19 and FY 2019-20 were included in the rates.
7. Indian Health Services supplemental payments are budgeted in the base PCs.
8. Non-Medical Transportation (NMT) for covered Managed Care services are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.
9. The MCAP services are included in the base rates as of July 1, 2017.
10. As of July 1, 2018, Whole Child Model costs for Health Plan of San Mateo are budgeted in this PC.
11. The Department receives 90% federal reimbursement for family planning services.
12. 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. This FMAP split will become 76.5/23.5 on October 1, 2019.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 86

13. COHS dollars on an accrual basis are:

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
501- San Luis Obispo	640,033	\$182,314
502- Santa Barbara	1,511,060	\$418,173
503- San Mateo	1,312,019	\$415,936
504- Solano	1,309,786	\$487,910
505- Santa Cruz	822,578	\$241,271
506-Orange	9,139,178	\$2,713,842
507- Napa	340,226	\$123,111
508-Monterey	1,903,536	\$462,763
509- Yolo	635,489	\$235,550
513- Sonoma	1,304,408	\$443,709
514- Merced	1,496,591	\$367,797
510 - Marin	458,458	\$178,522
512 - Mendocino	467,102	\$154,007
515 - Ventura	2,401,509	\$690,791
523 - Del Norte	138,349	\$51,053
517 - Humboldt	631,731	\$225,784
511 - Lake	372,157	\$131,087
518 - Lassen	88,877	\$31,901
519 - Modoc	37,711	\$14,456
520 - Shasta	719,412	\$274,021
521 - Siskiyou	211,935	\$72,234
522 - Trinity	52,645	\$19,257
Total FY 2018-19	25,994,788	\$7,935,489
Hepatitis C Adjustment		\$95,632
Total with Adjustments		\$8,031,121

(Dollars in Thousands)

Included in Above Dollars	FY 2018-19
Mental Health	\$133,875
AB 97	(\$67,273)

COUNTY ORGANIZED HEALTH SYSTEMS**BASE POLICY CHANGE NUMBER: 86**

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
501- San Luis Obispo	641,726	\$182,868
502- Santa Barbara	1,524,298	\$423,428
503- San Mateo	1,321,190	\$417,808
504- Solano	1,315,744	\$490,709
505- Santa Cruz	830,460	\$243,913
506-Orange	9,198,980	\$2,739,725
507- Napa	341,847	\$123,857
508-Monterey	1,915,133	\$466,580
509- Yolo	638,209	\$236,808
513- Sonoma	1,314,351	\$447,769
514- Merced	1,505,408	\$370,421
510 - Marin	462,673	\$180,378
512 - Mendocino	470,596	\$155,496
515 - Ventura	2,419,945	\$697,722
523 - Del Norte	139,181	\$51,425
517 - Humboldt	638,858	\$228,765
511 - Lake	375,987	\$132,541
518 - Lassen	89,542	\$32,163
519 - Modoc	37,923	\$14,556
520 - Shasta	724,570	\$276,348
521 - Siskiyou	213,794	\$72,979
522 - Trinity	53,019	\$19,419
Total FY 2019-20	26,173,435	\$8,005,678
Hepatitis C Adjustment		\$85,702
Total with Adjustments		\$8,091,380

(Dollars in Thousands)

Included in Above Dollars	FY 2019-20
Mental Health	\$133,875
AB 97	(\$67,273)

COUNTY ORGANIZED HEALTH SYSTEMS**BASE POLICY CHANGE NUMBER: 86****Funding:**

The dollars below account for a one month payment deferral:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	\$4,471,307	\$2,235,654	\$2,235,654
State GF	\$10,103	\$10,103	\$0
Family Planning 90/10 GF	\$46,805	\$4,681	\$42,125
Title XXI 88/12 GF	\$376,357	\$45,163	\$331,193
ACA Optional Expansion 94/6	\$1,870,454	\$112,228	\$1,758,226
ACA Optional Expansion 93/7	\$1,323,223	\$92,626	\$1,230,597
Title XIX 100% FFP	\$18,896	\$0	\$18,896
Total	\$8,117,145	\$2,500,454	\$5,616,691

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX 50/50	\$4,454,857	\$2,227,428	\$2,227,428
State GF	\$10,095	\$10,095	\$0
Family Planning 90/10 GF	\$46,549	\$4,655	\$41,894
Title XXI 88/12 GF	\$124,451	\$14,933	\$109,518
Title XXI 76.5/23.5 GF	\$249,996	\$58,750	\$191,246
ACA Optional Expansion 93/7	\$1,883,401	\$131,838	\$1,751,563
ACA Optional Expansion 90/10	\$1,348,963	\$134,897	\$1,214,067
Title XIX 100% FFP	\$19,841	\$0	\$19,841
Total	\$8,138,153	\$2,582,596	\$5,555,557

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 4/1994
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 58

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,600,376,000	\$3,614,500,000
- STATE FUNDS	\$1,121,065,420	\$1,159,792,440
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,600,376,000	\$3,614,500,000
STATE FUNDS	\$1,121,065,420	\$1,159,792,440
FEDERAL FUNDS	\$2,479,310,580	\$2,454,707,560

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:

Capitated Rate Adjustment for FY 2019-20

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 implemented two new health plans in Sacramento and San Diego, United Healthcare Community Plan of California (United) and Aetna Better Health of California (Aetna). United began providing services on October 1, 2017, and Aetna began providing services on January 1, 2018. Effective November 1, 2018, United will no longer provide services in Sacramento County. United will continue to provide services in San Diego County.

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.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 87

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to lower than previously expected eligible months and mental health costs.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase in the current estimate due to higher eligible months

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. FY 2018-19 draft weighted rates have been updated from the previous estimate. FY 2018-19 draft weighted rates are budgeted in FY 2019-20.
3. 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.
4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$44,100,000 for FY 2018-19 and FY 2019-20 were included in the rates.
5. The savings from AB 97 are included in the rates. Savings of \$39,900,000 for FY 2018-19 and FY 2019-20 were included in the rates.
6. Acupuncture services are included in the base rates as of July 1, 2016.
7. The Department receives 90% federal reimbursement for family planning services.
8. Indian Health Services supplemental payments are budgeted in the base PCs.
9. Non-Medical Transportation (NMT) for covered Managed Care Service are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.
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 split of 88/12 was budgeted for OTLICP. This FMAP split will become 76.5/23.5 on October 1, 2019.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 87

11. GMC dollars on an accrual basis are:

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Sacramento	5,244,208	\$1,330,151
San Diego	8,693,355	\$2,212,149
Total	13,937,563	\$3,542,300
Hepatitis C Adjustment		\$45,629
Total FY 2018-19		\$3,587,929

(Dollars in Thousands)

Included in Dollars Above	FY 2018-19
Mental Health	\$44,100
AB 97	(\$39,900)

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Sacramento	5,276,342	\$1,341,716
San Diego	8,762,610	\$2,234,218
Total	14,038,952	\$3,575,934
Hepatitis C Adjustment		\$40,893
Total FY 2019-20		\$3,616,827

(Dollars in Thousands)

Included in Dollars Above	FY 2019-20
Mental Health	\$44,100
AB 97	(\$39,900)

GEOGRAPHIC MANAGED CARE**BASE POLICY CHANGE NUMBER: 87****Funding:**

The dollars below account for a one month payment deferral:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	\$2,008,339	\$1,004,169	\$1,004,169
State GF	\$6,098	\$6,098	\$0
Family Planning 90/10 GF	\$24,231	\$2,423	\$21,808
Title XXI 88/12 GF	\$147,198	\$17,664	\$129,534
ACA Optional Expansion 93/7 GF	\$584,508	\$40,916	\$543,592
ACA Optional Expansion 94/6 GF	\$829,925	\$49,796	\$780,129
Title XIX 100% FFP	\$77	\$0	\$77
Total	\$3,600,376	\$1,121,065	\$2,479,310

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX 50/50	\$2,009,000	\$1,004,500	\$1,004,500
State GF	\$6,140	\$6,140	\$0
Family Planning 90/10 GF	\$24,199	\$2,420	\$21,779
Title XXI 88/12 GF	\$48,935	\$5,872	\$43,063
Title XXI 76.5/23.5 GF	\$97,868	\$22,999	\$74,869
ACA Optional Expansion 90/10 GF	\$596,080	\$59,608	\$536,472
ACA Optional Expansion 93/7 GF	\$832,198	\$58,254	\$773,944
Title XIX 100% FFP	\$81	\$0	\$81
Total	\$3,614,500	\$1,159,792	\$2,454,708

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 11/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1842

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,195,578,000	\$1,206,867,000
- STATE FUNDS	\$372,745,940	\$389,095,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,195,578,000	\$1,206,867,000
STATE FUNDS	\$372,745,940	\$389,095,200
FEDERAL FUNDS	\$822,832,060	\$817,771,800

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:

Capitated Rate Adjustment for FY 2019-20

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.

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.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 91

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to:

- Lower than previously expected eligibles, and
- Decreased Hepatitis C costs due to lower than previously expected average monthly utilizers.

The change from FY 2018-19 to FY 2019-20, is an increase in the current estimate due to higher expected eligible months.

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. FY 2018-19 draft weighted rates have been updated from the previous estimate. FY 2018-19 draft weighted rates are budgeted in FY 2019-20.
4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$21,500,000 for FY 2018-19 and FY 2019-20 were included in the rates.
5. The savings from AB 97 are included in the rates. Savings of \$11,600,000 for FY 2018-19 and FY 2019-20 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.
6. Indian Health Services supplemental payments are budgeted in the base PCs.
7. Non Medi-cal Transportation (NMT) for covered Managed Care services are included in the base rate as of July 1, 2017. NMT for non-covered Managed Care services are included in the base rate as of October 1, 2017.
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. This FMAP split will become 76.5/23.5 on October 1, 2019.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 91

10. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

FY 2018-19	Eligible Months	Total
Alpine	2,599	\$719
Amador	76,148	\$19,357
Butte	795,564	\$231,501
Calaveras	113,807	\$30,167
Colusa	92,075	\$19,195
El Dorado	357,209	\$93,776
Glenn	120,948	\$29,473
Inyo	48,343	\$11,708
Mariposa	46,425	\$12,144
Mono	31,523	\$7,177
Nevada	255,747	\$66,522
Placer	553,007	\$138,431
Plumas	59,482	\$16,551
Sierra	7,074	\$2,004
Sutter	385,565	\$92,030
Tehama	245,148	\$65,464
Tuolumne	127,403	\$35,434
Yuba	308,091	\$78,791
Imperial	927,174	\$215,020
San Benito	98,882	\$15,303
Total FY 2018-19	4,652,212	\$1,180,767
Hepatitis C Adjustment		\$14,638
Total with Adjustments		\$1,195,405

(Dollars in Thousands)

Included in Dollars Above	FY 2018-19
Mental Health	\$21,500
AB 97	(\$11,600)

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 91

(Dollars in Thousands)

FY 2019-20	Eligible Months	Total
Alpine	2,596	\$718
Amador	76,465	\$19,452
Butte	802,193	\$234,705
Calaveras	114,286	\$30,328
Colusa	92,729	\$19,431
El Dorado	359,601	\$94,663
Glenn	121,789	\$29,851
Inyo	48,557	\$11,767
Mariposa	46,839	\$12,298
Mono	31,877	\$7,288
Nevada	258,818	\$67,638
Placer	558,725	\$140,647
Plumas	60,099	\$16,732
Sierra	7,085	\$2,007
Sutter	389,153	\$93,337
Tehama	245,809	\$65,864
Tuolumne	127,522	\$35,498
Yuba	309,982	\$79,383
Imperial	934,194	\$217,568
San Benito	99,818	\$15,595
Total FY 2019-20	4,688,139	\$1,194,770
Hepatitis C Adjustment		\$13,118
Total with Adjustments		\$1,207,888

(Dollars in Thousands)

Included in Dollars Above	FY 2019-20
Mental Health	\$21,500
AB 97	(\$11,600)

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 91

Funding:

The dollars below account for a one month payment deferral:

(Dollars in Thousands)

FY 2018-19		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$668,314	\$334,157	\$334,157
State GF	4260-101-0001	\$1,906	\$1,906	\$0
ACA 94/6 GF	4260-101-0890	\$274,753	\$16,485	\$258,268
ACA 93/7 GF	4260-101-0890	\$194,042	\$13,583	\$180,458
Family Planning 90/10 GF	4260-101-0001/0890	\$8,541	\$854	\$7,687
OTLICP 88/12 GF	4260-113-0001/0890	\$48,006	\$5,761	\$42,245
Title XIX 100%	4260-101-0890	\$16	\$0	\$16
Total		\$1,195,578	\$372,746	\$822,831

(Dollars in Thousands)

FY 2019-20		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$675,724	\$337,862	\$337,862
State GF	4260-101-0001	\$1,917	\$1,917	\$0
ACA 93/7 GF	4260-101-0890	\$275,369	\$19,276	\$256,094
ACA 90/10 GF	4260-101-0890	\$197,134	\$19,713	\$177,421
Family Planning 90/10 GF	4260-101-0001/0890	\$8,537	\$854	\$7,683
OTLICP 88/12 GF	4260-113-0001/0890	\$16,056	\$1,927	\$14,129
OTLICP 76.5/23.5 GF	4260-113-0001/0890	\$32,113	\$7,547	\$24,566
Title XIX 100%	4260-101-0890	\$17	\$0	\$17
Total		\$1,206,867	\$389,096	\$817,772

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 7/1992
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 62

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$547,615,000	\$574,133,000
- STATE FUNDS	\$276,245,000	\$287,066,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$547,615,000	\$574,133,000
STATE FUNDS	\$276,245,000	\$287,066,500
FEDERAL FUNDS	\$271,370,000	\$287,066,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14591-14594
 Balanced Budget Act of 1997 (BBA)
 SB 870 (Chapter 40, Statutes 2014)
 SB 840 (Chapter 29, Statutes 2018)

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 lifetime 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

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 94

methodology. The legislation requires that the effective date for implementation of the new rate methodology will be no sooner than July 1, 2017. The Department submitted the 2018 rate methodology to CMS for review and approval, retroactive to January 1, 2018. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

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
Stockton PACE	San Joaquin	January 1, 2019
	Stanislaus	January 1, 2019
Gary & Mary West	San Diego	January 1, 2019
Family Health Centers of San Diego	San Diego	January 1, 2019
Pacific PACE	Los Angeles	July 1, 2019
Edenbridge	Los Angeles	January 1, 2019
Sequoia	Fresno	July 1, 2019
	Kings	July 1, 2019
	Madera	July 1, 2019
	Tulare	July 1, 2019
InnovAge	Sacramento	July 1, 2019
	Placer	July 1, 2019
LA Coast	Los Angeles	July 1, 2019
Golden Valley Health Centers	San Joaquin	January 1, 2020
	Stanislaus	January 1, 2020

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to the 2017 rates implementing later than expected and being adjusted in FY 2018-19. The change from FY 2018-19 to FY 2019-20, is a net increase due to additional plans being implemented and a full year of enrollment being captured for five newer plans.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 94

Methodology:

1. Assume the January 2018 through December 2018 rates are calculated using plan specific experienced-based data to build actuarially sound prospective rates.
2. Assume the calendar year (CY) 2019 and CY 2020 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.
3. FY 2018-19 and FY 2019-20 estimated funding is based on pending CMS approval of CY 2018 rates, a new experience-based methodology, and projected CY 2019 and CY 2020 rates.
4. Assume enrollment will increase based on past enrollment in PACE organizations by county and plan and projected enrollments for new PACE organizations.
5. The Department worked with PACE Organizations to support legislation authorizing changes to current law to transition from an Amount That Would Have Otherwise Been Paid (AWOP)-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. The Department submitted new rate methodology for CMS review. The rates will be implemented retroactive to January 1, 2018, based on CMS approval.
6. The Department received CMS approval of contract amendments implementing CY 2017 rates in June 2018, retroactive to January 2017. This will result in an adjustment of \$27,330,000 to the PACE plans. The adjustment is expected occurred during the September 2018 capitation cycle.
7. The Department submitted CY 2018 rates to CMS in August 2018 with a projected approval date by CMS in January 2019, retroactive to January 2018. This will result in an adjustment of approximately \$22,019,000 to the PACE plans. The adjustment is expected to occur during the March 2019 capitation cycle.
8. FY 2018-19 includes \$4,875,000 Proposition 56 revenue for qualifying organizations as determined by Department-developed criteria. This criteria shall include, but are not limited to, administrative and licensing delays or the need for one-time funds while new rate methodologies are implemented.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 94

FY 2018-19	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$47,151,000	8,375	698
Sutter Senior Care	\$17,499,000	3,477	290
AltaMed Senior BuenaCare	\$153,731,000	30,385	2,532
OnLok (SF, Alameda and Santa Clara)	\$111,325,000	17,700	1,475
St. Paul's PACE	\$42,606,000	8,764	730
Los Angeles Jewish Homes	\$13,506,000	2,681	223
CalOptima PACE	\$18,676,000	3,317	276
InnovAge (San Bernardino and Riverside)	\$29,638,000	5,599	467
Redwood Coast (Humboldt)	\$8,020,000	1,699	142
Central Valley Medical Services	\$25,895,000	4,974	415
San Ysidro San Diego	\$19,274,000	3,440	287
Stockton PACE (San Joaquin and Stanislaus)	\$2,231,000	420	70
Gary & Mary West (San Diego)	\$1,408,000	270	45
Family Health Centers of San Diego	\$223,000	40	7
Pacific PACE (Los Angeles)	\$2,208,000	420	70
Total Capitation Payments	\$493,391,000	91,561	7,727
2017 Rate Adjustment	\$27,330,000		
2018 Rate Adjustment	\$22,019,000		
Prop 56 Funding	\$4,875,000		
Total FY 2018-19	\$547,615,000		

*Totals may differ due to rounding.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 94

FY 2019-20	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$49,508,000	8,375	698
Sutter Senior Care	\$18,766,000	3,552	296
AltaMed Senior BuenaCare	\$168,194,000	31,661	2,638
OnLok (SF, Alameda and Santa Clara)	\$116,891,000	17,700	1,475
St. Paul's PACE	\$46,917,000	9,191	766
Los Angeles Jewish Homes	\$14,181,000	2,681	223
CalOptima PACE	\$22,843,000	3,864	322
InnovAge (San Bernardino and Riverside)	\$31,119,000	5,599	467
Redwood Coast (Humboldt)	\$8,421,000	1,699	142
Central Valley Medical Services	\$31,087,000	5,700	475
San Ysidro San Diego	\$20,238,000	3,440	287
Stockton PACE (San Joaquin and Stanislaus)	\$2,231,000	2,730	228
Gary & Mary West (San Diego)	\$8,692,000	1,620	135
Family Health Centers of San Diego	\$410,000	72	6
Edenbridge (Los Angeles)	\$136,000	26	9
Golden Valley (San Joaquin and Stanislaus)	\$744,000	130	26
LA Coast (Los Angeles)	\$7,800,000	1,434	120
Pacific PACE (Los Angeles)	\$14,769,000	2,730	228
Sequoia (Fresno, Kings, Madera, & Tulare)	\$7,089,000	1,435	120
InnovAge (Sacramento and Placer)	\$4,097,000	726	61
Total Capitation Payments	\$574,133,000	104,365	8,722
Total FY 2019-20	\$574,133,000		

*Totals may differ due to rounding.

Funding:

FY 2018-19: 50% Title XIX / 50% GF (4260-101-0001/0890) \$542,740,000
Healthcare Treatment Fund (4260-101-3305) \$4,875,000

FY 2019-20: 50% Title XIX / 50% GF (4260-101-0001/0890) \$574,133,000

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 7/2004
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1029

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$80,927,000	\$67,273,000
- STATE FUNDS	\$30,619,010	\$25,961,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$80,927,000	\$67,273,000
STATE FUNDS	\$30,619,010	\$25,961,960
FEDERAL FUNDS	\$50,307,990	\$41,311,040

DESCRIPTION**Purpose:**

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

Authority:

Social Security Act, Title XIX
 AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code
 Access Dental Plan Contract #12-89341
 Access Dental Plan Contract #13-90115
 Health Net of California Contract #12-89342
 Health Net of California Contract #13-90116
 Liberty Dental Plan of California, Inc. Contract #12-89343
 Liberty Dental Plan of California, Inc. Contract #13-90117

Interdependent Policy Changes:

Not Applicable

Background:

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

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

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including Federally Qualified Health Centers (FQHCs) and Rural Health

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 95

Clinics (RHCs), is limited to the adult optional benefits restored May 1, 2014, in addition to the adult dental benefits which include services for pregnant women, emergency services, Federally Required Adult Dental Services (FRADs), services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The impact of the restoration of adult dental benefits is included in the capitation rates. The policy change for Full Restoration of Adult Dental Benefits captures the estimated cost for fully restoring the adult dental benefits in the Medi-Cal Dental Program.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to changes in rate payment timing, updated eligibles, and changes in HIPF payment timing. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to no HIPF payments scheduled.

Methodology:

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates for prior years are shown in the Dental Retroactive Rate Changes policy change.
3. Any portions of the rate attributable to Proposition 56 Supplemental Payments, Full Adult Benefits Restoration, and Dental Transformation Initiative Utilization are captured in other policy changes.
4. The total cost of the HIPF payments in FY 2018-19 is \$4,206,385.
5. June capitation payments are paid in July of the following fiscal year.
6. For the Rating Periods below, certain rates indicate "with Prop 56." This description is for display purposes only as the actual Prop 56 portions of those rates are captured in the Supplemental Payments for Dental Services PC.

Time Period	Rate Package
June 2018 – January 2019	FY 2017-18 Rates with Prop 56
February 2019 – June 2019	FY 2018-19 Rates with Prop 56
July 2019 – January 2020	FY 2018-19 Rates without Prop 56
February 2020 – May 2020	FY 2019-20 Rates without Prop 56

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 95

FY 2018-19	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,649,963	220,830	\$10,557,364
Child - GMC	2,374,964	197,914	\$29,151,844
Adult - PHP	3,059,499	254,958	\$9,787,754
Child - PHP	1,916,417	159,701	\$27,222,682

FY 2019-20	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,643,300	220,275	\$9,110,345
Child - GMC	2,369,436	197,453	\$25,413,655
Adult - PHP	3,055,308	254,609	\$8,714,227
Child - PHP	1,913,160	159,430	\$24,033,972

Funding:

FY 2018-19	TF	GF	FF
Regular FMAP T19	\$57,988,000	\$28,994,000	\$28,994,000
ACA 94% FFP/6% GF (2018)	\$10,252,000	\$615,000	\$9,637,000
ACA 93% FFP/7% GF (2019)	\$10,251,000	\$718,000	\$9,533,000
Title 21 88% FFP/12% GF	\$2,436,000	\$292,000	\$2,144,000
Total	\$80,927,000	\$30,619,000	\$50,308,000

FY 2019-20	TF	GF	FF
Regular FMAP T19	\$48,190,000	\$24,095,000	\$24,095,000
ACA 93% FFP/7% GF (2019)	\$8,532,000	\$597,000	\$7,935,000
ACA 90% FFP/10% GF (2020)	\$8,531,000	\$853,000	\$7,678,000
Title 21 88% FFP/12% GF	\$505,000	\$61,000	\$444,000
Title 21 76.5% FFP/23.5% GF	\$1,515,000	\$356,000	\$1,159,000
Total	\$67,273,000	\$25,903,000	\$41,370,000

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 2/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 61

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$40,304,000	\$51,557,000
- STATE FUNDS	\$20,152,000	\$25,778,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,304,000	\$51,557,000
STATE FUNDS	\$20,152,000	\$25,778,500
FEDERAL FUNDS	\$20,152,000	\$25,778,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14200

Interdependent Policy Changes:

N/A

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to rate updates and anticipated rate timing. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to updated rates and eligibility projections as well as a FY 2017-18 rate recoupment occurring in FY 2018-19.

Methodology:

1. Estimated SCAN costs are calculated by multiplying the actual and estimated monthly eligible counts for each county by the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.
2. Assume an average monthly enrollment of 13,249 in FY 2018-19 and 13,381 in FY 2019-20.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 96

3. The CY 2018 rates CY 2019 rates are projected by trending forward CY 2017 rates.
4. Assume that a retroactive CY 2017 Rate Recoupment of \$10,901,000 and CY 2018 Rate Repayment of \$247,000 will both occur in FY 2018-19.
5. Assume one month of FY 2017-18 payments and 11 months of FY 2018-19 are paid in FY 2018-19.
6. Assume one month of FY 2018-19 payments and 11 months of FY 2019-20 are paid in FY 2019-20.
7. Anticipated costs on a cash basis are:

FY 2018-19	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$30,028,000	107,752	8,979
Riverside	\$9,977,000	30,853	2,571
San Bernardino	\$5,945,000	20,378	1,698
FY 2018-19*	\$45,950,000	158,983	13,249
FY 2017-18**	\$5,008,000		
2017 Rate Recoupment	(\$10,901,000)		
2018 Rate Repayment	\$247,000		
Total FY 2018-19	\$40,304,000		

FY 2019-20	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$30,770,000	108,829	9,069
Riverside	\$10,224,000	31,162	2,597
San Bernardino	\$6,093,000	20,582	1,715
FY 2019-20*	\$47,087,000	160,573	13,381
FY 2018-19**	\$4,177,000		
2019 Rate Repayment	\$251,000		
2020 Rate Repayment	\$43,000		
Total FY 2019-20***	\$51,557,000		

*Assumes 11 months of capitation payments.

**Assumes 1 month of capitation payments.

***Difference due to rounding.

Funding:

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 5/1985
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 63

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$12,536,000	\$15,701,000
- STATE FUNDS	\$6,268,000	\$7,850,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,536,000	\$15,701,000
STATE FUNDS	\$6,268,000	\$7,850,500
FEDERAL FUNDS	\$6,268,000	\$7,850,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14088.85

Interdependent Policy Changes:

Not Applicable

Background:

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with AIDS Healthcare Centers as a PCCM plan and participates in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation (AHF) received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department determined there were no shared savings for calendar year (CY) 2009. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a five-year contract with AHF for January 1, 2012, through December 31, 2016. Subsequently, the Department entered into two six-month contract extensions with AHF for January 1, 2017, through June 30, 2017, and July 1, 2017, through December 31, 2017. The Department has extended the contract through June 30, 2018 and is working with CMS on formal approval. The Department is currently assuming AHF will become a full-risk managed care plan no sooner than July 1, 2019 and anticipates further contract extensions.

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 was budgeted in the MCO Enrollment Tax Managed Care Plans – Funding Adjustment policy change.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 97

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to:

- Updated enrollment projections, and
- Revised draft FY 2018-19 rates that no longer factor full-risk implementation for AHF.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to AHF transitioning to a full-risk managed care plan as of July 1, 2019.

Methodology:

1) Assume the following eligible months on an accrual basis:

Member Months	Dual	Medi-Cal Only
FY 2017-18	4,206	4,045
FY 2018-19	4,290	4,126
FY 2019-20	4,376	4,208

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
FY 2017-18	\$51.62	\$2,732.76

3) Assume the following revised rates to be made for FY 2017-18 and draft rates for FY 2018-19 to be paid in FY 2018-19:

Revised Rates	Dual	Medi-Cal Only
FY 2017-18	\$52.24	\$2,708.21
FY 2018-19	\$164.77	\$2,920.33

4) The following amounts is estimate for this policy change based on the updated eligible months and rates:

FY 2018-19	Year	Paid Rate	Revised Rate	Rate Difference	MM	TF
Dual (Retro)	FY 2017-18	\$51.62	\$52.24	\$0.62	3,856	\$2,000
Medi-Cal Only (Retro)	FY 2017-18	\$2,736.76	\$2,708.21	(\$24.55)	3,708	(\$91,000)
*Dual	FY 2017-18	\$52.24	N/A	N/A	351	\$18,000
*Medi-Cal Only	FY 2017-18	\$2,708.21	N/A	N/A	337	\$913,000
**Dual	FY 2018-19	\$164.77	N/A	N/A	3,933	\$648,000
**Medi-Cal Only	FY 2018-19	\$2,920.33	N/A	N/A	3,782	\$11,045,000
Total						\$12,535,000

*Assumes one month of capitation payments.

**Assumes 11 months of capitation payments.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 97

FY 2019-20	Year	Paid Rate	Budget Rate	Rate Difference	MM	TF
*Dual	FY 2018-19	\$164.77	N/A	N/A	358	\$59,000
*Medi-Cal Only	FY 2018-19	\$2,920.33	N/A	N/A	344	\$1,004,000
**Dual	FY 2019-20	\$198.75	N/A	N/A	4,011	\$797,000
**Medi-Cal Only	FY 2019-20	\$3,587.86	N/A	N/A	3,858	\$13,841,000
Total						\$15,701,000

*Assumes one month of capitation payments.

**Assumes 11 months of capitation payments.

FY 2018-19	TF	GF	FF
Dual	\$668,000	\$334,000	\$334,000
Medi-Cal Only	\$11,867,000	\$5,933,000	\$5,934,000
Total FY 2018-19	\$12,535,000	\$6,267,000	\$6,267,000

FY 2019-20	TF	GF	FF
Dual	\$856,000	\$428,000	\$428,000
Medi-Cal Only	\$14,845,000	\$7,422,000	\$7,423,000
Total FY 2019-20	\$15,701,000	\$7,850,000	\$7,851,000

Funding:

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

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

BASE POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 3/2018
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 66

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,149,000	\$1,009,000
- STATE FUNDS	\$1,074,500	\$504,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,149,000	\$1,009,000
STATE FUNDS	\$1,074,500	\$504,500
FEDERAL FUNDS	\$1,074,500	\$504,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

Not Applicable

Background:

The Department's contract with the Family Mosaic Project was effective January 1, 2008. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out-of-home placement.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to previously budgeted retroactive payments now anticipated to occur in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to retroactive payments made in the prior period.

Methodology:

1) The Family Mosaic member months are assumed to be in the following:

- 300 in FY 2015-16
- 276 in FY 2016-17 through FY 2019-20

FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)**BASE POLICY CHANGE NUMBER: 101**

2) The Family Mosaic capitation rates are assumed to be:

- \$3,286.64 in FY 2015-16
- \$3,361.41 in FY 2016-17
- \$3,454.77 in FY 2017-18
- \$3,558.41 in FY 2018-19
- \$3,665.17 in FY 2019-20

3) A retroactive rate adjustment for FY 2015-16, FY 2016-17, and FY 2017-18 is expected to be made in FY 2018-19.

4) Payments for 11 months of FY 2018-19 are expected to be made in FY 2018-19.

5) Payments for one month of FY 2018-19, and 11 months of FY 2019-20 are expected to be made in FY 2019-20.

6) Anticipated costs on a cash basis are:

FY 2018-19	TF	GF	FF
FY 2015-16 (Retro)	\$431,000	\$216,000	\$215,000
FY 2016-17 (Retro)	\$417,000	\$208,000	\$209,000
FY 2017-18 (Retro)	\$443,000	\$221,000	\$222,000
FY 2018-19	\$858,000	\$429,000	\$429,000
Total FY 2018-19	\$2,149,000	\$1,074,000	\$1,075,000

FY 2019-20	TF	GF	FF
FY 2018-19**	\$82,000	\$41,000	\$41,000
FY 2019-20*	\$927,000	\$463,000	\$464,000
Total FY 2019-20	\$1,009,000	\$504,000	\$505,000

*Assumes 11 months of capitation payments.

**Assumes 1 month of capitation payments.

Funding:

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

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

BASE POLICY CHANGE NUMBER: 162
 IMPLEMENTATION DATE: 7/1988
 ANALYST: Joulia Dib
 FISCAL REFERENCE NUMBER: 76

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,296,170,000	\$3,451,743,000
- STATE FUNDS	\$1,749,979,500	\$1,831,872,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,296,170,000	\$3,451,743,000
STATE FUNDS	\$1,749,979,500	\$1,831,872,500
FEDERAL FUNDS	\$1,546,190,500	\$1,619,870,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not applicable

Background:

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

Reason for Change:

The change from the prior estimate for FY 2018-19 is due to:

1. Lower beneficiaries than previously estimated due to more timely reconciliation adjustments by CMS.
2. This reduction is slightly offset by higher 2019 Part A and Part B premiums of \$1.00 and \$1.50 respectively.

The increase from FY 2018-19 to FY 2019-20 is due to:

1. Moderate expected growth in beneficiaries based on the historical trend.
2. A projected increase in the 2020 Part A premium of \$18.00 and Part B premium of \$5.60.

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

BASE POLICY CHANGE NUMBER: 162

Premiums:

Calendar Year	2018	2019		2020
	Actual	May 2018 Estimate	November 2018 Actual	November 2018 Estimate
Part A	\$422.00	\$436.00	\$437.00	\$455.00
Part B	\$134.00	\$134.00	\$135.50	\$141.10

Average Estimated Monthly Beneficiaries:

FY	2017-18	2018-19		2019-20
	Actual	May 2018 Estimate	November 2018 Estimate	November 2018 Estimate
Part A	176,400	179,600	176,200	178,000
Part B	1,389,800	1,425,600	1,400,800	1,421,600

Methodology:

- The Centers for Medicare and Medicaid set the following rates for 2018 and 2019.

Calendar Year	Part A Premium	Part B Premium
2018	\$ 422.00	\$ 134.00
2019	\$ 437.00	\$ 135.50

- For 2020, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 4.12% growth in the Medicare Part A premium. Applying this growth to prior year Part A premium gives $\$437 \times 1.0412 = \455 (rounded).
- For 2020, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 4.13% growth in the Medicare Part B premium. Applying this growth to prior year Part B premium gives $\$135.50 \times 1.0413 = \141.10 (rounded).

FY 2018-19	Part A	Part B
Average Monthly Eligibles	176,200	1,400,800
Rate 07/2018-12/2018	\$422.00	\$134.00
Rate 01/2019-06/2019	\$437.00	\$135.50
FY 2019-20	Part A	Part B
Average Monthly Eligibles	178,000	1,421,600
Rate 07/2019-12/2019	\$437.00	\$135.50
Rate 01/2020-06/2020	\$455.00	\$141.10

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

BASE POLICY CHANGE NUMBER: 162

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	\$2,998,953	\$1,499,477	\$1,499,477
State GF 100%	\$250,503	\$250,503	\$0
Title XIX 100% FFP	\$46,714	\$0	\$46,714
Total	\$3,296,170	\$1,749,980	\$1,546,191

FY 2019-20	TF	GF	FF
Title XIX 50/50	\$3,142,547	\$1,571,274	\$1,571,274
State GF 100%	\$260,599	\$260,599	\$0
Title XIX 100% FFP	\$48,597	\$0	\$48,597
Total	\$3,451,743	\$1,831,873	\$1,619,871

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 163
IMPLEMENTATION DATE: 1/2006
ANALYST: Joulia Dib
FISCAL REFERENCE NUMBER: 1019

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,149,500,000	\$2,264,888,000
- STATE FUNDS	\$2,149,500,000	\$2,264,888,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,149,500,000	\$2,264,888,000
STATE FUNDS	\$2,149,500,000	\$2,264,888,000
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 ²/₃% 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:

<u>Calendar Year</u>	<u>PMPM rate</u>
2016	\$110.23
2017	\$123.38
2018	\$124.89
2019	\$127.31
2020	\$133.62 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 163

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 2015-16	\$1,670,974,353	1,357,168
FY 2016-17	\$1,911,686,565	1,390,393
FY 2017-18	\$2,094,822,127	1,410,215

Reason for Change:

The change from the prior estimate for FY 2018-19 is due to a decrease in recent eligible counts of approximately 5,500 average monthly eligibles. The change between FY 2018-19 and FY 2019-20 is due to an estimated increase of \$6.31 PMPM for 2020 and estimated historical growth in average monthly eligibles of approximately 33,300.

Methodology:

1. The 2018 growth increased 1.22% over 2017 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2018 is \$124.89.
2. The 2019 growth increased 1.93% over 2018 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2019 is \$127.31.
3. The 2020 growth is estimated to increase 4.96% over 2019 amounts based on an average of the annual percentage increase for the prior three years provided by the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2020 is \$133.62.
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 2013 to July 2018.
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 2018-19	12	1,424,993	\$179,125,000	\$2,149,500,000
FY 2019-20	12	1,458,253	\$188,740,700	\$2,264,888,000

Funding:

100% GF (4260-101-0001)

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 4/1993
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 22

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,688,030,000	\$1,841,100,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,688,030,000	\$1,841,100,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,688,030,000	\$1,841,100,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries participating in the In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program administered by CDSS.

Authority:

Social Security Act (42 U.S.C., Section 1396, et. seq.)

Interagency Agreements:

03-75676 (PCSP)

09-86307 (IPO)

SB 1036 (Chapter 45, Statutes of 2012)

SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS via interagency agreements for the IHSS PCSP and the IPO program.

SB 1008 enacted the Coordinated Care Initiative (CCI) which requires, in part, to mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change CCI-Managed Care Payments for more information. IHSS costs are currently budgeted in this policy change, but due to the transition of IHSS recipients to managed care, some IHSS costs have been paid through managed care capitation beginning April 1, 2014. IHSS costs related to the recipients transitioning to managed care are budgeted in the CCI-Managed Care Payments policy change. Effective January 1, 2018, IHSS are no longer included in the managed care capitation, thus all costs for IHSS eligible services are captured in this policy change.

PERSONAL CARE SERVICES (Misc. Svcs.)**BASE POLICY CHANGE NUMBER: 164**

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

The Governor's Budget estimate of the 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.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to revised expenditure data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to revised expenditure data.

Methodology:

1) The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

	TF	FFP	CDSS GF/ County Share
FY 2018-19	\$3,376,060	\$1,688,030	\$1,688,030
FY 2019-20	\$3,682,200	\$1,841,100	\$1,841,100

Funding:

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

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

BASE POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 7/1990
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 23

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,906,526,000	\$1,985,334,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,906,526,000	\$1,985,334,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,906,526,000	\$1,985,334,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

Authority:

Interagency Agreement 01-15834

Interdependent Policy Changes:

Not Applicable

Background:

CDDS, under a federal HCBS waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services covered under this waiver include but are not limited to: home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, and transition/set-up expenses.

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

Reason for Change:

The change for FY 2018-19, from the prior estimate, is an increase due to updated HCBS waiver caseload and higher prior year expenditures than previously expected in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to updated HCBS waiver caseload projections and expenditures expected in FY 2019-20.

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

BASE POLICY CHANGE NUMBER: 165

Methodology:

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

(Dollars in Thousands)

	TF	CDDS GF	DHCS FFP
FY 2018-19	\$3,813,052	\$1,906,526	\$1,906,526
FY 2019-20	\$3,970,668	\$1,985,334	\$1,985,334

Funding:

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 166
IMPLEMENTATION DATE: 7/1988
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 135

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$485,929,000	\$993,312,000
- STATE FUNDS	\$200,174,510	\$377,767,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$485,929,000	\$993,312,000
STATE FUNDS	\$200,174,510	\$377,767,700
FEDERAL FUNDS	\$285,754,490	\$615,544,300

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:

N/A

Background:

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.

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. DXC Technology Services (DXC) was awarded a multi-year FI contract in 2016. DXC 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 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. Effective January 1, 2018, the full restoration of adult dental benefits includes the remaining services which were not restored in 2014, such as restorative services (crowns), prosthodontic services (partial dentures), and endodontic services (root canals). The policy change for Full Restoration of Adult Dental Benefits captures the estimated cost for fully restoring the adult dental benefits in the Medi-Cal Dental Program.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 166

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a change in methodology to project using check write data, a shift of HIPF payments, and an underwriting gain to be returned to the Department. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to no underwriting gain return occurring in FY 2019-20.

Methodology:

1. The FY 2018-19 and FY 2019-20 estimate for dental services assumes the average of the weekly check write invoice amounts since February 2018. A growth factor of 0.62% was applied for FY 2019-20.
2. The estimates for Full Restoration of Adult Dental benefits, Proposition 56 Supplemental Payments, and Domain 2 of Dental Transformation Initiative are removed.
3. The following HIPF payments will be made in FY 2018-19:
 - HIPF for the second six months of CY 2016 is \$5,331,457
 - HIPF for July 2017 through January 2018 is \$13,520,495
4. Under the 2004 Delta Dental Contract, the contractor was required to have an annual independent audit which included the determination of any underwriting gain or loss. The audit for the period ending January 31, 2018 resulted in an underwriting gain of which approximately \$515 million TF/ \$168 million GF should be returned to the Department pending completion of the independent audit.

Funding (Totals may differ due to rounding):

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$674,902,000	\$337,451,000	\$337,451,000
100% GF	(\$167,254,000)	(\$167,254,000)	\$0
94% Title XIX ACA FF / 6% GF	\$82,621,000	\$4,957,000	\$77,664,000
93% Title XIX ACA FF / 7% GF	\$82,620,000	\$5,783,000	\$76,837,000
88% Title XXI / 12% GF	\$159,750,000	\$19,170,000	\$140,580,000
65% Title XIX / 35% GF	\$191,000	\$67,000	\$124,000
100% FFP	(\$346,901,000)	\$0	(\$346,901,000)
Total	\$485,929,000	\$200,174,000	\$285,755,000
FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$669,766,000	\$334,883,000	\$334,883,000
100% GF	\$740,000	\$740,000	\$0
90% Title XIX ACA FF / 10% GF	\$81,992,000	\$8,199,000	\$73,793,000
93% Title XIX ACA FF / 7% GF	\$81,992,000	\$5,739,000	\$76,253,000
88% Title XXI / 12% GF	\$79,268,000	\$9,512,000	\$69,756,000
76.5% Title XXI / 23.5% GF	\$79,267,000	\$18,628,000	\$60,639,000
65% Title XIX / 35% GF	\$189,000	\$66,000	\$123,000
100% FFP	\$98,000	\$0	\$98,000
Total	\$993,312,000	\$377,767,000	\$615,545,000

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

BASE POLICY CHANGE NUMBER: 168
IMPLEMENTATION DATE: 7/1991
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 26

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$267,117,000	\$240,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$267,117,000	\$240,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$267,117,000	\$240,500,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due an increased caseload, increased rates, and prior year expenditures.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net decrease due to a reduction in expected previous year expenditures and projected caseload increases in FY 2019-20.

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

BASE POLICY CHANGE NUMBER: 168

Methodology:

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

(Dollars in Thousands)

	TF	CDDS GF	DHCS FFP
FY 2018-19	\$534,234	\$267,117	\$267,117
FY 2019-20	\$481,000	\$240,500	\$240,500

Funding:

100% Title XIX (4260-101-0890)

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 169
IMPLEMENTATION DATE: 7/1997
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 77

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$99,725,000	\$65,300,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$99,725,000	\$65,300,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$99,725,000	\$65,300,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Developmental Centers (DCs) and State Operated Community Small Facilities (SOCFs).

Authority:

Interagency Agreement (IA) 03-75282
IA 03-75283

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOCFs. There are four DCs and one SOCF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOCFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

The General Fund (GF) is included in the CDDS budget on an accrual basis and the federal funds in the Department's budget are on a cash basis.

Reason for Change:

There change from the prior estimate, for FY 2018-19, is a decrease due to the expeditious decline of the Sonoma DC population.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the rapid reduction of DC populations.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**BASE POLICY CHANGE NUMBER: 169****Methodology:**

1. The following estimates, on a cash basis, have been provided by CDDS.

(Dollars in Thousands)

Fiscal Year	Total Funds	CDDS GF	FFP Regular
FY 2018-19	\$199,450	\$99,725	\$99,725
FY 2019-20	\$130,600	\$65,300	\$65,300

Funding:

100% Title XIX (4260-101-0890)

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 173
IMPLEMENTATION DATE: 4/2000
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 32

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$45,138,000	\$47,402,000
- STATE FUNDS	\$21,951,500	\$22,790,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,138,000	\$47,402,000
STATE FUNDS	\$21,951,500	\$22,790,000
FEDERAL FUNDS	\$23,186,500	\$24,612,000

DESCRIPTION

Purpose:

This policy change estimates the costs associated with adding personal care services (PCS) to the Home and Community-Based Alternatives (HCBA) and In Home Operations (IHO) Waivers.

Authority:

AB 668 (Chapter 896, Statutes of 1998)
 Interagency Agreement (IA) 03-75898
 AB 1811 (Chapter 35, Statutes of 2018)

Interdependent Policy Changes:

California Community Transitions (CCT) Costs

Background:

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

Beginning January 1, 2018, the minimum wage increased from \$10.50 to \$11.00 per hour. Beginning January 1, 2019, the minimum wage will increase from \$11.00 to \$12.00 per hour. Beginning January 1, 2020, the minimum wage will increase from \$12.00 to \$13.00 per hour.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)**BASE POLICY CHANGE NUMBER: 173**

Beginning FY 2018-19, the county, or the public authority or nonprofit consortium, as defined, deems to be the employer to meet and confer in good faith regarding wages, benefits, and other terms and conditions of employment of individuals providing WPCS. For service dates on or after the effective date of federal approval obtained by the Department, wages, benefits, and all other terms and conditions of employment for individuals providing WPCS would require to be equal to the wages, benefits, and other terms and conditions of employment in the respective county for the individual provider mode of services in the IHSS program. If eligibility for benefits requires a provider to work a threshold number of hours, eligibility would be required to be determined based on the aggregate number of monthly hours worked between IHSS and WPCS.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase resulting from additional costs for providing parity to WPCS providers. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to anticipated minimum wage increases each year through 2022 and a slight increase in projected hours in the HCBA waiver and the additional cost of WPCS parity.

Methodology:

1. Assume the number of current HCBA waiver beneficiaries using WPCS is estimated to increase by an average of four per month in FY 2018-19 and one per month in FY 2019-20.
2. Assume the number of current IHO beneficiaries using WPCS is estimated to decrease an average of three per month in FY 2018-19 and FY 2019-20 due to the IHO waiver participants transitioning to the HCBA waiver. The IHO Waiver ends December 31, 2019.
3. The Department's CCT Demonstration Project expects to transition 219 beneficiaries out of inpatient extended health care facilities in FY 2018-19. Based on actual data from July 2015 through June 2016, the Department assumes 2% of CCT beneficiaries will use WPCS in FY 2018-19 and FY 2019-20. The CCT program will stop new enrollments and transitions on December 31, 2018. After this date, no additional CCT funding will be available to enroll new beneficiaries and facilitate the transition of beneficiaries from inpatient facilities to their homes or community.
4. Assume the Department of Social Services will pay approximately 66% of benefit costs for providers that use IHSS and WPCS hours to qualify for benefits.
5. The average cost/hour is \$11.49 for FY 2018-19 and \$11.64 FY 2019-20.
6. The chart below displays the estimate on an accrual basis.

FY 2018-19	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,471,265	\$11.64	\$40,406,000	\$20,203,000	\$20,203,000
IHO Waiver	82,700	\$11.64	\$963,000	\$482,000	\$481,000
Total			\$41,369,000	\$20,685,000	\$20,684,000

FY 2019-20	Total Hours	Cost/Hour	TF	GF	FF
HCBA Waiver	3,500,775	\$12.27	\$42,955,000	\$21,478,000	\$21,447,000
IHO Waiver	1,466	\$12.27	\$18,000	\$9,000	\$9,000
Total			\$42,973,000	\$21,487,000	\$21,486,000

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 173

7. The chart below is adjusted on a cash basis. Costs include WPCS parity for FY 2018-19 and FY 2019-20.

(Dollars in Thousands)	TF	GF	FF
FY 2018-19	\$40,873	\$20,437	\$20,436
WPCS Parity	\$3,265	\$1,015	\$2,250
FY 2018-19 Total	\$44,138	\$21,452	\$22,686
	TF	GF	FF
FY 2019-20	\$42,706	\$21,353	\$21,353
WPCS Parity	\$4,696	\$1,437	\$3,259
FY 2019-20 Total	\$47,402	\$22,790	\$24,612

Funding:

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

100% State GF

Title XIX 100% FF

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 175
IMPLEMENTATION DATE: 7/2017
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 2080

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$33,122,000	\$32,350,000
- STATE FUNDS	\$16,561,000	\$16,175,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$33,122,000	\$32,350,000
STATE FUNDS	\$16,561,000	\$16,175,000
FEDERAL FUNDS	\$16,561,000	\$16,175,000

DESCRIPTION

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change:

The change from the prior estimate for FY 2018-19 is a decrease due to an update to a settlement owed to the Department.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the fewer lawsuit settlements or fees expected to be paid.

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 175

Methodology:

FY 2018-19	
<u>Attorney Fees</u>	
Freeman v. Kent; DHCS, et al.	\$23,000
Total	\$23,000
<u>Other Attorney Fees</u>	
Karen Meng v. Jennifer Kent; DHCS, et al.	\$135,000
Judith Boothby, et al. v. Jennifer Kent; DHCS, et al.	\$128,000
Helmuth v. Kent; DHCS, et al.	\$73,000
Total	\$336,000
<u>Other Provider Settlements</u>	
LA Care	\$31,000,000
Contra Costa	\$1,010,000
AHF	(\$624,000)
Total	\$31,386,000
<u>Other Beneficiary Settlements</u>	
Helmuth v. Kent; DHCS, et al.	\$50,000
Total	\$50,000
FY 2018-19 Total	\$31,795,000

FY 2019-20	
<u>Other Provider Settlements</u>	
LA Care	\$31,000,000
Total	\$31,000,000
FY 2019-20 Total	\$31,000,000

FY 2018-19		
	Committed	Balance
Attorney Fees <\$30,000	\$ -	\$ 200,000
Provider Settlements <\$100,000	\$ 23,300	\$ 976,700
Beneficiary Settlements <\$10,000]=	\$ -	\$ 150,000
Small Claims Court	\$ -	\$ -
Other Attorney Fees	\$ 336,000	
Other Provider Settlements	\$ 31,386,000	
Other Beneficiary Settlements	\$ 50,000	
Interest Paid	\$ -	
Totals (Rounded)	\$ 31,795,000	\$ 1,327,000

LAWSUITS/CLAIMS
BASE POLICY CHANGE NUMBER: 175

FY 2019-20	
	Budgeted
Attorney Fees<\$30,000;Provider Settlements<\$100,000; Beneficiary Settlements<\$10,000	\$ 1,350,000
Other Attorney Fees	\$ -
Other Provider Settlements	\$ 31,000,000
Other Beneficiary Settlements	\$ -
Interest Paid	\$ -
Totals (Rounded)	\$ 32,350,000

Funding:

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

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 176
IMPLEMENTATION DATE: 6/1995
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 27

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$30,915,000	\$34,224,000
- STATE FUNDS	\$229,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,915,000	\$34,224,000
STATE FUNDS	\$229,000	\$0
FEDERAL FUNDS	\$30,686,000	\$34,224,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:

Welfare & Institutions Code 14132.44
SB 910 (Chapter 1179, Statutes of 1991)

Interdependent Policy Changes:

Not Applicable

Background:

The TCM program provides funding to LGAs for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP).

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net decrease due to:

- A decrease in base payments,
- An increase in ACA payments for FY 2018-19,
- Updating reconciliation payments and recoupments based on actuals, and
- Shifting a portion of the FY 2010-11 and FY 2014-15 claims that were over the two-year claiming limit to be paid in FY 2018-19.

The change in FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to higher reconciliation payments in FY 2019-20.

MEDI-CAL TCM PROGRAM**BASE POLICY CHANGE NUMBER: 176****Methodology:**

1. SPA #10-010, approved on December 19, 2013, lifted the annual capitated amount (CAP removal), effective October 16, 2010. The annual capitated amount was the maximum amount of dollars an LGA could claim for reimbursement within a target population.
2. The projected payment amounts of \$26,460,000 (regular invoices) and \$5,225,000 (ACA invoices) for FY 2018-19 and FY 2019-20, are based on average expenditures from FY 2016-17 through FY 2017-18.
3. Assume an additional \$1,045,000 in ACA growth in FY 2018-19 and FY 2019-20 will be paid for the six additional counties that will be expanding their TCM program into their probation departments.
4. The Department will complete audits for FY 2010-11 through FY 2017-18 in FYs 2018-19 and 2019-20.
 - In FY 2018-19, the Department will:
 - Recoup \$11,342,000 and pay \$8,353,000 for a net recoupment of \$2,989,000 for regular reconciliations, and
 - Recoup \$461,000 and pay \$1,406,000 for a net payment of \$945,000 for ACA reconciliations.
 - In FY 2019-20, the Department will:
 - Recoup \$663,000 and pay \$1,888,000 for a net payment of \$1,225,000 for regular reconciliations, and
 - Recoup \$146,000 and pay \$415,000 for a net payment of \$269,000 for ACA reconciliations.
5. In FY 2018-19, upon approval, the Department will utilize the General Fund (GF) for additional SPA CAP removal claims for FY 2010-11, and for FY 2014-15 pending payments for a total of \$229,000. These claims exceed the federal two-year claiming limitation.

FY 2018-19	TF	GF	FF
FY 2018-19 Base (Average Expenditures)	\$26,460,000		\$26,460,000
FY 2018-19 Base (ACA Expenditures)	\$5,225,000		\$5,225,000
ACA Growth (Probation Dept. Expansion)	\$1,045,000		\$1,045,000
SPA#10-010 increase (CAP removal) and pending FY 2014-15 payments			
FY 2010-11	\$227,000	\$227,000	
FY 2014-15	\$2,000	\$2,000	
Reconciliation			
Regular Claims	(\$2,989,000)		(\$2,989,000)
ACA Claims	\$945,000		\$945,000
Total FY 2018-19	\$30,915,000	\$229,000	\$30,686,000

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 176

FY 2019-20	TF	FF
FY 2018-19 Base (Average Expenditures)	\$26,460,000	\$26,460,000
FY 2018-19 Base (ACA Expenditures)	\$5,225,000	\$5,225,000
ACA Growth (Probation Dept. Expansion)	\$1,045,000	\$1,045,000
Reconciliation		
Regular Claims	\$1,225,000	\$1,225,000
ACA Claims	\$269,000	\$269,000
Total FY 2019-20	\$34,224,000	\$34,224,000

Funding:

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

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

100% GF (4260-101-0001)

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 183
IMPLEMENTATION DATE: 7/1997
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1083

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,667,000	\$1,028,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,667,000	\$1,028,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,667,000	\$1,028,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for benefit costs associated with the Childhood Lead Poisoning Prevention (CLPP) program.

Authority:

Interagency Agreement (IA) 07-65689

Interdependent Policy Changes:

Not Applicable

Background:

The CLPP program provides case management services utilizing revenues collected from fees. County governments receive the CLPP revenues matched with the federal funds for case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an IA.

Reason for Change:

There change from the prior estimate for FY 2018-19, is due to delayed invoices for FY 2017-18 costs, previously budgeted in FY 2017-18, shifting to FY 2018-19.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to fewer prior year invoices in FY 2019-20.

Methodology:

1. Annual expenditures on an accrual basis are \$1,028,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 183

2. The estimates are provided by CDPH on a cash basis.

FY 2018-19	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Benefits Costs	\$896,000	\$896,000
FY 2018-19 Benefits Costs	\$771,000	\$771,000
Total for FY 2018-19	\$1,667,000	\$1,667,000

FY 2019-20	DHCS FFP	CDPH CLPP Fee Funds
FY 2018-19 Benefits Costs	\$257,000	\$257,000
FY 2019-20 Benefits Costs	\$771,000	\$771,000
Total for FY 2019-20	\$1,028,000	\$1,028,000

Funding:

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185
IMPLEMENTATION DATE: 1/1993
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 91

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,072,000	\$1,126,000
- STATE FUNDS	\$536,000	\$563,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,072,000	\$1,126,000
STATE FUNDS	\$536,000	\$563,000
FEDERAL FUNDS	\$536,000	\$563,000

DESCRIPTION**Purpose:**

This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:

Welfare & Institutions Code 14124.91
 Social Security Act 1916(e)
 Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)

Interdependent Policy Changes:

Not Applicable

Background:

The HIPP program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) allowing the Department to revise the methodology for determining cost effectiveness under the HIPP program. In addition to premiums, the Department also pays for coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net decrease due to an increase in the estimated premium costs and a decrease in the enrollment of active HIPP members.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to an increase in the estimated premium costs.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

Methodology:

1. Premium costs are determined by the prior fiscal year's actual premium expenses and include ancillary costs as incurred. There is also an assumption that premium costs will increase by 5% each fiscal year based on historical trends.
2. In FY 2018-19, based on actual data through June 2018, it is estimated that there will be an increase in premium costs and a decrease in enrollment for FY 2018-19 compared to the prior estimate.
3. The average monthly premium cost including ancillary costs is estimated to be \$502 in FY 2018-19 and \$527 in FY 2019-20.
4. The average monthly HIPP enrollment is estimated to be 178 in FY 2018-19 and 178 in FY 2019-20.
5. Costs for FY 2018-19 and FY 2019-20 are estimated to be:

FY 2018-19: $\$502 \times 178 \times 12 \text{ Months} = \$1,072,000 \text{ TF } (\$536,000 \text{ GF})$

FY 2019-20: $\$527 \times 178 \times 12 \text{ Months} = \$1,126,000 \text{ TF } (\$563,000 \text{ GF})$

Funding:

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

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 186
IMPLEMENTATION DATE: 7/2001
ANALYST: Sasha Jetton
FISCAL REFERENCE NUMBER: 136

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$747,000	\$717,000
- STATE FUNDS	\$357,160	\$347,480
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$747,000	\$717,000
STATE FUNDS	\$357,160	\$347,480
FEDERAL FUNDS	\$389,840	\$369,520

DESCRIPTION

Purpose:

This policy change estimates the screening costs for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Authority:

Title 22, California Code of Regulations 51340(a)

Interdependent Policy Changes:

Not Applicable

Background:

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

The Department is transitioning EPSDT claims to the standard Fee-For-Service (FFS) paid claims process to meet the Health Insurance Portability and Accountability Act (HIPAA) requirements. Claims for clinical laboratories transitioned February 1, 2017. All other claims, except school-based transitioned on July 1, 2017 and are now included in the Fee-For-Service Base expenditures. School-based claims are projected to transition by October 2019.

Reason for Change:

The estimated number of screens decreased while the cost per screen increased slightly from the prior estimate for FY 2018-19 (68,835 and \$0.79). The decrease in screens is due to the ongoing transition of EPSDT claims to Medi-Cal Fee-For-Service Base expenditures. There is no significant change between FY 2018-19 and FY 2019-20 in the current estimate except that Title XXI FMAP funding will step down from 88% to 76.5% federal share starting October 1, 2019.

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 186

There continues to be a small number of State-Only CHDP screens after the transition of undocumented children to Medi-Cal with the implementation of SB 75. These 100% GF expenditures have been moved from the Family Health Local Assistance Estimate to this policy change for FY 2019-20.

Methodology:

Costs are determined by multiplying the estimated screens by the estimated cost per screen for FY 2018-19 and FY 2019-20, based on historical trends from July 2013 to May 2018.

FY 2017-18

Screens 12,035 x \$62.07 (weighted average) = **\$747,000** (rounded)

FY 2018-19

Screens 11,520 x \$62.06 (weighted average) + \$2,000 (State-Only CHDP*) = **\$717,000** (rounded)

Funding:

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

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

100% GF (4260-111-0001)*

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 7/1987
ANALYST: Stephanie Hockman
FISCAL REFERENCE NUMBER: 127

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$381,841,000	-\$370,639,000
- STATE FUNDS	-\$167,167,000	-\$162,263,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$381,841,000	-\$370,639,000
STATE FUNDS	-\$167,167,000	-\$162,263,000
FEDERAL FUNDS	-\$214,674,000	-\$208,376,000

DESCRIPTION

Purpose:

This policy change estimates estate, personal injury, and other insurance recoveries and provider/beneficiary overpayment used to offset the cost of Medi-Cal services.

Authority:

- Welfare & Institutions Code 14009, 14009.5, 14124.70 – 14124.795, 14124.81-14124.86, 14124.90-14124.94, 14172, 14172.5, 14173, 14176, and 14177
- Probate Code Sections 215, 9202, 19202, 3600-3605, and 3610-3613
- Title 22, California Code of Regulations Chapter 2.5 and Sections 50781-50791, 51045, 51047, and 51458.1

Interdependent Policy Changes:

Medi-Cal Estate Recoveries

Background:

Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from personal injury or workers' compensation settlements, judgements or awards; special needs trusts; estates; provider/beneficiary overpayments; and other health insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Effective May 1, 2017, the Department ceased outsourcing of the Worker's Compensation Recovery Program (WCRP). WCRP contracts contain provisions that may enable the contractors to work existing WCRP cases, but prevent contractors from accepting new WCRP cases. Therefore, the Worker's Compensation contract estimates will trend downward, and Personal Injury Collections, consisting of both personal injury and worker's compensation recoveries, will trend upward in the future.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 196

Reason for Change:

Recovery collections vary greatly from month to month, depending on the number of provider audits completed, the financial circumstance of beneficiaries, and the fluctuations of settlements, judgements, and awards. Overall, FY 2018-19 recoveries are projected to be higher than the prior estimate. Special Needs Trust payments for personal injury recoveries increased starting in February 2018. Provider overpayment collections had higher than average collections March through July 2018 due to the clearing of a backlog of audits and a few large, one-time payments. These increases are partially offset by lower beneficiary and estate collections. The decrease in estate recoveries is due to changes to the Medi-Cal Estate Recovery program, limiting the types of estates and services the Department is allowed to collect pursuant to Senate Bill 833 implemented January 1, 2017. Recoveries are projected to decrease between FY 2018-19 and FY 2019-20 in the current estimate primarily in provider overpayment collections, based on the historical trend.

(Dollars in Thousands)

Recovery Type	FY 2018-19	FY 2019-20
Personal Injury Collections	(\$118,860)	(\$118,767)
Workers' Comp. Collections	(\$900)	(\$1,500)
Health Insurance Contingency Contract	(\$105,000)	(\$109,000)
General Collections	(\$157,081)	(\$141,372)
TOTAL	(\$381,841)	(\$370,639)

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2015 – July 2018.
2. The General Fund ratio for collections is estimated to be 43.78% in FY 2018-19 and FY 2019-20. The Federal Medical Assistance Percentages (FMAPs) for Medi-Cal recoveries includes an adjustment related to the Repayment to CMS for Medi-Cal Recoveries policy change.

Funding:

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

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**MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX****POLICY CHANGE
NUMBER****POLICY CHANGE TITLE**

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199

FUNDING ADJUST.—OTLICP

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 1/2002
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 3

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$71,405,000	\$72,722,000
- STATE FUNDS	\$46,166,950	\$47,211,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$71,405,000	\$72,722,000
STATE FUNDS	\$46,166,950	\$47,211,550
FEDERAL FUNDS	\$25,238,050	\$25,510,450

DESCRIPTION

Purpose:

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

Authority:

AB 430 (Chapter 171, Statutes of 2001)
 AB 1810 (Chapter 34, Statutes of 2018)

Interdependent Policy Changes:

Not Applicable

Background:

AB 430 authorized the BCCTP effective January 1, 2002, for individuals at or below 200% of the federal poverty level. Enhanced Title XIX Medicaid funds (65% FFP/35% GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for individuals under 65 years of age who are citizens or legal immigrants with no other health coverage. Every Woman Counts and Family Planning, Access, Care, and Treatment (Family PACT) providers screen beneficiaries.

A State-Only program covers women 65 years of age or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for breast cancer treatment only. In FY 2017-18 the coverage term is 18 months for breast cancer and 24 months for cervical cancer, however, coverage limits are removed through AB 1810 beginning in FY 2018-19. Estimated State-Only costs include undocumented individuals' non-emergency services during cancer treatment. With the implementation of the Affordable Care Act (ACA) in January 2014, some BCCTP beneficiaries now have other coverage options available through Covered California and the Individual Insurance Market.

Health Omnibus Trailer Bill AB 1810, Chapter 34, Statutes of 2018, signed June 27, 2018, appropriates funding to the General Fund for the elimination of the 18 and 24-month treatment limitations. Funding is effective July 1, 2018.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 1

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a slight decrease due to updated enrollment data for January 2018 through March 2018. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a slight increase due to the predicted growth in enrollment.

Methodology:

- There were 3,930 FFS and 1,822 managed care beneficiaries as of March 2018 (total of 5,752).
2,153 of the FFS beneficiaries were eligible for State-Only services.
- 138 of the FFS beneficiaries were in accelerated enrollment as of March 2018.
- Assume the State will pay Medicare and other health coverage premiums for an average of 482 beneficiaries monthly in FY 2018-19 and FY 2019-20. Assume an average monthly premium cost per beneficiary of \$149.61.
FY 2018-19: 482 x \$149.61 x 12 months = \$865,000 TF (\$865,000 GF)
FY 2019-20: 482 x \$149.61 x 12 months = \$865,000 TF (\$865,000 GF)
- Assume 45% of beneficiaries will require a third year of treatment, and 20% of those beneficiaries will require a fourth year of treatment.
- FFS costs are estimated as follows:
(Dollars in Thousands)

FFS Costs	FY 2018-19		FY 2019-20	
	TF	GF	TF	GF
Full Scope Costs	\$ 39,198	\$ 13,959	\$ 39,641	\$ 14,131
State-Only Services	\$ 31,342	\$ 31,342	\$ 32,216	\$ 32,216
State-Only Premiums	\$ 865	\$ 865	\$ 865	\$ 865
Total	\$ 71,405	\$ 46,167	\$ 72,722	\$ 47,212

- Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems, Geographic Managed Care, and Regional Model policy changes.
- In FY 2017-18, AB 1795 increases State-Only BCCTP coverage necessary for the treatment of breast/cervical cancer recurrences with coverage limits of 18 to 24 months.
- In FY 2018-19, AB 1810 removed the coverage limits for State-Only BCCTP.

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
General Fund 4260-101-001	\$ 32,208	\$ 32,208	\$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	\$ 1,601	\$ 800	\$ 800
Title XIX 65/35 FFP4260-101-0001/0890	\$ 37,597	\$ 13,159	\$ 24,438
Total	\$ 71,405	\$ 46,167	\$ 25,238

FY 2019-20	TF	GF	FF
General Fund 4260-101-001	\$ 33,081	\$ 33,081	\$ -
50 Title XIX FFP / 50 GF (4260-101-0001/0890)	\$ 1,708	\$ 854	\$ 854
Title XIX 65/35 FFP4260-101-0001/0890	\$ 37,933	\$ 13,277	\$ 24,656
Total	\$ 72,722	\$ 47,212	\$ 25,510

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 12/2016
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1569

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$64,798,000	\$42,342,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$64,798,000	\$42,342,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$64,798,000	\$42,342,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for the costs of providing inpatient services for adult and juvenile inmates who are deemed eligible for Medi-Cal. This includes health care services to former inmates who have been granted medical parole.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)
 SB 1399 (Chapter 405, Statutes of 2010)
 AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

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

MEDI-CAL STATE INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 2

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

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

For State inmates, with implementation of the Affordable Care Act (ACA), the CDCR utilizes the Single Streamlined Application, currently used by counties, and the Department makes an eligibility determination according to current standard Medi-Cal eligibility rules. Federal Medicaid regulations and federal guidance provided to states, allow for coverage of specified services to eligible inmates when provided off the grounds of a correctional facility. The Department currently has an interagency agreement with the CCHCS in order to claim Title XIX FFP.

These programs require adherence to the utilization review requirements established by the Superior System Waiver.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to using updated payment data from FY 2017-18 to project payments for FY 2018-19 and FY 2019-20. Additionally, retroactive payments have decreased due to payments exceeding the two-year claiming limit being removed and the resolution to an aid code issue which was causing certain ACA payments to be delayed.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to assuming no retroactive claims to be paid in FY 2019-20 based on anticipating to pay all retroactive claims in FY 2018-19.

Methodology:

1. The adult State inmate program began in November 2010. Eligibility began in April 2011 with claiming beginning in April 2012. The juvenile State inmate program began in January 2012 with claiming beginning in April 2013.
2. Applications for State inmates in Medi-Cal are processed by the Department if the applicant received off-site inpatient hospital-related services.
3. Estimated costs for FY 2018-19 and FY 2019-20 are based on FY 2017-18 paid claims data.
4. Assume \$22,456,000 FF in retroactive payments will be paid in FY 2018-19.
5. The Department will continue to pay ACA payments based on the Federal Medical Assistance Percentage of 100% for calendar years 2014 through 2016, 95% for calendar year 2017, 94% for calendar year 2018, 93% for calendar year 2019, and 90% for calendar year 2020.
6. Assume a six month lag in ongoing payments.

MEDI-CAL STATE INMATE PROGRAMS**REGULAR POLICY CHANGE NUMBER: 2**

7. The Non-Federal share for this policy change is budgeted in the CDCR's budget. Included below is the total estimated FFP, including retroactive payments, for the Medi-Cal Inpatient Hospital Costs for all eligible (Medi-Cal and ACA) adult and juvenile inmates in FY 2018-19 and FY 2019-20:

FY 2018-19	TF	FF
Adults - Non ACA	\$9,012,000	\$4,506,000
Adults - ACA	\$39,797,000	\$37,148,000
Medical Parole	\$1,348,000	\$674,000
Juveniles	\$28,000	\$14,000
Total Retroactive Payments	\$37,422,000	\$22,456,000
ACA	\$7,490,000	\$7,490,000
Non-ACA	\$29,932,000	\$14,966,000
Total FY 2018-19	\$87,607,000	\$64,798,000

FY 2019-20	TF	FF
Adults - Non ACA	\$9,012,000	\$4,506,000
Adults - ACA	\$40,815,000	\$37,148,000
Medical Parole	\$28,000	\$14,000
Juveniles	\$1,348,000	\$674,000
Total FY 2019-20	\$51,203,000	\$42,342,000

*Totals may differ due to rounding.

Funding:

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

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

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1755

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$46,739,000	\$152,018,000
- STATE FUNDS	\$811,220	\$969,610
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,739,000	\$152,018,000
STATE FUNDS	\$811,220	\$969,610
FEDERAL FUNDS	\$45,927,780	\$151,048,390

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the counties for the cost of inpatient services for adult and juvenile inmates who are deemed eligible for Medi-Cal. This includes health care services to former inmates who have been compassionately released or granted medical probation.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)
 AB 396 (Chapter 394, Statutes of 2011)
 SB 1462 (Chapter 837, Statutes of 2012)
 AB 720 (Chapter 646, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

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

- Claim FFP for inpatient hospital services to Low Income Health Program (LIHP) eligible adult inmates in county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by the county.

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates, in county correctional facilities, when these services are provided off the grounds of the facility. Previously these services were paid by the county.

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

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

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

responsible for determining Medi-Cal eligibility for county inmates seeking medical probation or compassionate release.

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

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

For county inmates, effective April 1, 2017, counties may participate in the Medi-Cal County Inmate Program (MCIP) that will allow for coverage of specified services to eligible inmates when provided off the grounds of a county correctional facility. MCIP is a voluntary program that allows providers to directly bill the Department's Fiscal Intermediary for allowable MCIP services, consistent with standard Medi-Cal claiming upon an executed MCIP Agreement in which Counties will reimburse the Department for the nonfederal share of the medical costs associated with the county Medi-Cal eligible inmate. County welfare departments will process Medi-Cal eligibility applications submitted by incarcerating counties on behalf of their eligible inmates.

These programs require adherence to the utilization review requirements established by the Superior System Waiver.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net decrease due to actual MCIP payment data for FY 2017-18 being used to project payments for FY 2018-19 and delaying the processing of retroactive claims from FY 2018-19 to FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to applying a growth factor to the FY 2018-19 payments and delaying the retro payments from FY 2018-19 to FY 2019-20.

Methodology:

1. The adult county inmate program began in November 2010. The juvenile county inmate program began in January 2012.
2. County inmate claims with dates of services (DOS) beginning April 1, 2017, will be processed by the fiscal intermediary.
3. Claims with dates of services prior to April 1, 2017, retroactive to the beginning of the adult and juvenile programs, will be part of the retroactive claiming process that will begin in FY 2019-20. Previously, counties paid for these services. The retroactive claiming will be processed manually and the counties will be reimbursed with federal funds for non GF payment portions made for dates of services prior to April 1, 2017.
4. Assume \$103,804,000 in retroactive payments will be paid in FY 2019-20.
5. Claims with dates of services starting April 1, 2017, will be processed by the fiscal intermediary and paid with GF and federal funds. The Department will invoice counties for the GF share of the medical costs associated with the county Medi-Cal eligible inmate on a quarterly basis. The fourth quarter reimbursement will be received the following fiscal year; therefore a GF impact will occur, see the Medi-Cal County Inmate Reimbursement policy change for more information.

MEDI-CAL COUNTY INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

6. The Department will continue to pay ACA payments based on the Federal Medical Assistance Percentage of 100% for calendar years 2014 through 2016, 95% for calendar year 2017, 94% for calendar year 2018, 93% for calendar year 2019, and 90% for calendar year 2020.
7. County inmate claims data for FY 2018-19 and FY 2019-20 is based on actual claims paid from July 2017 through June 2018. The highest quarter in FY 2017-18 was multiplied by four to estimate the annual payments in FY 2018-19.
8. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for County adult and juvenile inmates in FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)	FY 2018-19			FY 2019-20		
County Adult	TF	GF	FF	TF	GF	FF
Adult County - Non ACA	\$2,523	\$418	\$2,105	\$2,649	\$439	\$2,210
Adult County - ACA	\$43,922	\$361	\$43,561	\$45,256	\$495	\$44,761
Compassionate Release	\$238	\$23	\$215	\$250	\$24	\$226
Compassionate Release ACA	\$14	\$7	\$7	\$15	\$7	\$8
Juvenile	\$42	\$3	\$39	\$44	\$4	\$40
Total Retroactive Payments	\$0	\$0	\$0	\$103,804	\$0	\$103,804
Retro ACA	\$0	\$0	\$0	\$49,150	\$0	\$49,150
Retro Non-ACA	\$0	\$0	\$0	\$54,654	\$0	\$54,654
Grand Total	\$46,739	\$812	\$45,927	\$152,018	\$969	\$151,049

*Difference in totals is due to rounding

Funding:

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

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

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

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

94% Title XIX ACA / 6% GF (4260-101-0001/0890)

93% Title XIX ACA / 7% GF (4260-101-0001/0890)

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

NON-OTLIPC CHIP

REGULAR POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 12/1998
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 13

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$156,948,120	-\$173,975,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$156,948,120	-\$173,975,950
FEDERAL FUNDS	-\$156,948,120	\$173,975,950

DESCRIPTION

Purpose:

This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLIPC) 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 88% FFP or Title XXI 76.5%.

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 OTLIPC 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 OTLIPC FPL (aid codes M5, M6).

NON-OTLIP CHIP**REGULAR POLICY CHANGE NUMBER: 7**

- 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 2018-19, is a General Fund (GF) decrease due to changes made to the FY 2018-19 proxy adjustments. The change from FY 2018-19 to FY 2019-20 is a GF decrease due to the prior payments being made in FY 2018-19.

Methodology:

1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be \$570,460,000 TF in FY 2018-19 and FY 2019-20.
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, through September 30, 2019, estimated costs are eligible for Title XXI 88/12 FMAP. From October 1, 2019, through September 30, 2020, estimated costs are eligible for Title XXI 76.5/23.5 FMAP
3. The Department started claiming under the CS3-Proxy in March 2016 with a two-year lag. The Department claims with a one-year lag as of FY 2018-19. This adjustment shifts funding from Title 19 federal funds with a 50% General Fund match to Title 21 federal funds with a 12% General Fund match for claims dated on or after October 1, 2015. Four quarterly adjustments will occur in FY 2018-19 and FY 2019-20 (ongoing adjustment).
4. In FY 2018-19, the Department will repay the CHIP Title XXI federal funds and corresponding General Fund (Fund 4260-113-0001).
5. Total estimated costs for FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)

FY 2018-19	TF	GF
Resource Disregard	\$4,971	(\$1,889)
HPE	\$7,314	(\$2,779)
Medicaid Expansion	\$558,175	(\$212,106)
Proxy/Ongoing Adjustments	\$0	(\$105,837)
Prior Payments	\$0	\$479,557
Total Cost	\$570,460	\$156,945

NON-OTLIP CHIP
REGULAR POLICY CHANGE NUMBER: 7

FY 2019-20	TF	GF
Resource Disregard	\$4,971	(\$1,460)
HPE	\$7,314	(\$2,149)
Medicaid Expansion	\$558,175	(\$163,964)
Ongoing Adjustments	\$0	(\$6,403)
Total Cost	\$570,460	(\$173,976)

Funding:

(Dollars in Thousands)

FY 2018-19	Fund Number	TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	(\$776,826)	(\$388,413)	(\$388,413)
Title XIX FF	4260-101-0890	(\$36,077)	\$0	(\$36,077)
Title XIX GF	4260-101-0001	\$708,417	\$708,417	\$0
Title XXI FF	4260-113-0890	(\$416,065)	\$0	(\$416,065)
Title XXI GF	4260-113-0001	(\$256,275)	(\$256,275)	\$0
88 % Title XXI /12 % GF	4260-113-0001/0890	\$776,826	\$93,219	\$683,607
Net Impact (rounded)		\$0	\$156,948	(\$156,948)

FY 2019-20	Fund Number	TF	GF	FF
50 % Title XIX /50 % GF	4260-101-0001/0890	(\$776,348)	(\$388,174)	(\$388,174)
Title XIX FF	4260-101-0890	(\$26,027)	\$0	(\$26,027)
Title XIX GF	4260-101-0001	\$26,027	\$26,027	\$0
Title XXI FF	4260-113-0890	(\$45,807)	\$0	(\$45,807)
Title XXI GF	4260-113-0001	\$45,807	\$45,807	\$0
88 % Title XXI /12 % GF	4260-113-0001/0890	\$348,502	\$41,820	\$306,682
76.5 % Title XXI /23.5 % GF	4260-113-0001/0890	\$427,846	\$100,544	\$327,302
Net Impact (rounded)		\$0	(\$173,976)	\$173,976

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 12/1997
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 15

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$905,934,000	\$886,182,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$905,934,000	\$886,182,000
FEDERAL FUNDS	-\$905,934,000	-\$886,182,000

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 nonexempt New Qualified Immigrants (NQI) subject to the five-year bar, 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. 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 GF.

NON-EMERGENCY FUNDING ADJUSTMENT**REGULAR POLICY CHANGE NUMBER: 8****Reason for Change:**

The change from the prior estimate, for both FY 2018-19 and FY 2019-20, is due to a decrease in managed care and Fee-for-Service (FFS) expenditures. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to changes in the FMAP for Title XXI and Title XIX ACA expenditures.

Methodology:

1. Based on updated January 2018 through June 2018 FFS expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be \$287,832,000 TF in FY 2018-19 and FY 2019-20.
2. Based on July 2017 through June 2018 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 \$386,663,000 TF in FY 2018-19 and FY 2019-20. The repayment for this group will be 94% FFP for FY 2018-19 until January 2019, when FFP changes to 93%. For FY 2019-20, the repayment for this group will be 93% from January 2019 to December 2019, and then 90% from January 2020 forward.
3. Based on July 2017 through June 2018 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 \$619,472,000 TF in FY 2018-19 and FY 2019-20. The repayment for this group is at 50/50 FMAP, 88/12 FMAP, and 76.5/23.5 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 120,582 undocumented children enrolled in restricted-scope Medi-Cal transitioned to full-scope Medi-Cal. As of September 10, 2018, 134,267 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 254,881.
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 the 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. The estimated FFP Repayment in FY 2018-19 and FY 2019-20:

(Dollars in Thousands)

FFS and MC costs	FY 2018-19		FY 2019-20	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	\$679,437	\$339,719	\$679,437	\$339,719
All Others (65% FF / 35% GF)	\$7,213	\$4,688	\$7,213	\$4,688
All Others (Title XXI)	\$114,802	\$101,026	\$114,802	\$91,124
ACA	\$492,514	\$460,501	\$492,514	\$450,651
Total	\$1,293,966	\$905,934	\$1,293,966	\$886,182

NON-EMERGENCY FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 8

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)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1007

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$94,438,960	-\$83,130,260
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$94,438,960	-\$83,130,260
FEDERAL FUNDS	\$94,438,960	\$83,130,260

DESCRIPTION

Purpose:

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

Authority:

AB 131 (Chapter 80, Statutes of 2005)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updated expenditure reports capturing all prenatal costs for undocumented women. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a slight decrease due to a decrease in estimated prenatal costs for undocumented women.

Methodology:

1. The cost of prenatal care for undocumented women is estimated to be \$95,779,000 TF in FY 2018-19 and \$93,193,000 TF in FY 2019-20.
2. Assume estimated prenatal costs for undocumented women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP. Assume the FMAP for Title XXI is 76.5% FF and 23.5% GF beginning October 1, 2019, and 65% FF and 35% GF on October 1, 2020.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 9

(Dollars in Thousands)

FY 2018-19:	\$95,779 TF x .88 =	\$84,286 FFP
FY 2019-20:	\$23,298 TF x .88 =	\$20,502 FFP
FY 2019-20	\$69,894 TF x .765 =	\$53,469 FFP

- The cost of prenatal care for legal immigrant women is estimated to be \$11,538,000 TF in FY 2018-19 and \$11,538,000 in FY 2019-20.
- Assume estimated prenatal costs for legal immigrant women beginning October 1, 2015, are eligible for Title XXI 88/12 FMAP. Assume the FMAP for Title XXI is 76.5% FF and 23.5% GF beginning October 1, 2019, and 65% FF and 35% GF on October 1, 2020.

(Dollars in Thousands)

FY 2018-19:	\$11,538 x .88 =	\$10,153 FFP
FY 2019-20:	\$2,884 x .88 =	\$2,538 FFP
FY 2019-20	\$8,654 x .765 =	\$6,621 FFP

- The federal funding received on a cash basis will be:

(Dollars in Thousands)

Fiscal Year	Calculation	GF Savings
FY 2018-19	\$84,286 + \$10,153 =	\$94,439
FY 2019-20:	\$20,502 + \$53,469 + \$2,538 + \$6,621 =	\$83,130

Funding:

76.5% Title XXI FF /23.5% GF (4260-113-0001/0890)

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

100% GF (4260-101-0001)

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 12/2016
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1371

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$14,677,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$14,677,000	\$0
FEDERAL FUNDS	-\$14,677,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the retroactive technical adjustments in funding from 100% State General Fund (GF) to claim Title XIX or Title XXI federal match for the health care expenditures of "Qualified Immigrant" children and pregnant women who have not yet met the federal five-year bar, and other specified lawfully present children and pregnant women who are eligible for full scope Medi-Cal with federal financial participation (FFP).

Authority:

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Interdependent Policy Changes:

Not Applicable

Background:

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

CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to NQIs and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US. System changes have been completed, therefore an ongoing adjustment is no longer needed.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to the payment of the remaining retroactive adjustments shifting from FY 2017-18 to FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the cost of the remaining retroactive adjustments being paid in FY 2018-19 only. Adjustments are not needed for ongoing costs as the expenditure reports that originally

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 10

identified this population as 100% State GF have been corrected as of June 2016.

Methodology:

1. Title XXI funding of 88/12 FFP is available for this age group effective October 1, 2015, and Title XIX funding of 50/50 FFP is available for children under the age of 21 and pregnant women.
2. Assume that the retroactive claims from July 2011 through December 2014 will be paid in FY 2018-19.
3. The Department has identified \$14,677,000 that is owed to the federal government for quarters from July 2011 through December 2014 that will be repaid in FY 2018-19.

FY 2018-19	GF	FF
Total	\$14,677,000	(\$14,677,000)

Funding:

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

65% Title XIX FF/ 35% GF (4260-101-0001/0890)

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

MEDI-CAL COUNTY INMATE REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 2/2018
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2029

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement from counties for the General Fund (GF) share of the medical costs associated with the Medi-Cal County Inmate Program (MCIP).

Authority:

AB 1628 (Chapter 729, Statutes of 2010)
 AB 396 (Chapter 394, Statutes of 2011)
 SB 1462 (Chapter 837, Statutes of 2012)
 AB 720 (Chapter 646, Statutes of 2013)

Interdependent Policy Changes:

Medi-Cal County Inmate Programs

Background:

For county inmates, counties may participate in the MCIP that will allow coverage for specified services to eligible inmates when provided off the grounds of a county correctional facility. MCIP is a voluntary program that allows providers to directly bill the Department's Fiscal Intermediary (FI) for allowable MCIP services, consistent with standard Medi-Cal claiming upon an executed MCIP Agreement in which counties will reimburse the Department for the nonfederal share of the medical costs associated with county Medi-Cal eligible inmates.

Claims processed by the FI are paid with GF and federal funds (FF). The Department will invoice counties for the GF share of the medical costs associated with the county Medi-Cal eligible inmate on a quarterly basis. The fourth quarter reimbursement will be received the following fiscal year; therefore, a GF impact will occur each year.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to actual payment data for FY 2017-18 being used to project payments for FY 2018-19. The updated payment data resulted in an increase in projected payments for FY 2018-19 and FY 2019-20.

MEDI-CAL COUNTY INMATE REIMBURSEMENT**REGULAR POLICY CHANGE NUMBER: 11**

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to applying a growth factor to the FY 2018-19 payments to project FY 2019-20. Additionally, the non-federal share for the Affordable Care Act (ACA) payments increases each fiscal year through FY 2019-20.

Methodology:

1. Claims with dates of services beginning April 1, 2017 will be processed by the FI.
2. The Department will invoice the counties on a quarterly basis for the GF share of the medical costs; therefore, the fourth quarter reimbursement will be received the following fiscal year.
3. The Department estimates payments of \$46,739,000 TF (\$45,927,000 FF) and \$152,018,000 TF (\$151,049,000 FF) will be paid in FY 2018-19 and FY 2019-20, respectively.
4. Assume reimbursement will occur in the second month of each quarter for medical costs.
5. The total estimated GF reimbursement in FY 2018-19 and FY 2019-20 will be:

FY 2018-19	GF	Reimbursement
Non ACA	\$401,000	\$401,000
ACA	\$300,000	\$300,000
Juvenile	\$33,000	\$33,000
Compassionate Release	\$9,000	\$9,000
Compassionate Release ACA	\$3,000	\$3,000
Total	\$746,000	\$746,000

FY 2019-20	GF	Reimbursement
Non ACA	\$434,000	\$434,000
ACA	\$461,000	\$461,000
Juvenile	\$23,000	\$23,000
Compassionate Release	\$8,000	\$8,000
Compassionate Release ACA	\$3,000	\$3,000
Total	\$929,000	\$929,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-610-0995)

CDCR RETRO REPAYMENT

REGULAR POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 12/2018
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2109

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$17,206,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$17,206,000	\$0
FEDERAL FUNDS	-\$17,206,000	\$0

DESCRIPTION

Purpose:

The purpose of this policy change is to repay monies to the Centers for Medicare and Medicaid Services (CMS) for State inmates that were erroneously enrolled into Medi-Cal.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)
 SB 1399 (Chapter 405, Statutes of 2010)
 AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

California Department of Corrections and Rehabilitation's State inmate participants of the Custody to Community Transitional Reentry Program (CCTRP) and the Male Community Reentry Program (MCRP) may have been erroneously enrolled in Medi-Cal during any period of their participation in the CCTRP/MCRP programs. The Department will repay any federal monies associated with the Fee-For-Service Claims or Medi-Cal Managed Care Capitation Payments (calendar year 2011-current) for this specific population of inmates (approximately 6,100 inmates) that participated in the CCTRP and MCRP programs.

Federal Funds must be returned for the inmates that were erroneously enrolled into Medi-Cal. Upon completion of the data match by the Department, funds will be returned to CMS.

Reason for Change:

This is a new policy change.

CDCR RETRO REPAYMENT

REGULAR POLICY CHANGE NUMBER: 12

Methodology:

1. Approximately \$17,206,000 will be returned to the appropriate federal fund sources below.

FY 2018-19	TF	GF	FF
Title XIX ACA Recoupment	\$0	\$14,160,000	(\$14,160,000)
Title XIX Recoupment	\$0	\$3,026,000	(\$3,026,000)
Title XXI Recoupment	\$0	\$20,000	(\$20,000)
Total FY 2018-19	\$0	\$17,206,000	(\$17,206,000)

Funding:

- 100% GF (4260-101-0001)
- 100% Title XIX ACA FF (4260-101-0890)
- 100% Title XIX FF (4260-101-0890)
- 100% Title XXI FF (4260-113-0890)

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 2033

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$6,971,000	\$0
- STATE FUNDS	\$96,097,800	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$6,971,000	\$0
STATE FUNDS	\$96,097,800	\$0
FEDERAL FUNDS	-\$103,068,800	\$0

DESCRIPTION

Purpose:

This policy change adjusts the funding from the Optional Expansion FMAP to Medi-Cal's 50/50 FMAP for beneficiaries eligible or already enrolled in Medicare Part A and/or Part B and enrolled in the Optional Expansion eligibility group.

Authority:

Affordable Care Act

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to previously ineligible persons, primarily adults at or below 138 percent of the federal poverty level. To be eligible for the Optional Expansion, a beneficiary cannot be eligible or enrolled in Medicare Part A and/or Part B. Due to system limitations, certain Optional Expansion beneficiaries with Medicare Part A and/or Part B were enrolled in the Optional Expansion group. Enrollment systems were corrected in August 2016 to eliminate further enrollment of Medicare Part A and/or Part B eligibles into the Optional Expansion eligibility group.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to updated actuals and an added one-time reimbursement payment for any Long Term Care (LTC) services these duals may have received from managed care plans participating in CCI. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to no further funding adjustments needed in FY 2019-20. All eligibility redeterminations for this population were completed as of March 31, 2018.

MEDICARE OPTIONAL EXPANSION ADJUSTMENT**REGULAR POLICY CHANGE NUMBER: 13****Methodology:**

1. Medicare Part A and/or Part B eligibles currently enrolled in Optional Expansion are assumed to be eligible for Medi-Cal with a 50% FFP. The Optional Expansion eligibility group's FFP is

CY 2014 – CY 2016	100% FFP
CY 2017	95% FFP
CY 2018	94% FFP
CY 2019	93% FFP
2. Adjustments will continue until all eligibles have been redetermined and no Medicare Part A and/or Part B eligibles remain in the Optional Expansion aid codes. The counties completed the manual effort to redetermine eligibility for this population as of March 31, 2018. For January 2014 – June 2016, the actual expenditures were adjusted for in FY 2017-18. For July 2016 – March 2018, the actual expenditures will be adjusted for in FY 2018-19.
3. The Department recouped the difference between the Optional Expansion managed care capitation rate and the Dual/Partial Eligible managed care capitation rate from the managed care plans in FY 2017-18.
4. Those Medi-Cal eligibles with Part A and/or Part B are estimated in the Optional Expansion aid category, this policy also adjusts the funding for expenditures estimated for FY 2018-19.
5. This policy change will reduce the expenditures estimated in the managed care policy changes for FY 2018-19 payments.
6. Assume the Department will reimburse any LTC services these duals may have received from managed care plans participating in CCI. This will be a one-time payment made at 50/50 FMAP.
7. Changes in the managed care capitation rates will result in changes for related supplemental payments.
 - a. Hospital Quality Assurance Payments (HQAF) made at the 100% ACA FFP will need to be returned to the Department and HQAF payments will be made at the lower dual capitation rate.
 - b. Rate Ranged IGT payments will need to be made for the dual capitation rate.
 - c. Recoupment of General Fund Reimbursement from Designated Public Hospitals (DPHs) from the managed care plans will be needed along with the return of the Intergovernmental Transfer (IGT) to the DPHs.
8. Assume Drug Medi-Cal and Specialty Mental Health Services (SMHS) will include County Funds (CF) once the adjustment to 50% FMAP occurs. The CF are displayed for informational purposes.
9. The overall adjustment is estimated to be:

(Dollars in Thousands)

	TF	FF	GF	HQAF	CF (Display only)
FY 2018-19	(\$6,971)	(\$103,068)	\$96,097	\$0	\$28,310

MEDICARE OPTIONAL EXPANSION ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 13

Funding:*(Dollars in Thousands)*

FY 2018-19	Total Funds	Federal Funds	State Funds
100% ACA Title XIX FF (4260-101-0890)	(\$31,603)	(\$31,603)	
95% ACA Title XIX FF /5% GF (4260-101-0890/0001)	(\$55,917)	(\$53,121)	(\$2,796)
94% ACA Title XIX FF /6% GF (4260-101-0890/0001)	(\$92,780)	(\$87,213)	(\$5,567)
93% ACA Title XIX FF /7% GF (4260-101-0890/0001)	(\$68,465)	(\$63,672)	(\$4,793)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	\$218,506	\$109,253	\$109,253
100% Title XIX FF (4260-101-0890)	\$23,288	\$23,288	
Total	(\$6,971)	(\$103,068)	\$96,097

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1879

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$63,513,000	-\$63,537,000
- STATE FUNDS	-\$7,621,560	-\$13,104,420
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$63,513,000	-\$63,537,000
STATE FUNDS	-\$7,621,560	-\$13,104,420
FEDERAL FUNDS	-\$55,891,440	-\$50,432,580

DESCRIPTION

Purpose:

This policy change estimates the premium revenue associated with the Optional Targeted Low Income Children's Program (OTLICP).

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Change:

Not Applicable

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease resulting from a smaller percent of the population having family income over 160% of the FPL. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to an estimated increase of average monthly eligibles.

Methodology:

1. The Department estimates in FY 2018-19 there will be 927,479 average monthly OTLICP eligibles and 927,812 in FY 2019-20. Based on FY 2016-17 data, 58.07% of the OTLICP population has family incomes over 160% of the FPL.

OTLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 14

2. In FY 2018-19, the Department estimates there are 6,463,044 member months subject to monthly premiums and 6,465,366 in FY 2019-20.

FY 2018-19: $927,479 \times 12 \text{ months} \times 58.07\% = \mathbf{6,463,044}$ member months

FY 2019-20: $927,812 \times 12 \text{ months} \times 58.07\% = \mathbf{6,465,366}$ member months

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

Exempt Member Months	FY 2018-19	FY 2019-20
Total Exempt Member Months	90,954	90,954

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

Loss of Premiums	FY 2018-19	FY 2019-20
Discount Program	840,165	840,467
Delinquent Premiums	646,280	646,513
Total Loss of Premium Member Months	1,486,445	1,486,979

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

Member Months	FY 2018-19	FY 2019-20
Eligible Member Months	6,463,044	6,465,366
Exempt Member Months	(90,954)	(90,954)
Loss Member Months	(1,486,445)	(1,486,979)
Net Member Months	4,885,645	4,887,433

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

7. Beginning October 1, 2015, assume estimated costs are eligible for Title XXI 88/12 FMAP. Beginning October 1, 2019, assume estimated costs are eligible for Title XXI 76.5/23.5 FMAP. The total estimated premium revenue for OTLICP are:
(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$ 63,513	\$ 7,621	\$ 55,892
FY 2019-20	\$ 63,537	\$ 13,106	\$ 50,432

Funding:

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

76.5% Title XXI / 23.5% GF (4260-113-0890/0001)

MINIMUM WAGE INCREASE - CASELOAD SAVINGS

REGULAR POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1979

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$156,975,000	-\$218,606,000
- STATE FUNDS	-\$29,215,000	-\$44,626,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$156,975,000	-\$218,606,000
STATE FUNDS	-\$29,215,000	-\$44,626,000
FEDERAL FUNDS	-\$127,760,000	-\$173,980,000

DESCRIPTION

Purpose:

This policy change estimates savings due to a reduction in caseload resulting from the increase in minimum wage.

Authority:

SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:

Not Applicable

Background:

SB 3 authorized a phased-in increase in the minimum wage from \$10.50 per hour to \$15.00 per hour beginning January 1, 2017 through January 1, 2022. The incremental minimum wage increases may be temporarily suspended by the governor based on certain determinations, such as determination of a General Fund deficit. From January 2022 (or 2023 for employers with 25 employees or fewer) or once the minimum wage reaches \$15 per hour, the minimum wage will be adjusted annually. The minimum wage will increase by the lesser of 3.5% or by the rate of change to the U.S. Consumer Price Index.

The minimum wage increase for employers with 26 or more employees will phase in as follows:

- From January 1, 2017 to December 31, 2017, inclusive, \$10.50 per hour
- From January 1, 2018 to December 31, 2018, inclusive, \$11.00 per hour
- From January 1, 2019 to December 31, 2019, inclusive, \$12.00 per hour
- From January 1, 2020 to December 31, 2020, inclusive, \$13.00 per hour
- From January 1, 2021 to December 31, 2021, inclusive, \$14.00 per hour
- From January 1, 2022, until adjusted, \$15.00 per hour.

The minimum wage increase for employers with 25 employees or fewer began on January 1, 2018, with the minimum wage reaching \$15 per hour on January 1, 2023, excluding any suspensions.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an overall decrease in savings based on a

MINIMUM WAGE INCREASE - CASELOAD SAVINGS**REGULAR POLICY CHANGE NUMBER: 15**

revised estimating methodology. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to caseload reduction, updated PMPM costs, and an increase in incremental savings as a result of the minimum wage increasing to \$13 per hour.

Methodology:

1. Minimum wage was increased to \$11.00 as of January 1, 2018, and will increase to \$12 starting January 1, 2019. The implementation date for the increase to \$13.00 is January 1, 2020.
2. Assume a delay in savings to account for individuals not reporting a change in income immediately. In addition, if individuals are deemed ineligible during redetermination, the individual receives a 90 day period in which they can provide additional information to remain eligible. The combination of these items is assumed to be 6 months.
3. Assume a 60,000 caseload reduction in FY 2018-19 and a 90,000 caseload reduction in FY 2019-20. These reductions are then decreased by 25% to account for local areas that already have increased minimum wages.
4. Assume 60% of the caseload reduction would be considered part of the Optional Expansion population. The remaining caseload would fall into other non-elderly aid categories.
5. The caseload population is approximately split 20% Fee-for-Service and 80% Managed Care. Corresponding payment lags are applied accordingly to calculate the estimated savings.
6. On a cash basis, savings are estimated to be:

FISCAL YEAR	TF	GF	FF
FY 2018-19	\$ (156,975,000)	\$ (29,215,000)	\$ (127,760,000)
FY 2019-20	\$ (218,606,000)	\$ (44,626,000)	\$ (173,980,000)

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)
 94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)
 93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)
 90% Title XIX ACA FF / 10% GF (4260-101-0001/0890)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 16
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1595

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,588,620,000	\$3,814,150,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,588,620,000	\$3,814,150,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,588,620,000	\$3,814,150,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132.956
 Affordable Care Act (ACA) 2401
 Interagency Agreement 11-88407

Interdependent Policy Changes:

Not Applicable

Background:

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

The SPA was approved on August 31, 2012, with an effective date of December 1, 2011. In addition, CMS approved SPA 13-007, effective July 1, 2013, updating eligibility language for compliance with the Social Security Act section 1915(k)(1) and 42 CFR section 441.510.

The CFCO generates new federal funds and creates General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO.

COMMUNITY FIRST CHOICE OPTION**REGULAR POLICY CHANGE NUMBER: 16****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is an increase due to revised expenditure data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to revised expenditure data.

Methodology:

1. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%. The CFCO policy change include 56% Federal Financial Participation (FFP).
2. The estimated costs were provided by CDSS on a cash basis.

Funding:

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

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 4/2015
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1831

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$287,808,000	\$0
- STATE FUNDS	\$97,523,020	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$287,808,000	\$0
STATE FUNDS	\$97,523,020	\$0
FEDERAL FUNDS	\$190,284,980	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of Medi-Cal managed care capitation rate increases to fund the federally required Health Insurer Provider Fee (HIPF).

Authority:

Affordable Care Act (ACA)

Interdependent Policy Changes:

Not Applicable

Background:

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

Federal spending legislation signed in 2015 suspended the HIPF for the 2017 calendar year (the tax to be paid on CY 2016 revenues). This one year moratorium precludes collection of the HIPF as required under the ACA. The moratorium eliminated the CY 2016 HIPF payments. Subsequently, additional federal legislation was signed on January 22, 2018, that suspended the HIPF for the 2019 calendar year (the tax to be paid on CY 2018 revenues).

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 17

Reason for Change:

There is no change from the prior estimate for FY 2018-19.

The change from FY 2018-19 to FY 2019-20 is due to a moratorium on the CY 2018 HIPF. No payments are anticipated to be made in FY 2019-20.

Methodology:

1. This fee applies to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population.
2. CY 2017 estimated payments are expected to occur in FY 2018-19.
3. Payments for CY 2018 have been suspended due to federal budget legislation.
4. Assume the following amounts:

(Dollars in Thousands)

	FY 2018-19	FY 2019-20
CY 2017 Payments	\$287,808	\$0
Total	\$287,808	\$0

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

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	\$181,358	\$90,679	\$90,679
95% Title XIX ACA / 5% GF (4260-101-0890)	\$84,714	\$4,236	\$80,478
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	\$21,736	\$2,608	\$19,128
Total*	\$287,808	\$97,523	\$190,285

*Difference due to rounding.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 18
 IMPLEMENTATION DATE: 2/2016
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1967

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$15,806,000	\$15,452,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,806,000	\$15,452,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$15,806,000	\$15,452,000

DESCRIPTION

Purpose:

This policy change estimates the payment and technical adjustment in funding from Title XIX 50/50 Federal Medical Assistance Percentage (FMAP) to the enhanced Title XIX Affordable Care Act (ACA) FMAP for services provided at Designated Public Hospitals (DPHs) for Hospital Presumptive Eligibility (HPE) to the ACA Optional Expansion Population. HPE is a required provision of the ACA.

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine 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. Individuals complete the HPE application on-line with a qualified HPE provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the decreased federal match for ACA Optional Expansion funding. FY 2018-19 has two quarters of payments for the calendar year 2017 ACA FFP at 95%, and two with CY 2018 ACA FFP at 94%. FY 2019-20 has two quarters with CY 2018 ACA FFP at 94%, and two with CY 2019 ACA FFP at 93%.

HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 18

Methodology:

1. The Department assumes enhanced Title XIX ACA FMAP is available for services provided under the temporary HPE program to those individuals who enroll in temporary HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.
2. The Department submits claims for beneficiaries receiving services in DPHs and makes payments to DPHs for the enhanced FFP. The Department generates reports six months after the last day of the quarter to allow for lagged claims submission. The estimated average quarterly payment for enhanced Title XIX ACA FFP is \$3,952,000 for FY 2018-19 and \$3,863,000 for FY 2019-20.
3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs \$15,806,000 in FY 2018-19 and \$15,452,000 in FY 2019-20. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

FY 2018-19	TF	FF
FY 2017-18 Q1	\$ 3,996	\$ 3,996
FY 2017-18 Q2	\$ 3,996	\$ 3,996
FY 2017-18 Q3	\$ 3,907	\$ 3,907
FY 2017-18 Q4	\$ 3,907	\$ 3,907
Net Impact	\$ 15,806	\$ 15,806

FY 2019-20	TF	FF
FY 2018-19 Q1	\$ 3,907	\$ 3,907
FY 2018-19 Q2	\$ 3,907	\$ 3,907
FY 2018-19 Q3	\$ 3,819	\$ 3,819
FY 2018-19 Q4	\$ 3,819	\$ 3,819
Net Impact	\$ 15,452	\$ 15,452

Funding:

(Dollars in Thousands)

FY 2018-19	TF	FF
95% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	\$ 7,992	\$ 7,992
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	\$ 7,814	\$ 7,814
Net Impact	\$ 15,806	\$ 15,806

FY 2019-20	TF	FF
94% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	\$ 7,814	\$ 7,814
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	\$ 7,638	\$ 7,638
Net Impact	\$ 15,452	\$ 15,452

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1821

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$44,182,250	-\$42,667,430
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$44,182,250	-\$42,667,430
FEDERAL FUNDS	\$44,182,250	\$42,667,430

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the ACA requires the Department to give hospitals the option to determine 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. Individuals complete the HPE application on-line with a qualified HPE Provider at a participating, qualified hospital. Eligibility is determined in real-time.

Individuals granted temporary HPE must complete the Medi-Cal application process in order to enroll in a permanent Medi-Cal program.

Reason for Change:

The increase in General Fund savings from the prior estimate, for FY 2018-19, resulted from the addition of quarterly claims for FY 2017-18 quarters 2 and 3, which continue a higher trend. The decrease in General Fund savings from FY 2018-19 to FY 2019-20, in the current estimate, results from the enhanced ACA FMAP decreasing from 94% in 2018 to 93% in 2019, and decreasing further to 90% in 2020.

HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

REGULAR POLICY CHANGE NUMBER: 19

Methodology:

1. The Department assumes enhanced Title XIX ACA Federal Funding (FF) is available for services provided under the HPE program to those individuals who enroll in HPE at a qualified hospital, then successfully complete the Medi-Cal application process, and are enrolled in the ACA Optional Expansion program.
2. Based on actual claims for individuals identified above, the Department retroactively requests enhanced Title XIX ACA FF.
3. Using claims from FY 2017-18 Q1 through FY 2017-18 Q3, the estimated average quarterly adjustment for FY 2018-19 and FY 2019-20 is \$25,247,000.
4. The Department estimates to adjust \$100,988,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2018-19 and FY 2019-20. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX FF / 50% GF	\$ (100,988)	\$ (50,494)	\$ (50,494)
94% Title XIX FF / 6% GF	\$ 75,741	\$ 4,545	\$ 71,196
93% Title XIX FF / 7% GF	\$ 25,247	\$ 1,767	\$ 23,480
Net Impact	\$ -	\$ (44,182)	\$ 44,182

FY 2019-20	TF	GF	FF
50% Title XIX FF / 50% GF	\$ (100,988)	\$ (50,494)	\$ (50,494)
93% Title XIX FF / 7% GF	\$ 75,741	\$ 5,302	\$ 70,439
90% Title XIX FF / 10% GF	\$ 25,247	\$ 2,525	\$ 22,722
Net Impact	\$ -	\$ (42,667)	\$ 42,667

Funding:

- 94% Title XIX FF (4260-101-0001)
- 93% Title XIX FF (4260-101-0001)
- 90% Title XIX FF (4260-101-0001)
- 50% Title XIX FF (4260-101-0890/0001)

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 20
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1845

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the Affordable Care Act (ACA) expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups, and imposes a penalty upon the uninsured which will be in force through calendar year 2018. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as a result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of both the ACA optional and mandatory expansions.

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

As of the November 2015 Estimate, the estimated savings are assumed to be 100% in the ACA Optional Expansion base trends. This policy change is informational only.

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 20

Reason for Change:

There is no change, from the previous estimate, for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, resulted from increased per member per month (PMPM) rates and decreased federal match rates, dropping from an average of 93.5% in FY 2018-19 to 91.5% in FY 2019-20.

Methodology:

- Effective January 1, 2014, the ACA simplified eligibility for several coverage groups (Children, Pregnant Women, and 1931(b)).
- The Department estimates six select populations who were eligible prior to the ACA, that will take-up coverage as part of the ACA expansion group. Following are the six select populations and the estimated General Fund savings associated with each population:

(Dollars in Thousands)

Select Populations:	FY 2018-19	FY 2019-20
Individuals who forego applying for disability	\$ (6,217)	\$ (6,228)
Disabled not enrolled in Medicare but need LTSS	\$ (4,877)	\$ (4,885)
Medically Needy 19/20 no SOC not <i>Sneede v. Kizer</i>	\$ (1,457)	\$ (1,459)
Medically Needy parents with SOC	\$ (25,733)	\$ (25,777)
Pregnant women income 109-138% FPL	\$ (1,698)	\$ (1,759)
SB 87 pending disability individuals	\$ (27,890)	\$ (27,938)
TOTAL	\$ (67,872)	\$ (68,046)

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

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$ (135,744)	\$ (67,872)
94% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	\$ 67,872	\$ 4,072
93% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	\$ 67,872	\$ 4,751
Net Impact	\$ -	\$ (59,049)

FY 2019-20	TF	GF
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$ (136,092)	\$ (68,046)
93% Title XIX ACA FF / 5% GF (4260-101-0890/0001)	\$ 68,046	\$ 4,763
90% Title XIX ACA FF / 6% GF(4260-101-0890/0001)	\$ 68,046	\$ 6,805
Net Impact	\$ -	\$ (56,478)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 21
 IMPLEMENTATION DATE: 1/2016
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1791

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$2,349,000	-\$2,372,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$2,349,000	-\$2,372,000
FEDERAL FUNDS	\$2,349,000	\$2,372,000

DESCRIPTION

Purpose:

This policy change estimates an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services.

Authority:

Affordable Care Act (ACA), Section 4106

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2013, the ACA provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned Grade A or B by the United States Preventive Services Task Force (USPSTF), and approved adult vaccines and their administration as recommended by the Advisory Committee on Immunization Practices (ACIP). To be eligible to receive the enhanced FMAP, States must cover the specified preventive services in their standard Medicaid benefit package and cannot impose cost sharing for these services. States may only claim the 1% FMAP on services that adhere to the USPSTF Grade A and B recommendations on age, gender, periodicity and other criteria as indicated in the summary of recommendations. The Department previously incorporated, and continues to provide USPSTF recommended Grade A and B preventative services and ACIP approved adult vaccines as part of the Medi-Cal benefit package without cost-sharing.

The majority of the USPSTF Grade A and B recommendations include preventive screening services for adults only. The 1% FMAP policy does not apply to family planning services that are eligible for 90% match and prescription drugs (including over-the-counter).

For Fee-for-Service (FFS) beneficiaries, many of the 1% FMAP eligible services for children, such as those for newborns prior to discharge from the hospital, cannot be pulled from the bundled rate. Additionally, the 1% FMAP can only be claimed if the primary purpose of the visit is the delivery of preventive services under USPSTF and ACIP.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 21

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to updated data, for both FFS and managed care that includes 1% FMAP reimbursement for ACA optional expansion costs for the period from January 1, 2017 through June 30, 2018 and updated USPSTF recommendations.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to a higher FFS savings projected for FY 2019-20.

Methodology:

1. The 1% FMAP savings for period July 1, 2017 through June 30, 2018, for both FFS and managed care, will occur in FY 2018-19. For FY 2019-20, both FFS and managed care savings will include the period from July 1, 2018 through June 30, 2019.
2. Total savings for the 1% FMAP increase for preventive services are as follows:

FY 2018-19	TF	GF	FF
FFS:			
FY 2017-18 Savings	\$0	(\$240,000)	\$240,000
Total FFS	\$0	(\$240,000)	\$240,000
Managed Care:			
FY 2017-18 Savings	\$0	(\$2,109,000)	\$2,109,000
Total Managed Care	\$0	(\$2,109,000)	\$2,109,000
Total FY 2018-19	\$0	(\$2,349,000)	\$2,349,000

FY 2019-20	TF	GF	FF
FFS:			
FY 2018-19 Savings	\$0	(\$263,000)	\$263,000
Total FFS	\$0	(\$263,000)	\$263,000
Managed Care:			
FY 2018-19 Savings	\$0	(\$2,109,000)	\$2,109,000
Total Managed Care	\$0	(\$2,109,000)	\$2,109,000
Total FY 2019-20	\$0	(\$2,372,000)	\$2,372,000

Funding:

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 10/2019
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 2105

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$603,179,000
- STATE FUNDS	\$0	-\$268,502,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$603,179,000
STATE FUNDS	\$0	-\$268,502,000
FEDERAL FUNDS	\$0	-\$334,677,000

DESCRIPTION

Purpose:

This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

Authority:

Affordable Care Act (ACA), H.R. 3590, Section 2551
 HR 2 (2015)
 HR 1892 (2018)

Interdependent Policy Changes:

Not Applicable

Background:

The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of DSH allotments in FY 2019-20 in the amount of \$4 billion. The original effective date of the reduction was October 1, 2013; however, HR 2 (2015) delayed the start date of the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. Scheduled reductions for each fiscal year are expected to continue through Federal Fiscal Year 2025, for a total aggregate reduction of \$44 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

The first-year reduction amount was originally set at an aggregate nationwide amount of \$2 billion. In October 2017, CMS released a simulated California DSH reduction amount of \$166 million, which represented 8.35% of the total national reduction. The reduction schedule and annual amounts have since been modified. California's portion of the national reduction is assumed to be 8.35%.

The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The non-federal share of the payment is funded via the General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs). However, private hospitals receive Medi-Cal DSH replacement payment adjustments from Title XIX funding, along with \$160.00 from the

ACA DSH REDUCTION

REGULAR POLICY CHANGE NUMBER: 22

annual DSH allotment. The \$160.00 of the annual DSH allotment satisfies the State's payment obligations under the Federal DSH statute. See the Private Hospital DSH Replacement, DSH Payment, and Global Payment Program (GPP) policy changes for more information.

Reason for Change:

This is a new policy change.

Methodology:

- California's DSH allotment for FY 2019-20 is estimated to be \$1.282 billion.
- California's reduction for FY 2019-20 results in a total reduction of \$334 million FF for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs). The DSH allotment reduction will offset DSH payments for NDPHs and DPHs in the DSH Payment and Global Payment Program (GPP) policy changes.
- The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate DSH replacement funding. That amount is estimated to be \$78 million FF for FY 2019-20. The Private DSH allotment reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.
- Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

FY 2019-20 (Annual)	TF	GF	FF	IGT
Private DSH	(\$156,114)	(\$78,057)	(\$78,057)	\$0
DSH NDPH	(\$8,334)	(\$4,167)	(\$4,167)	\$0
DSH UC	(\$72,191)	\$0	(\$72,191)	\$0
GPP	(\$515,014)	\$0	(\$257,507)	(\$257,507)
Total Reduction FY 2019-20	(\$751,653)	(\$82,224)	(\$411,922)	(\$257,507)

- Assume 11/12 of the FY 2019-20 DSH payment reduction will occur in FY 2019-20 and 1/12 will occur in FY 2020-21 for Private Hospital DSH Replacement, DSH NDPH, and DSH UC.
- Assume 3/4 of the FY 2019-20 DSH payment reduction will occur in FY 2019-20 and 1/4 will occur in FY 2020-21 for GPP.

The aggregate DSH reduction is as follows on a cash basis:

(Dollars in Thousands)

FY 2019-20 (Cash Basis)	TF	GF***	FF	IGT
FY 2019-20 Private DSH	(\$143,104)	(\$71,552)	(\$71,552)	\$0
FY 2019-20 DSH NDPH	(\$7,640)	(\$3,820)	(\$3,820)	\$0
FY 2019-20 DSH UC*	(\$66,175)	\$0	(\$66,175)	\$0
FY 2019-20 GPP**	(\$386,260)	\$0	(\$193,130)	(\$193,130)
Total Reduction FY 2019-20	(\$603,179)	(\$75,372)	(\$334,677)	(\$193,130)

ACA DSH REDUCTION
REGULAR POLICY CHANGE NUMBER: 22

Funding:

100% Demonstration DSH Fund (4260-601-7502)*

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

100% Global Payment Program Special Fund (4260-601-8108)**

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

PAYMENTS TO PRIMARY CARE PHYSICIANS

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

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,547,000	-\$4,548,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,547,000	-\$4,548,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$4,547,000	-\$4,548,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Section 1202 of the ACA required Medi-Cal to provide increased reimbursement for primary care physician (PCP) services. The rates were increased to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The increased rate reimbursement amounts were determined by using Medi-Cal rates that were in effect as of July 1, 2009 compared to the 2013 and 2014 Medicare rates respectively. The Department received 100% FFP for the increased reimbursements for PCP services.

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

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

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 23

primary care specialists, regardless of whether furnished by the physician directly or under the physician's personal supervision.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to additional recoupments expected to be completed. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to less recoupments expected in FY 2019-20.

Methodology:

1. Implementation began November 4, 2013, and the increase was retroactive to January 1, 2013.
2. The Department is in the process of reconciling claims for the ACA increase against interim payments to determine the amount of true-up payments that need to be completed.
3. The total remaining recoupments is estimated to be \$10,600,000 TF. A total of \$4,547,000 TF is estimated to be recouped in FY 2018-19. For FY 2019-20, a total of \$4,548,000 TF is expected to be recouped.

(Dollars in Thousands)

Recoupments	TF	FF
FY 2018-19	(\$4,547)	(\$4,547)
FY 2019-20	(\$4,548)	(\$4,548)

Funding:

100% Title XIX (4260-101-0890)

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 2064

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,400,000,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,400,000,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$2,400,000,000	\$0

DESCRIPTION

Purpose:

This policy change budgets additional federally funded payments to and recoveries from managed care health plans (MCPs) related to the Medical Loss Ratio (MLR) risk corridor calculations for ACA Optional Expansion (ACA OE) members.

Authority:

Affordable Care Act (ACA)

Interdependent Policy Changes:

MCO Tax Managed Care Plans
 MCO Tax Mgd. Care Plans-Funding Adjustment
 MCO Tax Mgd. Care Plans-Incr. Cap. Rates.

Background:

Full-risk Medi-Cal MCP contracts establish a risk corridor pertaining to MLR for ACA OE members, for the incurred periods of January 1, 2014, through June 30, 2015, and July 1, 2015, through June 30, 2016. MCPs are required to expend at least 85% of net capitation payments received for ACA OE members on allowed medical expenses for ACA OE members, for each county or region. An MCP which does not meet the minimum 85% threshold for a given county or region must return to DHCS the difference between 85% of total net capitation payments and actual allowed medical expenses. If an MCP's MLR exceeds 95% of total net capitation payments, then DHCS must make additional payment to the MCP equal to the difference between the MCP's allowed medical expenses and 95% of net capitation payments.

This policy change budgets additional payments to and recoveries from MCPs related to the ACA OE MLR risk corridor calculations, as required by the existing Medi-Cal MCP contracts. On aggregate, the Department expects to recover funds from MCPs following the completion of the ACA OE MLR calculations.

ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

REGULAR POLICY CHANGE NUMBER: 24

Reason for Change:

The change from the prior estimate for FY 2018-19 is due to finalizing recoupment calculations.

The change from FY 2018-19 to FY 2019-20, is a decrease in recoupment due to all recoupments for the 30-month MLR time period occurring in FY 2018-19.

Methodology:

1. MCPs will report data for the MLR corridor calculation for the following 18-month time period:
 - January 1, 2014, through June 30, 2014
 - July 1, 2014, through December 31, 2014
 - January 1, 2015, through June 30, 2015
2. MCPs will report data for the MLR corridor calculation for the following 12-month time period:
 - July 1, 2015, through June 30, 2016
3. The Department calculated a single MLR calculation for this 18-month time period of (January 1, 2014, through June 30, 2015). Applicable recoupments and/or paybacks are expect to occur in FY 2018-19.
4. The Department performed a single MLR calculation for the 12-month period (July 1, 2015, through June 30, 2016). Applicable recoupments and/or paybacks of federal dollars are expected to occur in FY 2018-19.
5. For each MLR period, the Department determined MCPs that do not meet the minimum MLR standard of 85 percent. Any dollar amount below this threshold will be reimbursed to the Centers for Medicare and Medicaid Services (CMS), as capitation payments for this rating period were 100% federally funded.
6. For each MLR period, the Department determined MCPs that exceed an MLR of 95%. Total amounts exceeding this threshold will be paid to the applicable MCP(s), any repayments will be federally funded.
7. Based on final calculations, it is assumed \$2,400,000,000 will be recouped from the MCPs for both reporting periods.

(Dollars in Thousands)

	TF	FF	GF
FY 2018-19	(\$2,400,000)	(\$2,400,000)	\$0

Funding:

ACA 100% FFP (2014-2016) Title XIX 100% FF

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 25
 IMPLEMENTATION DATE: 10/2016
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1855

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$582,841,000	\$695,404,000
- STATE FUNDS	\$258,502,240	\$315,423,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$582,841,000	\$695,404,000
STATE FUNDS	\$258,502,240	\$315,423,250
FEDERAL FUNDS	\$324,338,760	\$379,980,750

DESCRIPTION

Purpose:

This policy change estimates the costs for providing Behavioral Health Treatment (BHT) services for children under age 21 with a diagnosis of autism spectrum disorder (ASD).

Authority:

Social Security Act Section 1905(a)(13)
 SB 870 (Chapter 40, Statutes of 2014)
 State Plan Amendment (SPA) 14-026
 Welfare and Institutions (W&I) Code 14132.56
 Interagency Agreement 15-92451

Interdependent Policy Changes:

Not Applicable

Background:

SB 870 added W&I Code, Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals under 21 years of age. On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance for states to cover BHT services for Medicaid beneficiaries with an Autism Spectrum Disorder (ASD) diagnosis.

On September 15, 2014, the Department issued interim guidance to Medi-Cal managed care health plans (MCPs) requiring the MCPs to cover all medically necessary BHT services effective on or after September 15, 2014. The Department received approval of SPA 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit.

Prior to the addition of BHT as a Medi-Cal benefit, BHT and other Medi-Cal related services were provided under the Medicaid 1915(c) and (i) waivers for individuals with developmental disabilities that met certain eligibility criteria. These services were provided through a system of Regional Centers (RC) contracted with the Department of Developmental Services (DDS).

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 25

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016. Medi-Cal beneficiaries age 21 and over receiving BHT services from RCs will continue to receive those services from the RCs pursuant to the 1915(c) and (i) waivers.

The transition to Medi-Cal BHT services from 1915(c) and (i) waiver services occurred as follows:

- Fee-for-Service (FFS) Beneficiaries
The transition of financial responsibility for BHT services for FFS beneficiaries receiving RC BHT services occurred on February 1, 2016. These beneficiaries continue to receive services with their current BHT provider(s) in the RC delivery system, at the existing levels of BHT service. On July 7, 2017, the Department entered into an Interagency Agreement (IA) contract with DDS to reimburse for costs incurred for BHT clients.
- Managed Care Beneficiaries
The transition for managed care beneficiaries began on February 1, 2016, and was completed in September 2016. Transition was based on the beneficiary's birth month (or RC if residing in Los Angeles County).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to the following:

- For Fee-for-Service, the net increase is due to the following:
 - Due to delayed invoices, FY 2017-18 claims shifted to be paid in FY 2018-19.
 - FY 2018-19 estimated claims are lower than previously projected.
- For managed care, the increase is due to:
 - Delayed FY 2017-18 supplemental capitation payments that were paid in FY 2018-19,
 - A higher number of supplemental capitation payments based on actual paid claims data as of June 2018,
 - An increase to the FY 2018-19 managed care capitation rate.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to:

- For FFS, fewer prior year payments estimated in FY 2019-20.
- For managed care, the increase is due to:
 - An increase in the projected supplemental capitation payments in FY 2019-20, and
 - An increase to the FY 2019-20 managed care capitation rate.

Methodology:

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

Fee-for-Service

2. A total of 1,683 FFS beneficiaries transitioned from DDS on February 1, 2016.
3. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016. DDS began submitting invoices in July, 1 2017.
4. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.
5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost, on an accrual basis, for FY 2018-19 and FY 2019-20, is \$7,016,000 TF.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 25

6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

(Dollars in Thousands)

Fee-for-Service Claims	Accrual	FY 2018-19	FY 2019-20
FY 2017-18 claims		\$4,483	
FY 2018-19 claims	\$7,016	\$5,847	\$1,169
FY 2019-20 claims	\$7,016		\$6,431
Total		\$10,330	\$7,600

Managed Care

7. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.
8. Assume 24,225 members received BHT services in FY 2017-18; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2017-18 is 193,980.

$$\text{FY 2017-18: } 193,980 \times \$2,334.04 = \$452,757,000 \text{ TF}$$

9. Assume 28,293 members receive BHT services in FY 2018-19; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2018-19 is 236,639.

$$\text{FY 2018-19: } 236,639 \times \$2,508.41 = \$593,588,000 \text{ TF}$$

10. Assume 32,361 members receive BHT services in FY 2019-20; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2019-20 is 273,066.

$$\text{FY 2019-20: } 273,066 \times \$2,633.83 = \$719,209,000 \text{ TF}$$

11. Due to the supplemental capitation payment methodology, assume the following payment lags:
- For FY 2017-18, assume 72% of payments was paid in the same fiscal year and 28% of payments will be paid in the following fiscal year, due to a delay in supplemental capitation payments.
 - For FY 2018-19 and FY 2019-20, assume 75% of payments will be paid in the same fiscal year and 25% of payments will be paid the following fiscal year.

(Dollars in Thousands)

Rate Year	Accrual	FY 2018-19	FY 2019-20
FY 2017-18 - FFS		\$4,483	\$0
FY 2017-18 - MC	\$452,757	\$127,320	\$0
FY 2018-19 - FFS	\$7,016	\$5,847	\$1,169
FY 2018-19 - MC	\$593,588	\$445,191	\$148,397
FY 2019-20 - FFS	\$7,016	\$0	\$6,431
FY 2019-20 - MC	\$719,209	\$0	\$539,407
Total		\$582,841	\$695,404

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 25

(Dollars in Thousands)

FY 2018-19	TF	GF	FF XIX	FF XXI
Fee-for-Service	\$10,330	\$4,582	\$4,397	\$1,351
Managed Care	\$572,511	\$253,920	\$243,710	\$74,881
Total	\$582,841	\$258,502	\$248,107	\$76,232

(Dollars in Thousands)

FY 2019-20	TF	GF	FF XIX	FF XXI
Fee-for-Service	\$7,600	\$3,453	\$3,235	\$912
Managed Care	\$687,804	\$311,970	\$292,789	\$83,045
Total	\$695,404	\$315,423	\$296,024	\$83,957

Funding:

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

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 1/1997
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$410,507,000	\$417,392,000
- STATE FUNDS	\$129,132,800	\$131,299,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$410,507,000	\$417,392,000
STATE FUNDS	\$129,132,800	\$131,299,100
FEDERAL FUNDS	\$281,374,200	\$286,092,900

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

Reason for Change:

The increase from the prior estimate, for FY 2018-19, is due to increased reimbursement rates. The slight increase in the current estimate, from FY 2018-19 to FY 2019-20, is due to the continuing implementation of rate increases and finalization of Erroneous Payment Corrections.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 26

Methodology:

1. The Department used linear regressions on actual data from September 2011 to July 2018 for users, units per user, and dollars per unit.
2. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.
3. The treatment of STIs and other family planning-related services are eligible for Title XIX 50/50 FFP.
4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

(Dollars in Thousands)

Service Category	FY 2018-19		FY 2019-20	
	TF	GF	TF	GF
Physicians	\$ 98,618	\$ 23,512	\$ 102,281	\$ 24,385
Other Medical	\$ 266,461	\$ 63,527	\$ 267,336	\$ 63,736
Co. & Comm. Outpatient	\$ 2,555	\$ 609	\$ 2,620	\$ 625
Pharmacy	\$ 42,873	\$ 10,221	\$45,155	
Total	\$ 410,507	\$ 97,869	\$ 417,392	\$ 99,511

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$ 13,198	\$ 6,599	\$ 6,599
100% GF (4260-101-0001)	\$ 57,266	\$ 57,266	\$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	\$ 340,043	\$ 34,004	\$ 306,039
Total	\$ 410,507	\$ 97,869	\$ 312,638

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$ 13,420	\$ 6,710	\$ 6,710
100% GF (4260-101-0001)	\$ 58,226	\$ 58,226	\$ -
90% Family Planning / 10% GF (4260-101-0001/0890)	\$ 345,746	\$ 34,575	\$ 311,171
Total	\$ 417,392	\$ 99,511	\$ 317,881

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 27
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1476

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$266,213,000	\$276,138,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$266,213,000	\$276,138,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$266,213,000	\$276,138,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

On September 29, 2016, SPA 16-016 was approved by the Centers for Medicare and Medicaid Services (CMS) to renew SPA 09-023A with an effective date of October 1, 2016. The SPA will expire on September 30, 2021.

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 27

On October 9, 2015, SPA 11-040 was approved, retroactive to October 1, 2011, which extends Medi-Cal coverage for existing infant development programs provided to Medi-Cal eligible infants and toddlers with a developmental delay. The Department and CDDS have a separate interagency agreement to draw down FFP for infant development services.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to updating expenditures with actuals.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to a projected increase in caseload.

Methodology:

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

(Dollars in Thousands)

	TF	CDDS GF	FF
FY 2018-19	\$532,426	\$266,213	\$266,213
FY 2019-20	\$552,276	\$276,138	\$276,138

Funding:

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 25

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$132,312,000	\$135,275,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$132,312,000	\$135,275,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$132,312,000	\$135,275,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132.06 and 14115.8

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to updated interim payments, an increased annual rate inflation estimate, additional FY 2015-16 withholds due to LEAs, and including estimated reconciliations due to the State.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to higher interim payments based on the prior year's increased payments, an increased annual rate inflation estimate, and no withholds due to LEAs in FY 2019-20.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. The estimate is based on the preceding three fiscal year claims submitted by LEAs.
2. The FY 2018-19 and FY 2019-20 interim payments are adjusted based on the Implicit Price Deflators for Gross Domestic Products through an erroneous payment correction. A 2.71% interim growth rate is assumed for FY 2018-19 and FY 2019-20, respectively.
3. Assume an over collection of withholds due to the LEAs for FY 2015-16 will be paid in FY 2018-19.
4. Assume adjustments for cost report reconciliation due back to the State will be received in FY 2018-19 and FY 2019-20.

FY 2018-19	TF	Title XIX FF	Title XXI FF
FY 2018-19 Interim Payments	\$140,401,000	\$114,242,000	\$26,159,000
Annual Rate Inflation	\$3,806,000	\$3,097,000	\$709,000
FY 2015-16 Withholds due to LEAs	\$946,000	\$770,000	\$176,000
FY 2018-19 Reconciliation due to State	(\$12,841,000)	(\$10,449,000)	(\$2,392,000)
Total	\$132,312,000	\$107,660,000	\$24,652,000

FY 2019-20	TF	Title XIX FF	Title XXI FF
FY 2019-20 Interim Payments	\$144,207,000	\$117,339,000	\$26,868,000
Annual Rate Inflation	\$3,909,000	\$3,181,000	\$728,000
FY 2019-20 Reconciliation due to State	(\$12,841,000)	(\$10,449,000)	(\$2,392,000)
Total	\$135,275,000	\$110,071,000	\$25,204,000

Funding:

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

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

FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 29
 IMPLEMENTATION DATE: 1/2018
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2043

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$84,057,000	\$79,032,000
- STATE FUNDS	\$27,765,280	\$26,721,520
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$84,057,000	\$79,032,000
STATE FUNDS	\$27,765,280	\$26,721,520
FEDERAL FUNDS	\$56,291,720	\$52,310,480

DESCRIPTION

Purpose:

The policy change estimates the cost of fully restoring adult dental benefits to the Medi-Cal Dental Program. This policy increases 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 included 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:

The change from the prior estimate, for FY 2018-19, is a net decrease due to a projected decrease in eligibles in Dental Managed Care and a change in methodology to project Fee-For-Service costs based on actual data. The change from FY 2018-19 to FY 2019-20 in the current estimate is a net decrease due to lower Dental Managed Care rates.

FULL RESTORATION OF ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 29

Methodology:

1. This policy implemented January 1, 2018. As such six (6) months of actuals are available from FY 2017-18, which are used to project costs.
2. Utilized data regarding the number of paid incidences by procedure code for January through June 2018 specific to adult beneficiaries ages 21 and older.
3. For Dental Managed Care, the portion of the capitated rate attributed to the restoration of adult dental benefits is applied to the projected eligible count.

Fiscal Year	TF	GF	FF
FY 2018-19	\$84,057,000	\$27,766,000	\$56,291,000
FY 2019-20	\$79,032,000	\$26,721,000	\$52,311,000

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 94% Title XIX ACA FF/6% GF (4260-101-0001/0890)
 93% Title XIX ACA FF/7% GF (4260-101-0001/0890)
 90% Title XIX ACA FF/10% GF (4260-101-0001/0890)

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 30
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2041

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$101,777,000	\$150,352,000
- STATE FUNDS	\$45,140,240	\$68,194,780
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$101,777,000	\$150,352,000
STATE FUNDS	\$45,140,240	\$68,194,780
FEDERAL FUNDS	\$56,636,760	\$82,157,220

DESCRIPTION

Purpose:

This policy change estimates the costs for transitioning additional Regional Center (RC) clients and providing medically necessary Behavioral Health Treatment (BHT)/ Behavioral Intervention Services (BIS) as recommended by a physician or psychologist for eligible beneficiaries under 21 years of age under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit from the Department of Developmental Services (DDS) RCs to Medi-Cal.

Authority:

Social Security Act Section 1905(a)(13)
 SB 870 (Chapter 40, Statutes of 2014)
 State Plan Amendment (SPA) 14-026

Interdependent Policy Changes:

Not Applicable

Background:

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance requiring states to cover BHT services for Medicaid beneficiaries under 21 years of age with an Autism Spectrum Disorder (ASD) diagnosis. Subsequently, CMS determined that Medi-Cal must cover medically necessary BHT services for all individuals under the age of 21, regardless of diagnosis.

On September 15, 2014, the Department issued interim guidance to Medi-Cal managed care health plans (MCPs) requiring the MCPs to cover all medically necessary BHT services for beneficiaries under 21 years of age with an ASD diagnosis effective on or after September 15, 2014. The Department received approval for SPA 14-026 on January 21, 2016, to include BHT as a covered Medi-Cal benefit pursuant to Section 14132.56 of the Welfare and Institutions (W&I) Code.

BHT and other Medi-Cal related services were previously provided under the Medicaid 1915(c) and (i) waivers for individuals with developmental disabilities that meet certain eligibility criteria. These services are provided through a system of RCs contracted with DDS.

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION

REGULAR POLICY CHANGE NUMBER: 30

The Department, in collaboration with DDS, transitioned responsibility for BHT services for consumers with an ASD diagnosis in 2016. Costs for the DDS transition are budgeted in the Behavioral Health Treatment policy change.

Additional RC clients, without an ASD diagnosis, have been receiving BHT/BIS through the RCs. On March 1, 2018, the Department transitioned these additional RC clients enrolled in Fee-for-Service (FFS) Medi-Cal to Medi-Cal coverage for BHT/BIS. The transition of Medi-Cal managed care clients began on July 1, 2018 and is expected to be completed by December 1, 2018.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to:

- Updated number of managed care beneficiaries in the transition population.
- FY 2018-19 managed care capitation rate change.
- Extended county phase-in to December 2018 for the managed care transition.
- For FFS, FY 2017-18 estimated claims increased.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to:

- Increase in the managed care capitation rate for FY 2019-20.
- Full county phase-in for managed care in FY 2019-20.
- For FFS, FY 2019-20 costs includes less prior year claims than FY 2018-19.

Methodology:

1. An estimated 5,193 beneficiaries will transition into the Medi-Cal BHT program. Transition began in March 2018 and is estimated to end in December 2018.

Fee-for-Service

2. A total of 461 beneficiaries transitioned from DDS on March 1, 2018.
3. The Department is currently in the process of amending the BHT IA contract to include BHT/BIS. The amended contract is projected to be executed in December 2018. DDS will submit claims on a monthly basis and payments are expected to begin in January 2019.
4. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.
5. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost, on an accrual basis, is \$6,187,000 TF for FY 2018-19 and FY 2019-20.
6. On a cash basis, FFS reimbursements are estimated to be paid as follows:

(Dollars in Thousands)

Fee-for-Service Claims	Accrual	FY 2018-19	FY 2019-20
FY 2017-18 claims		\$2,181	\$0
FY 2018-19 claims	\$6,187	\$5,156	\$1,031
FY 2019-20 claims	\$6,187		\$5,671
Total		\$7,337	\$6,702

BEHAVIORAL HEALTH TREATMENT - BIS DDS TRANSITION**REGULAR POLICY CHANGE NUMBER: 30**Managed Care

7. Assume 4,732 managed care beneficiaries will transition on a phase-in basis starting July 1, 2018 through December 1, 2018.
8. The estimated monthly capitation rate for BHT/BIS supplemental payments is \$2,508.41 for FY 2018-19 and \$2,633.83 for FY 2019-20.
9. The estimated number of supplemental capitation payments for FY 2018-19 is 50,199.

FY 2018-19: 50,199 eligible months x \$2,508.41 = \$125,920,000 TF

10. The estimated number of supplemental capitation payments for FY 2019-20 is 56,784.

FY 2019-20: 56,784 eligible months x \$2,633.83 = \$149,559,000 TF

11. Due to the supplemental capitation payment methodology, assume 75% of managed care payments will be paid the same year and 25% will be paid in the following fiscal year.

12. On a cash basis, managed care costs are estimated to be:

(Dollars in Thousands)

Managed Care Claims	Accrual	FY 2018-19	FY 2019-20
FY 2018-19 claims	\$125,920	\$94,440	\$31,480
FY 2019-20 claims	\$149,559	\$0	\$112,170
Total		\$94,440	\$143,650

13. Total estimated payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	Title XIX	Title XXI
Fee-for-Service	\$7,337	\$3,254	\$3,123	\$960
Managed Care	\$94,440	\$41,886	\$40,202	\$12,352
Total	\$101,777	\$45,140	\$43,325	\$13,312

FY 2019-20	TF	GF	Title XIX	Title XXI
Fee-for-Service	\$6,702	\$3,045	\$2,853	\$804
Managed Care	\$143,650	\$65,150	\$61,149	\$17,351
Total	\$150,352	\$68,195	\$64,002	\$18,155

Funding:

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

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 32
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1971

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$28,539,000	\$791,000
- STATE FUNDS	\$12,807,640	\$364,680
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$28,539,000	\$791,000
STATE FUNDS	\$12,807,640	\$364,680
FEDERAL FUNDS	\$15,731,360	\$426,320

DESCRIPTION

Purpose:

This policy change estimates the cost of shifting services for California Children's Services (CCS) eligible children from Fee-for-Service (FFS) to the existing managed care County Organized Health System (COHS) under the Whole-Child Model (WCM).

Authority:

Welfare & Institutions Code 14093-14094.3

Interdependent Policy Changes:

Not applicable

Background:

Building on existing successful models and delivery systems, the WCM provides an organized delivery system of care for comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals, specialty care providers, and counties. The WCM will improve care coordination and remove fragmented healthcare delivery by providing comprehensive healthcare inclusive of CCS eligible conditions and primary care for children with special healthcare needs.

The WCM will incorporate CCS services into the integrated care systems of select counties in the existing managed care County Organized Health System (COHS). The implementation process will happen in two phases and include an initial readiness review and ongoing monitoring following implementation to ensure continuity of care and continued access to specialty care. These plans will be required to demonstrate support from various stakeholders that may include the respective counties CCS program, local providers and hospitals, and local families of children with CCS eligible conditions or local advocacy groups representing those families. Phase One of the implementation process began July 1, 2018, in six of the twenty-one designated COHS counties and Phase Two is scheduled to begin no sooner than January 1, 2019, in the remaining designated COHS counties. Implementation in designated counties is dependent on a readiness review completed by the Department.

WHOLE CHILD MODEL IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 32

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a slight decrease due to updated FFS payment lags. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to a reduced FFS payment lag for the second year.

Methodology:

1. Assume CCS services for an additional six counties of the CCS Medi-Cal population will incorporate into COHS Medi-Cal managed care plans starting July 1, 2018 (Phase One), and an additional fifteen counties starting January 1, 2019 (Phase Two).
2. The payments under capitation are assumed to be equal to the costs under FFS.
3. Based on actual FFS costs for CCS eligibles in the selected COHS counties and a lag in processing FFS claims, the estimated benefit costs are:

FY 2018-19: \$28,539,000 TF (\$12,808,000 GF)

FY 2019-20: \$791,000 TF (\$365,000 GF)

Funding:

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

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 33
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$20,125,000	\$20,125,000
- STATE FUNDS	\$10,062,500	\$10,062,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,125,000	\$20,125,000
STATE FUNDS	\$10,062,500	\$10,062,500
FEDERAL FUNDS	\$10,062,500	\$10,062,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services (HCBS) waiver for up to 11,797 participants in 9,283 participant slots in FY 2018-19 and FY 2019-20.

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only. In the seven CCI demonstration counties, dual eligibles and SPDs are mandatorily enrolled into managed care for their Medi-Cal benefits. Those benefits comprise long-term supports and services (LTSS) including facility-based long-term care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and MSSP. Under CCI, managed care capitation includes MSSP services. In the seven CCI demonstration counties, participating managed care health plans will contract with the MSSP sites in their service area to deliver MSSP waiver services to their eligible health plan members. Eligible plan members will be enrolled into the MSSP waiver, subject to the availability of a waiver slot.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 33

As CCI is implemented, MSSP will transition to a Medi-Cal managed care benefit in all CCI demonstration counties (San Mateo, Santa Clara, Los Angeles, Orange, San Diego, San Bernardino, and Riverside). All CCI counties expect to complete MSSP transition from a 1915(c) HCBS waiver benefit to a managed care health plan benefit by January 1, 2020. The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) is budgeted in this policy change. The reimbursement for CCI activities are budgeted in the CCI-Administrative Costs policy change. The reimbursement is estimated to be \$20,125,000 TF for FY 2018-19 and FY 2019-20.

Reason for Change:

The change from the prior estimate, for FY 2017-18 and FY 2018-19, is a decrease due to CCI related costs increases that are captured in the CCI Costs policy change. There is no change from FY 2017-18 to FY 2018-19 in the current estimate.

Methodology:

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

	FY 2018-19	FY 2019-20
Total MSSP	\$39,778,000	\$39,778,000
MSSP Costs in CCI	\$19,653,000	\$19,653,000
Total MSSP in this PC	\$20,125,000	\$20,125,000

FY 2018-19				
	TF	GF	FF	GF Reimb.
MSSP in this PC	\$ 20,125,000	\$ 10,062,500	\$ 10,062,500	\$ -
Total Reimb.	\$ -	\$ (19,889,000)	\$ -	\$ 19,889,000
Total	\$ 20,125,000	\$ (9,826,500)	\$ 10,062,500	\$ 19,889,000

FY 2019-20				
	TF	GF	FF	GF Reimb.
MSSP in this PC	\$ 20,125,000	\$ 10,062,500	\$ 10,062,500	\$ -
Total Reimb.	\$ -	\$ (19,889,000)	\$ -	\$ 19,889,000
Total	\$ 20,125,000	\$ (9,826,500)	\$ 10,062,500	\$ 19,889,000

Funding:

50% Title XIX FF / 50% GF (4260-101-001/0890)
Reimbursement (4260-610-0995)

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 34
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 1976

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$19,895,000	\$25,419,000
- STATE FUNDS	\$7,726,820	\$10,260,920
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$19,895,000	\$25,419,000
STATE FUNDS	\$7,726,820	\$10,260,920
FEDERAL FUNDS	\$12,168,180	\$15,158,080

DESCRIPTION

Purpose:

This policy change estimates the amount of utilization based costs associated with all four domains of the Dental Transformation Initiative (DTI) effort.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Through the Medi-Cal 2020 Waiver, the Department is implementing and overseeing four dental efforts (domains), which are collectively referred to as the Dental Transformation Initiative (DTI) program.

The four domains of the DTI program are as follows:

- (1) Increase Preventive Services Utilization for Children,
- (2) Caries Risk Assessment and Disease Management,
- (3) Increase the Continuity of Care, and
- (4) LDPPs

The Increase Preventive Services Utilization for Children domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department's goal is to increase the utilization amongst children enrolled in either the Fee-For-Services (FFS) or Dental Managed Care (DMC) delivery system or who receive dental services at a Federally Qualified Health Center (FQHC) by at least ten percentage points over a five year period. The Department offers payments as financial incentives for dental service office locations to increase delivery of preventive oral care to Medi-Cal children. These payments are made in the form of semi-annual incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. A reassessment of this Domain and the applicable benchmarks will take place between years two and

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 34

three in order to evaluate program effectiveness, increases in preventive services, adjustments for population growth or decline throughout the state, and other factors as may be appropriate.

The Caries Risk Assessment and Disease Management domain enables eligible Medi-Cal Dental program enrolled dentists to receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under, based upon the beneficiary's risk level as determined by the dentist via the caries risk assessment. Incentive payments are paid monthly upon the billing of each of the aforementioned services. The key elements of this program are to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures. This domain has been implemented on a pilot basis in select counties based on the percentage of restorative to preventive services, representative sampling across the state, and likelihood of provider participation. DHCS will consider expansion no sooner than nine (9) months following the end of Program Year 2. Pilot expansion is subject to the availability of funding under the Dental Transformation Initiative funding.

The Increase the Continuity of Care domain aims to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. An annual incentive payment is paid to dental provider service office locations that have maintained continuity of care through providing examinations for their enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain has been implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. DHCS will consider expansion no sooner than nine (9) months following the end of Program Year 2. Pilot expansion is subject to the availability of funding under the Dental Transformation Initiative funding.

The Department requires the selected LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three abovementioned programs. The Department issued payments to pilot providers (i.e. the entity or entities providing the pilot proposal application) only on the basis of an approved application. Fifteen LDPPs were approved; however, two LDPP were unable to execute their contracts. No more than 25 percent of the annual DTI funding will be allocated to this domain.

Reason for Change:

The change from the prior estimate for, FY 2018-19, is a net decrease due to updated utilization data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to projected increases in utilization.

Methodology:

1. Domain 1: Based on the percent of the total payment by delivery system, determine a weighted average. Determine the percent of the providers that received a Domain 1 payment by delivery system. Multiply the total utilization actuals dollar figure by the two percents to determine the assumed utilization attributable to DTI.

Total Domain 1 costs are expected to be \$8,384,589 TF in FY 2018-19 and \$17,522,215 TF in FY 2019-20.

2. Domain 2: Existing methodology in Domain 2 accounts for new services, as such; additional utilization is not included here.
3. Domain 3: Assume that Domain 3 incentives will assist in efforts to establish a dental home for

DENTAL TRANSFORMATION INITIATIVE UTILIZATION

REGULAR POLICY CHANGE NUMBER: 34

beneficiaries at a growth rate of 2.25% per year. Assume that returning users will receive one dental exam (\$20), one prophylaxis (\$30), and one fluoride treatment (\$13) per year for a total per year cost per additional beneficiary of \$63. The increase in returning beneficiaries will result in increased utilization costs which will not be absorbed in the DTI incentive payments.

Total Domain 3 costs are expected to be \$3,902,621 TF in FY 2018-19 and \$449,067 TF in FY 2019-20.

4. Domain 4: Assume a 5% utilization increase within the target population multiplied by the average cost per use. Total Domain 4 costs are expected to be \$6,140,297 TF in FY 2018-19 and \$6,193,007 TF in FY 2019-20.
5. The DTI Utilization portion of the Dental Managed Care rate are calculated to be \$1,467,275 TF in FY 2018-19 and \$1,254,378 TF in FY 2019-20.

	TF	GF	FF
FY 2018-19	\$19,895,000	\$7,726,000	\$12,169,000
FY 2019-20	\$25,419,000	\$10,260,000	\$15,159,000

Funding:

50% Title XIX / 50% GF
 88% Title XXI FF/12% GF
 76.5% Title XXI FF/23.5% GF
 ACA 94% FF/6% GF
 ACA 93% FF/7% GF
 ACA 90% FF/10% GF

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 35
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1775

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$11,234,000	\$13,722,000
- STATE FUNDS	\$5,041,680	\$6,303,630
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,234,000	\$13,722,000
STATE FUNDS	\$5,041,680	\$6,303,630
FEDERAL FUNDS	\$6,192,320	\$7,418,370

DESCRIPTION

Purpose:

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

Authority:

ABX4 6 (Chapter 6, Statutes of 2009)
 SB 208 (Chapter 714, Statutes of 2010)
 California Bridge to Reform (BTR), Section 1115(a) Medicaid Demonstration
 California Medi-Cal 2020, Section 1115(a) Demonstration

Interdependent Policy Changes:

N/A

Background:

The BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, and the Medi-Cal 2020 extension, allows the Department to develop and implement organized health care delivery models to provide comprehensive health care services to CCS Medi-Cal eligible children. This includes both primary preventive care and services specific to the child's CCS eligible health condition.

Effective April 1, 2013, the Health Plan of San Mateo (HPSM) an existing managed care organization, began operations as a demonstration project under the Department's 1115 BTR waiver model. As of FY 2018-19 rating period, the CCS demonstration project for HPSM shifted to the Whole Child Model (WCM).

Rady Children's Hospital – San Diego (RCHSD) demonstration project has implemented effective July 1, 2018. RCHSD will be acting as an Accountable Care Organization in providing services to those with any one or more of the following acute conditions: cystic fibrosis, acute lymphoid leukemia, sickle cell disease, hemophilia, and diabetes. Participating members must be under the age of 21, with the exception of treatment for diabetes type 1 and 2, which holds an age requirement of 1 to 10 years old. The Department entered into a risk corridor arrangement for the first two years of the program.

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 35

Subsequent to the second year of the program, the Department will annually assess the continuation of the risk corridor.

Reason for Change:

The changes from the prior estimate for FY 2018-19 is due to:

- Updated FY 2018-19 rates for RCHSD
- CCS San Mateo transitioning to WCM. WCM costs are budgeted in the County Organized Health Systems base policy change.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to a ramp-up period in FY 2018-19.

Methodology:

1. The estimated HPSM capitation rate for FY 2017-18 is \$1,596.12. These rates include health care and administrative costs. Due to standard payment timeframes, one month of FY 2017-18 payments is budgeted in FY 2018-19.
2. The RCHSD demonstration project implemented in July 2018 and FY 2018-19 payments began in September 2018.
3. Assume 11 months of FY 2018-19 RCHSD will pay in FY 2018-19 and one month will pay in FY 2019-20.
4. Assume 11 months of FY 2019-20 RCHSD will pay in FY 2019-20 and one month will pay in the subsequent fiscal year.
5. The estimated RCHSD capitation rate and member months for FY 2018-19 and FY 2019-20 on an accrual basis are expected to be:

Fiscal Year	Average Monthly Enrollment	Capitation Rate	Average Monthly Payment	RCHSD Annual Payment
FY 2018-19*	298	\$2,733.54	\$816,000	\$9,786,000
FY 2019-20	400	\$2,870.22	\$1,148,000	\$13,777,000

*Assumes enrollment ramp-up.

6. Assume the June capitation payment will be deferred to the following fiscal year.
7. Total estimated costs for FY 2018-19 and FY 2019-20 are:

Fiscal Year	TF	RCHSD	HPSM
FY 2018-19	\$11,234,000	\$8,693,000	\$2,541,000
FY 2019-20	\$13,722,000	\$13,722,000	\$0

CCS DEMONSTRATION PROJECT

REGULAR POLICY CHANGE NUMBER: 35

Funding:

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$9,720,000	\$4,860,000	\$4,860,000
88% Title XXI / 12% GF (4260-113-0001/0890)	\$1,514,000	\$182,000	\$1,332,000
Total	\$11,234,000	\$5,042,000	\$6,192,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$11,883,000	\$5,941,000	\$5,942,000
88% Title XXI / 12% GF (4260-113-0001/0890)	\$609,000	\$73,000	\$536,000
76.5% Title XXI / 23.5%GF(4260-113-0001/0890)	\$1,230,000	\$289,000	\$941,000
Total	\$13,722,000	\$6,303,000	\$7,419,000

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1228

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$10,308,000	\$548,000
- STATE FUNDS	\$1,521,000	\$137,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,308,000	\$548,000
STATE FUNDS	\$1,521,000	\$137,000
FEDERAL FUNDS	\$8,787,000	\$411,000

DESCRIPTION

Purpose:

This policy change estimates the costs of transitioning beneficiaries who have continuously resided in health care facilities for 90 days or longer to federally-allowed home and community based services (HCBS). It also estimates the costs for providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project.

Authority:

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

Interdependent Policy Changes:

CCT Fund Transfer to CDSS and CDDS

Background:

In January 2007, the Centers for Medicare and Medicaid Services awarded the Department the Money Follows the Person (MFP) Rebalancing Demonstration Grant for \$130 million in federal funds. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and extended by the ACA. It is effective from January 1, 2007, through September 30, 2020. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for 90 days or longer, transition into qualified residences with the support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 365-days post-transition, but also receive pre-transition services prior to leaving the inpatient facility. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2018, through December 31, 2018, are 219 individuals. The Department will discontinue processing new transitions effective January 1, 2019 to ensure sufficient time to bill the 365-day post transition period and perform grant close-out functions.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD beneficiaries expected to transition into CCT is included in this policy change. The cost of transitioning, providing

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 36

HCBS, and the supplemental federal funding that is associated with providing CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a slight decrease due to the actual enrollments being less than previously estimated in the prior estimate. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to DD transitions ending by June 30, 2018 and non-DD transitions ending December 31, 2018.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be \$82,435 in FY 2018-19 and in FY 2019-20. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of \$8,357 annually; reimbursed at 75% MFP and 25% GF.
3. Assume 360 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2017-18 and 219 in FY 2018-19 cost \$1,128 annually; reimbursed at 100% MFP.
4. Assume non-DD beneficiaries, upon transitioning into CCT, cost \$18,000 annually in FY 2017-18 and FY 2018-19; reimbursed at 75% MFP and 25% GF.
5. Assume 159 DD beneficiaries will transition through CCT in FY 2017-18. The Department will pay for pre and post-transition costs for 69 transitions and will pay for pre-transition costs for only 90 transitions.
6. Assume DD beneficiaries who participate in CCT have a one-time cost of \$64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF. The Department will no longer process DD transitions after June 30, 2018.
7. Assume DD beneficiaries, cost \$105,000 in FY 2017-18 and FY 2018-19 upon transitioning into CCT for 1915(c) waiver services; reimbursed at 75% MFP and 25% GF. The Department will no longer provide reimbursement for 1915(c) waiver services utilized by DD beneficiaries as of July 1, 2019.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 36

8. Below is the overall impact of the CCT Demonstration project in FY 2018-19 and FY 2019-20.

FY 2018-19	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$10,308,000	\$1,521,000	\$8,787,000
CCT Savings:			
Total Non-DD GF savings and Total FFP*	(\$24,545,000)	(\$12,273,000)	(\$12,272,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	\$1,365,000	\$0	\$1,365,000
CCT Outreach - Admin costs (OA 44)	\$342,000	\$0	\$342,000
Total of CCT PCs including pass through	(\$12,530,000)	(\$10,752,000)	(\$1,778,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

**Not included in the Total of CCT PCs including pass through

FY 2019-20	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$548,000	\$137,000	\$411,000
CCT Savings:			
Total Non-DD GF savings and Total FFP*	(\$2,562,000)	(\$1,281,000)	(\$1,281,000)
Total of CCT PCs including pass through	(\$2,014,000)	(\$1,144,000)	(\$870,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:

100% GF (4260-101-0001)

MFP Federal Grant (4260-106-0890)

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 37
 IMPLEMENTATION DATE: 12/2018
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2037

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$6,463,000	\$27,700,000
- STATE FUNDS	\$2,452,790	\$10,696,400
PAYMENT LAG	0.6560	0.8610
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,239,700	\$23,849,700
STATE FUNDS	\$1,609,030	\$9,209,600
FEDERAL FUNDS	\$2,630,700	\$14,640,100

DESCRIPTION

Purpose:

This policy change estimates the Fee-for-Service (FFS) costs of covering Medi-Cal nonmedical transportation (NMT) services.

Authority:

AB 2394 (Chapter 615, Statutes of 2016)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2394 added Welfare and Institutions Code Section 14132(ad), which requires Medi-Cal to cover NMT for all full-scope Medi-Cal beneficiaries, subject to utilization controls and federally permissible time and distance standards. AB 2394 defines Medi-Cal NMT services to include, at a minimum, round trip transportation by passenger car, taxicab, bus passes, taxi vouchers, train tickets, any other form of public or private transportation, and mileage reimbursement if a private vehicle (not arranged by a transportation broker) is used. NMT services shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized and any necessary federal approvals have been obtained.

The Centers for Medicare and Medicaid Services (CMS) allow transportation services to be provided as either an Administrative Service under Title 42 Code of Federal Regulations (CFR) Section 431.53 or Optional Medical Service under 42 CFR 440.170. Under 42 CFR 431.53, Medicaid states must ensure necessary transportation for beneficiaries to and from providers and describe the methods that the agency will use to meet this requirement. Similarly, under 42 CFR 440.170, Medicaid states must reimburse for transportation expenses and other related travel expenses determined to be necessary to secure medical examinations and treatment for a beneficiary. Under this section, transportation is furnished only by a provider to whom a direct vendor payment can appropriately be made by the state Medicaid agency.

MEDI-CAL NONMEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 37

In Medi-Cal FFS, NMT services are available as an indirect benefit and covered administratively at the local county through transportation resources reimbursed through the County-Based Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) as optional programs. Under CMAA/TMAA, local governmental agencies (LGA) that choose to provide NMT participate in CMAA/TMAA to perform administrative activities that directly support access to health care for beneficiaries. Managed care costs for providing NMT services are included in base capitation rates, and currently budgeted in the following policy changes: County Organized Health Systems, Two Plan Model, Regional Model, and Geographic Managed Care.

The Department is currently implementing a uniform and statewide NMT coverage and reimbursement policy to help ensure eligible FFS beneficiaries have access to the NMT benefit. The policy will enable NMT providers to bill Medi-Cal and be reimbursed for providing these services, subject to utilization controls. The NMT implementation for FFS will happen in two phases:

Phase I

Effective July 1, 2018, the Department's current network of existing non-emergency medical transportation (NEMT) providers, as well as new transportation providers specializing in NMT services can bill Medi-Cal and be reimbursed for providing services, subject to utilization control.

Phase II

The Department is working towards developing a policy and process for beneficiary reimbursement by procuring a contracted vendor to arrange for transportation services and/or reimburse beneficiaries for services provided in a private vehicle. This phase of NMT implementation is expected to occur in FY 2020-21.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to an increase in the estimated average round-trip NMT cost based on an increase in the mileage reimbursement rate and delayed start of payments in FY 2018-19.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to a higher projected utilization and more payment months in FY 2019-20.

Methodology:

1. Phase I for FFS NMT services started effective July 1, 2018. As a result of the provider enrollment process, it is estimated that payments will begin starting December 1, 2018.
2. Assume approximately 400,000 full scope FFS beneficiaries are eligible to utilize NMT services. Of these, approximately 157,000 beneficiaries are pregnant women and 243,000 are the remaining beneficiaries.
3. Assume that 10% of the 400,000 FFS beneficiaries will utilize NMT services in the first year and 25% will utilize these services on an annual basis.
4. Assume FFS pregnant women will utilize NMT services to visit their doctors seven times per year on average. It is estimated that all other beneficiaries will visit their doctors four times annually.
5. Assume each round-trip NMT service will cost approximately \$53.50.

MEDI-CAL NONMEDICAL TRANSPORTATION**REGULAR POLICY CHANGE NUMBER: 37**

6. Costs for NMT services on an annual basis is estimated to be \$27,700,000 TF.

- Perinatal Services: $(157,000 \times 25\%) \times 7 \times \$53.50 = \$14,699,000$ TF
- Non-Perinatal Services: $(243,000 \times 25\%) \times 4 \times \$53.50 = \$13,001,000$ TF

7. The first year costs are estimated to be \$11,080,000 TF.

- Perinatal Services: $(157,000 \times 10\%) \times 7 \times \$53.50 = \$5,880,000$ TF
- Non-Perinatal Services: $(243,000 \times 10\%) \times 4 \times \$53.50 = \$5,200,000$ TF

8. Assume FY 2018-19 includes seven months of first year costs beginning December 1, 2018. This is estimated to be \$6,463,000 TF (\$2,453,000 GF)

Funding:

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$4,648,000	\$2,324,000	\$2,324,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	\$146,000	\$18,000	\$128,000
94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)	\$1,113,000	\$78,000	\$1,035,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	\$556,000	\$33,000	\$523,000
Total	\$6,463,000	\$2,453,000	\$4,010,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$19,919,000	\$9,959,000	\$9,960,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	\$156,000	\$19,000	\$137,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$467,000	\$110,000	\$357,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	\$3,579,000	\$250,000	\$3,329,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$3,579,000	\$358,000	\$3,221,000
Total	\$27,700,000	\$10,696,000	\$17,004,000

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1772

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,893,000	\$3,079,000
- STATE FUNDS	\$22,000	\$24,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,893,000	\$3,079,000
STATE FUNDS	\$22,000	\$24,000
FEDERAL FUNDS	\$2,871,000	\$3,055,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for Youth Regional Treatment Centers (YRTC's).

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The change from the prior estimate, for FY 2018-19, is a decrease due to lower average users and rates than previously estimated. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to updated future rate adjustments for CY 2019 and CY 2020.

Methodology:

1. The program was implemented January 2014 with an effective date of September 1, 2013.
2. Assume the daily rate per youth for CY 2018 is \$641, \$680 in CY 2019, and \$726 in CY 2020.

CY 2018: \$641 daily rate x 365 days ÷ 12 months = \$19,497 monthly

CY 2019: \$680 daily rate x 365 days ÷ 12 months = \$20,683 monthly

CY 2020: \$726 daily rate x 365 days ÷ 12 months = \$22,083 monthly

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 38

FY 2018-19Monthly enrollee costs:

12 enrollees x 6 months x \$19,497 = \$1,404,000

12 enrollees x 6 months x \$20,683 = \$1,489,000

\$1,404,000 + \$1,489,000 = **\$2,893,000 TF****FY 2019-20**Monthly enrollee costs:

12 enrollees x 6 months x \$20,683 = \$1,489,000

12 enrollees x 6 months x \$22,083 = \$1,590,000

\$1,489,000 + \$1,590,000 = **\$3,079,000 TF**

3. Assume the program will pay expenditures at 50% GF/50% FFP upfront and receive 100% FFP reimbursement in the following quarter.
4. \$351,000 FFP from last quarter of FY 2017-18 will be reimbursed in FY 2018-19 and \$377,000 from last quarter FY 2018-19 will be reimbursed in FY 2019-20.

FY 2018-19	TF	GF	FFP
*Apr - June 2018	\$0	(\$351,000)	\$351,000
Jul - Sep 2018	\$702,000	\$0	\$702,000
Oct - Dec 2018	\$702,000	\$0	\$702,000
Jan - Mar 2019	\$745,000	\$0	\$745,000
**Apr - Jun 2019	\$745,000	\$373,000	\$372,000
Total	\$2,893,000	\$22,000	\$2,871,000

FY 2019-20	TF	GF	FFP
*Apr - June 2019	\$0	(\$373,000)	\$372,000
Jul - Sep 2019	\$745,000	\$0	\$745,000
Oct - Dec 2019	\$745,000	\$0	\$745,000
Jan - Mar 2020	\$795,000	\$0	\$795,000
**Apr - Jun 2020	\$795,000	\$397,000	\$398,000
Total	\$3,079,000	\$24,000	\$3,055,000

*Totals may differ due to rounding

* FFP reimbursement from previous quarter

** FFP to be reimbursed in the following fiscal year

Funding:

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

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

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 4/2018
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 2046

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,400,000	\$1,600,000
- STATE FUNDS	\$2,400,000	\$1,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,400,000	\$1,600,000
STATE FUNDS	\$2,400,000	\$1,600,000
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:

The change from the prior estimate, for FY 2018-19, is an increase due to the shift of unused funds from the prior fiscal year to the current fiscal year. Enrollment was lower than previously estimated. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to enrollment stabilizing.

MEDICALLY TAILORED MEALS PILOT PROGRAM

REGULAR POLICY CHANGE NUMBER: 39

Methodology:

1. The Pilot began in April 2018.
2. Assume the cost for FY 2018-19 is \$2,400,000 TF and \$1,600,000 TF for FY 2019-20.

Funding:

100% GF (4260-101-0001)

PROP 56 - CBAS PROGRAMS

REGULAR POLICY CHANGE NUMBER: 40
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 2099

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$0
- STATE FUNDS	\$2,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$0
STATE FUNDS	\$2,000,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the costs for providing qualifying Community-Based Adult Services (CBAS) Programs.

Authority:

SB 856 (Chapter 30, Statutes of 2017-18)

Interdependent Policy Changes:

Not Applicable

Background:

SB 856 appropriates funding for qualifying Community-Based Adult Services programs based upon criteria that include, but are not limited to, the need for one-time funds based on operating costs in high cost areas of the state.

Reason for Change:

This is a new policy change.

Methodology:

- \$2 million is allocated for the funding of CBAS programs.

Fiscal Year	TF	SF
FY 2018-19	\$2,000,000	\$2,000,000

Funding:

Prop 56 Health Care Treatment Fund

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 41
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1787

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,270,000	\$0
- STATE FUNDS	\$2,268,900	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	41.50 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,913,000	\$0
STATE FUNDS	\$1,327,310	\$0
FEDERAL FUNDS	\$585,640	\$0

DESCRIPTION

Purpose:

This policy change estimates payment and reimbursement costs to participating Pediatric Palliative Care Waiver (PPCW) providers.

Authority:

AB 1745 (Chapter 330, Statutes of 2006)
 Social Security Act, Section 1915(c)

Interdependent Policy Changes:

Pediatric Palliative Care Expansion and Savings

Background:

AB 1745 required the Department to submit a federal waiver application through the Centers for Medicare and Medicaid Services (CMS) 1915(c) waiver option for a Pediatric Palliative Care pilot project. The PPCW makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The PPCW was approved from April 1, 2009 through December 26, 2017. On February 1, 2018, CMS approved an extension through May 15, 2018 and is expected to be renewed prior to its expiration.

Due to technical constraints in the Medi-Cal automated claims payment system, all PPCW provider claims for payment of PPCW services could not be processed in the automated system. The Department began manually paying claims using the Payment Adjustment Notice (PAN) process for providers serving PPCW beneficiaries, which resulted in unpaid and partially paid claims for FY 2009-10 through FY 2014-15. The Department transferred claims processing back to the Fiscal Intermediary for claims with dates of service after July 1, 2016. All unpaid or partially paid claims from January 1, 2014, through June 30, 2016, will be paid in FY 2018-19. Any unpaid or partially paid claims past the two year claiming limit will be paid at 100% GF.

Effective July 1, 2013, the Department began reimbursing PPCW agencies \$300 per member per month (PMPM) for administrative costs. The Department received approval on June 29, 2017, for a waiver amendment to include a supplemental payment for specified services to be paid no sooner than

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 41

July 1, 2017. The supplemental payment is necessary to address the enhanced burden on providers due to the implementation of new conflict of interest requirements, provider retention, enhanced training and certification for waiver providers, and to improve access.

The Department submitted a waiver renewal application on September 29, 2017, to request a new five-year waiver term. After discussions with CMS, the Department determined there were service delivery issues with the waiver and to end the PPC Waiver and transition current waiver participants to other systems of care. CMS is expected to approve an extension of the current waiver term through December 31, 2018. Transition is expected to begin by January 1, 2019.

Reason for Change:

The change from the prior estimate, for FY 2018-19, as well as the change from CY to BY, is a decrease due to PPCW not being renewed and all services ending on December 31, 2018.

Methodology:

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

1. Assume 226 members were enrolled in PPCW for FY 2018-19.

226 members x 6 months = 1,356 member months (MM) prior to caseload expansion.

2. Assume all PCCW services will end on December 31, 2018.

3. For FY 2018-19, assume a \$300 PMPM cost at 50% FFP for supplemental payments paid through December 31, 2018. Assume that all payments will be paid in FY 2018-19.

1356 MM x \$300 PMPM = \$407,000 TF

4. Assume an average claims payment of \$701 PMPM.

FY 2018-19: 1,356 MM x \$701 = \$951,000 TF (rounded)

5. Underpaid and improperly denied claims from January 1, 2009 through June 30, 2018 equals \$1,913,000 TF. These back payments are assumed to be paid in FY 2018-19.

6. Total estimated PPCW costs are:

FY 2018-19: \$3,270,000 TF (\$2,331,000 GF)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$1,187,000	\$594,000	\$593,000
88% Title XXI / 12% GF	\$170,000	\$20,000	\$150,000
Back Payments	\$1,913,000	\$1,655,000	\$258,000
FY 2018-19 Total	\$3,270,000	\$2,269,000	\$1,001,000

Funding:

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

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

100% GF (4260-101-0001)

CCT FUND TRANSFER TO CDSS AND CDDS

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

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,365,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,365,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,365,000	\$0

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2020. The grant requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals who have resided continuously in health care facilities for 90 days or longer to transition into federally-qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS).

The Department will discontinue processing new transitions effective January 1, 2019, to ensure sufficient time to bill for 365-day post transition costs and perform grant close-out functions.

Reason for Change:

The change from the prior estimate for FY 2018-19 is an increase due to higher non-DD enrollee utilization of IHSS under CCT. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to DD transitions ending by June 30, 2018 and non-DD transitions ending December 31, 2018.

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 42

Methodology:

1. The Department provides HCBS to developmentally disabled CCT participants and CCT participants who are receiving IHSS. The Department provides federal funding to CDDS and CDSS as the base federal match through HCBS policy changes.
2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDDS is budgeted in the Home & Community Based Svcs.-CDDS policy change. The GF for CDSS is provided by CDSS and is budgeted in the Personal Care Services (Misc. Svcs.) policy change.
3. In FY 2010-11, the Department established IA 09-86345 with CDDS and in FY 2011-12 IA 10-87274 was established with CDSS. Both IAs transfer the additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.
4. It is assumed that 29% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs \$10,460 in FY 2018-19. The Department will provide 25% of these costs to CDSS.
5. Assume CDDS will receive an additional 25% FF for post transitional services for the DD population.

	FY 2018-19
CDSS	\$140,000
CDDS	\$1,225,000
Total	\$1,365,000

FY 2018-19	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$10,308,000	\$1,521,000	\$8,787,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$24,545,000)	(\$12,273,000)	(\$12,272,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	\$1,365,000	\$0	\$1,365,000
CCT Outreach - Admin costs (OA 44)	\$342,000	\$0	\$342,000
Total of CCT PCs including pass through	(\$12,530,000)	(\$10,752,000)	(\$1,778,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 42

FY 2019-20	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$548,000	\$137,000	\$411,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$2,562,000)	(\$1,281,000)	(\$1,281,000)
Total of CCT PCs including pass through	(\$2,014,000)	(\$1,144,000)	(\$870,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:

MFP Federal Grant (4260-106-0890)

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 43
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2056

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$2,589,000
- STATE FUNDS	\$0	\$796,880
PAYMENT LAG	1.0000	0.7734
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$2,002,300
STATE FUNDS	\$0	\$616,300
FEDERAL FUNDS	\$0	\$1,386,030

DESCRIPTION

Purpose:

This policy change estimates the cost associated with developing and implementing the Diabetes Prevention Program (DPP).

Authority:

SB 97 (Chapter 52, Statutes of 2017)
 AB 1810 (Chapter 34, Statutes of 2018)
 Welfare and Institutions Code, Section 14149.9

Interdependent Policy Changes:

Not Applicable

Background:

SB 97 requires the Department to establish the DPP, no sooner than July 1, 2018. The DPP is a lifestyle change program for adults age 18 and older designed to prevent or delay Type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes. The Centers for Medicare & Medicaid Services (CMS) allows for reimbursement of DPP services, as recognized by the U.S. Centers for Disease Control and Prevention (CDC). Trained peer coaches, who promote realistic lifestyle changes and emphasize weight loss through healthy eating and physical activity, lead the DPP curriculum. Beneficiaries can qualify for the program based on meeting specific clinical indicators, a prior diagnosis of gestational diabetes, or a positive self-assessment from the American Diabetes Association (ADA) or CDC.

The program consists of the following sets of benefits separated in three periods:

- Core Sessions (Months 1-6) – The Core Sessions consist of 16 sessions over the first six months. Payments for the core sessions are attendance and performance based.
- Core Maintenance Sessions (Months 7-12) – The Core Maintenance Sessions include two intervals of two-monthly sessions; Payments for these sessions are performance based, depending on whether the required weight loss was achieved.

DIABETES PREVENTION PROGRAM

REGULAR POLICY CHANGE NUMBER: 43

- Ongoing Maintenance Sessions (Months 13-24) – consists of up to four intervals of 3-monthly ongoing maintenance sessions offered during months 13 through 24 of the DPP services period.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to a delay in implementation from January 1, 2019 to July 1, 2019.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due no costs incurring in FY 2018-19 as a result of implementation delays.

Methodology:

1. Assume the DPP will be implemented July 1, 2019.
2. Assume an estimated 1,022,136 individuals enrolled in Medi-Cal, age 18 and over, have prediabetes. Assume an estimated 2% of those eligible for DPP will enroll in the program each year. Therefore, approximately 20,443 individuals are estimated to enroll in the DPP.

$$1,022,136 \times 2\% = 20,443$$

Core Sessions

3. Assume the total maximum payments per beneficiary for the Core Sessions include \$132.00 for the 16 core session attendance and \$128.00 performance payments for reaching the weight loss goal.
4. Assume 90% of beneficiaries eligible for DPP will complete the Core Sessions and 40% will reach the weight loss goal.
5. Total annual cost for the Core Sessions is estimated to be \$3,476,000 TF.

$$\text{Attendance: } 20,443 \times 90\% \times \$132.00 = \$2,429,000 \text{ TF}$$

$$\text{Performance: } 20,443 \times 40\% \times \$128.00 = \$1,047,000 \text{ TF}$$

Core Maintenance Sessions

6. Assume the total maximum payments per beneficiary for the Core Maintenance Sessions include \$96.00 (\$48.00 for each interval) if a beneficiary achieves the performance goal. If the performance goal is not met, the DPP provider would then be paid \$12.00 for each interval.
7. Assume 90% of the beneficiaries will complete the Core Maintenance Sessions. From those who complete the sessions, assume 40% will complete the core maintenance sessions with the required weight loss in both intervals, 40% will meet the required weight loss goal in one of the two intervals, and 20% will complete the core maintenance without meeting the required weight loss.
8. Total annual cost for the Core Maintenance Sessions is estimated to be \$1,237,000 TF.

$$20,443 \times 90\% \times 40\% \times \$96.00 = \$707,000 \text{ TF}$$

$$20,443 \times 90\% \times 40\% \times (\$48.00 + \$12.00) = \$442,000 \text{ TF}$$

$$20,443 \times 90\% \times 20\% \times \$24.00 = \$88,000 \text{ TF}$$

Ongoing Maintenance Sessions

9. Assume the total maximum payments for the Ongoing Maintenance Sessions include \$160.00 (\$40.00 for each interval) if the beneficiary maintains the required weight loss for all four intervals.

DIABETES PREVENTION PROGRAM**REGULAR POLICY CHANGE NUMBER: 43**

10. Assume 40% of the beneficiaries will complete the Ongoing Maintenance Sessions. From the 40% who will participate in the Ongoing Maintenance Sessions, assume 10% of beneficiaries will maintain the required weight loss goal for all four intervals, 20% will maintain the required weight loss goal for three intervals, 30% will maintain the required weight loss goal for two intervals, and the remaining 40% will maintain the weight loss goal for one interval.

11. Total annual cost for the Ongoing Maintenance Sessions is estimated to be \$654,000 TF.

$$20,443 \times 40\% \times 10\% \times \$160.00 = \$131,000$$

$$20,443 \times 40\% \times 20\% \times \$120.00 = \$196,000$$

$$20,443 \times 40\% \times 30\% \times \$80.00 = \$196,000$$

$$20,443 \times 40\% \times 40\% \times \$40.00 = \$131,000$$

12. Assume a six-month phase-in for beneficiary participation in the Core Sessions beginning July 1, 2019. Assume Performance payments will be phased-in over a six-month period and will be paid at the end of Core Sessions, beginning January 1, 2020, on a six-month phase in basis.

13. Assume Core Maintenance Sessions will start January 1, 2020, and will be phased-in over a six-month period.

14. Assume Ongoing Maintenance Sessions will start July 1, 2020, and will be phased-in over a six-month period.

15. Total estimated payments are:

DPP	Annual	FY 2019-20
Core Sessions – Attendance	\$2,429,000	\$1,923,000
Core Sessions – Performance	\$1,047,000	\$305,000
Core Maintenance	\$1,237,000	\$361,000
Ongoing Maintenance	\$654,000	\$0
Total	\$5,367,000	\$2,589,000

Funding:

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	\$1,366,000	\$683,000	\$683,000
88% Title XXI FF / 12% GF (4260-113-0001/0890)	\$1,000	\$0	\$1,000
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$11,000	\$3,000	\$8,000
93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)	\$331,000	\$23,000	\$308,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$880,000	\$88,000	\$792,000
Total	\$2,589,000	\$797,000	\$1,792,000

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 8/2017
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1885

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,248,000	\$0
- STATE FUNDS	-\$1,921,460	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	15.80 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,576,800	\$0
STATE FUNDS	-\$1,617,870	\$0
FEDERAL FUNDS	-\$1,958,950	\$0

DESCRIPTION

Purpose:

This policy change budgets projected savings attributed to the expansion of the Pediatric Palliative Care Waiver (PPCW).

Authority:

AB 1745 (Chapter 330, Statutes of 2006)
 Social Security Act, Section 1915(c)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1745 required the Department to submit a federal waiver application through the Centers for Medicare and Medicaid Services (CMS) 1915(c) waiver option for a Pediatric Palliative Care pilot project. The PPCW makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The PPCW was approved beginning April 1, 2009, through December 26, 2017. On February 1, 2018, CMS approved an extension through May 15, 2018 and is expected to be renewed prior to its expiration.

AB 1745 also included an evaluation component which was conducted by the University of California, Los Angeles (UCLA), Center for Policy Research. The evaluation reflected a reduction of \$3,133 per member per month (PMPM) under the Pediatric Palliative Care Pilot, predominantly resulting from a decrease in inpatient care. The current level of participants is 226 members.

The administrative costs of the PPCW are budgeted in other policy changes. Other Administration policy change California Children's Services (CCS) Case Management (OA 2) budgets for nurse liaisons and support staff. The Pediatric Palliative Care Waiver (PC 39) policy change budgets for the provider payment and reimbursement costs.

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 44

Reason for Change:

The change from the prior estimate, FY 2018-19, is an increase in savings due to account for the existing member's enrollment months. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease in savings due to the waiver ending December 31, 2018.

Methodology:

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

1. Assume 226 current members will receive services through the PPCW through December 31, 2018.
2. Based on the number of members enrolled each year and \$3,133 PMPM savings, assume a gross savings of \$4,248,000 for FY 2018-19.
3. When accounting for nurse liaison costs (OA 2) and provider payment and reimbursement costs (PC 39), the net savings of the PPC expansion are indicated in the table below.

FY 2018-19	TF	GF	FF
OA 2-CCS Case Management	\$47,000	\$12,000	\$35,000
PC 39-PPCW	\$407,000	\$184,000	\$223,000
Savings	(\$4,248,000)	(\$1,922,000)	(\$2,326,000)
Net Cost/Savings	(\$3,794,000)	(\$1,726,000)	(\$2,068,000)

Funding:

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

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

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER: 45
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1909

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$64,833,000	\$70,387,000
- STATE FUNDS	\$20,423,060	\$22,847,310
PAYMENT LAG	0.9967	1.0000
% REFLECTED IN BASE	0.50 %	0.44 %
APPLIED TO BASE		
TOTAL FUNDS	\$64,296,000	\$70,077,300
STATE FUNDS	\$20,253,890	\$22,746,780
FEDERAL FUNDS	\$44,042,070	\$47,330,520

DESCRIPTION

Purpose:

This policy change estimates the increased costs of Hepatitis C (Hep C) drugs to include the expansion of clinical guidelines to all stages of the disease.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Chronic Hep C is a common blood-borne infection that can lead to liver damage or liver failure. The Medi-Cal program currently treats patients with a Stage 2 diagnosis and patients with liver manifestations or post-liver transplants. The current policy also includes Hep C patients, regardless of stage, who also have:

- Diabetes,
- HIV,
- Hepatitis B,
- Debilitating fatigue,
- A desire to become pregnant, and
- Other comorbid conditions.

The Department is updating the Hep C policy to authorize treatment for all patients ages 13 and above with the disease, regardless of liver fibrosis stage or co-morbidity, except for patients with a life expectancy of less than 12 months.

HEPATITIS C REVISED CLINICAL GUIDELINES

REGULAR POLICY CHANGE NUMBER: 45

Reason for Change:

The change from the previous estimate, for FY 2018-19, is a decrease due to:

- Applying payment lags for the estimated Fee-For-Service (FFS) and Managed Care costs; and
- Adjusting the funding to account for estimated costs for ACA optional beneficiaries, and for estimated Children's Health Insurance Program (CHIP) costs.

The change between FY 2018-19 and FY 2019-20, in the estimate, is due to including the full year of estimated costs in FY 2019-20.

Methodology:

1. Assume the revised Hep C policy will be effective July 1, 2018.
2. The increased costs are estimated to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	ACA FF
FFS	\$3,738	\$1,348	\$1,396	\$994
Managed Care	\$61,095	\$19,075	\$19,085	\$22,935
Total	\$64,833	\$20,423	\$20,481	\$23,929

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	ACA FF
FFS	\$3,738	\$1,382	\$1,384	\$972
Managed Care	\$66,649	\$21,465	\$20,644	\$24,540
Total	\$70,387	\$22,847	\$22,028	\$25,512

Funding:

- 50% Title XIX / 50% GF (4260-101-0001/0890)
- 90% Title XIX / 10% GF (4260-101-0001/0890)
- 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
- 93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
- 88% Title XXI / 12% GF (4260-113-0001/0890)
- 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

PHARMACIST-DELIVERED MEDI-CAL SERVICES

REGULAR POLICY CHANGE NUMBER: 47
 IMPLEMENTATION DATE: 4/2019
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2120

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$316,000	\$949,000
- STATE FUNDS	\$119,300	\$361,100
PAYMENT LAG	0.7920	0.9603
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$250,300	\$911,300
STATE FUNDS	\$94,490	\$346,760
FEDERAL FUNDS	\$155,790	\$564,560

DESCRIPTION

Purpose:

This policy change estimates the costs of reimbursing pharmacies for certain pharmacist-delivered services under Medi-Cal.

Authority:

AB 1114 (Chapter 602, Statutes of 2016)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1114 required the Department to allow the following services as a pharmacy benefit under the Medi-Cal program, subject to the Centers for Medicare and Medicaid Services (CMS) approval:

- Furnish travel medications;
- Furnish naloxone hydrochloride;
- Furnish self-administered hormonal contraception;
- Administer immunizations; and,
- Provide tobacco cessation counseling and furnishing nicotine replacement therapy.

The Department will reimburse pharmacies for the provision of the services listed above, allowable under Medi-Cal, and the reimbursement rate will be 85% of the physician fee schedule. The Board of Pharmacy requires pharmacists to be trained and certified to provide these services. Pharmacies will bill the Department for these services using three physician procedure codes.

A State Plan Amendment (SPA) for the services and the new payment methodology will be required. AB 1114 mandates the Department to adopt new regulations by July 1, 2021.

Reason for Change:

This is a new policy change.

PHARMACIST-DELIVERED MEDI-CAL SERVICES

REGULAR POLICY CHANGE NUMBER: 47

Methodology:

1. Assume the SPA and new payment methodology will be effective April 1, 2019.
2. The fiscal impact is developed using FY 2017-18 Fee-For-Service (FFS) claims data, for physician prescriptions that were dispensed at a pharmacy, for the benefit categories listed above.
3. Assume each beneficiary, with one claim in FY 2017-18, receives one service unit each of Current Procedural Terminology (CPT) 99201 New Patient, and CPT 99211 Established Patient, and will be paid at 85% of the Medi-Cal physician reimbursement rate. CPT codes are defined as, widely accepted codes used to report medical procedures and services.
4. For FY 2018-19, assume 5% of physician-provided medical services costs, for the services listed above, will shift and be provided by certified pharmacists. Beginning in July 2020, assume 10% more of physician-provided medical services costs, for the services listed above, will shift and be provided by certified pharmacists.
5. Assume travel medication services are excluded from the fiscal calculations due to the inability to identify this service category in the claims data.
6. The ACA Optional populations is eligible for Title XIX federal reimbursement at 93% beginning January 2019, and 90% beginning January 2020.
7. On a cash basis, the cost is estimated to be:

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$226,000	\$113,000	\$113,000
93% Title XIX/ 7% GF	\$90,000	\$6,000	\$84,000
Total	\$316,000	\$119,000	\$197,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$679,000	\$339,000	\$340,000
93% Title XIX/ 7% GF	\$180,000	\$13,000	\$167,000
90% Title XIX/ 10% GF	\$90,000	\$9,000	\$81,000
Total	\$949,000	\$361,000	\$588,000

Funding:

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

93% Title XIX / 7% GF (4260-101-0001/0890)

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

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 8/2009
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1449

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,453,000	\$0
- STATE FUNDS	-\$2,453,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,453,000	\$0
STATE FUNDS	-\$2,453,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to illegal promotion of drugs, kickbacks and overcharges.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department works collaboratively with the Office of the Attorney General to pursue charges related to Qui-Tam lawsuits (civil lawsuits filed under the False Claims Act by individuals not affiliated with the government, that result in a recovery of funds due to the Department), illegal promotion of drugs, kickbacks, and overcharging of Medicaid.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase in the amount the Department is expecting to receive based on updated expected settlement payments. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to only being able to budget for current year settlement amounts.

Methodology:

The following settlements are expected to be received in FY 2018-19:

Settlement Name	FY 2018-19
AngioDynamics, Inc.	(\$89,000)
Natera, Inc.	(\$5,000)
AmerisourceBergen Co.	(\$2,359,000)
Total GF Savings	(\$2,453,000)

LITIGATION SETTLEMENTS
REGULAR POLICY CHANGE NUMBER: 48

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1433

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$9,942,000	-\$6,956,000
- STATE FUNDS	-\$3,166,450	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$9,942,000	-\$6,956,000
STATE FUNDS	-\$3,166,450	\$0
FEDERAL FUNDS	-\$6,775,550	-\$6,956,000

DESCRIPTION

Purpose:

This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:

Social Security Act, section 1927 [42 U.S.C. 1396r-8]
 Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
 Welfare & Institutions Code 14105.33
 Proposed Trailer Bill Language

Interdependent Policy Changes:

Medi-Cal Drug Rebates Fund

Background:

Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP in January 2010. This policy change reflects ongoing rebates collected.

The Department is proposing to establish the Medi-Cal Drug Rebates Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebates Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to the result of projecting collections based on:

- The addition of one quarter of actual BCCTP rebate collections from April 2018 through June 2018; and
- Decreased BCCTP drug expenditures for the applicable expenditure period.

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to an estimated increase in BCCTP drug expenditures. Additionally, the non-federal share of the FY 2019-20 BCCTP drug rebate collections are not included in this policy change and are instead included in the Medi-Cal Drug Rebates Fund policy change.

Methodology:

1. Payments began in January 2010.
2. Rebates are invoiced quarterly.
3. The estimated rebates to collect are \$9,942,000 in FY 2018-19 and \$10,207,000 in FY 2019-20.
4. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is \$895,000 in FY 2018-19 and \$919,000 in FY 2019-20.
5. The Department estimates to transfer \$3.251 million BCCTP drug rebates collections to the Medi-Cal Drug Rebates Fund in FY 2019-20.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
65% Title XIX / 35% GF	(\$9,047)	(\$3,166)	(\$5,881)
ACA Offset	(\$895)	\$0	(\$895)
Total	(\$9,942)	(\$3,166)	(\$6,776)

(Dollars in Thousands)

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$6,037)	(\$6,037)	(\$3,251)
ACA Offset	(\$919)	(\$919)	\$0
Total	(\$6,956)	(\$6,956)	(\$3,251)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

Funding:

65% Title XIX / 35% GF (4260-101-0001/0890)

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 50
 IMPLEMENTATION DATE: 12/1999
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 51

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$23,327,000	-\$21,226,000
- STATE FUNDS	-\$3,066,800	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$23,327,000	-\$21,226,000
STATE FUNDS	-\$3,066,800	\$0
FEDERAL FUNDS	-\$20,260,200	-\$21,226,000

DESCRIPTION

Purpose:

This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:

Social Security Act, section 1927 [42 U.S.C. 1396r-8]
 Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
 Welfare & Institutions Code 14105.33
 Proposed Trailer Bill Language

Interdependent Policy Changes:

Medi-Cal Drug Rebates Fund

Background:

Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

The Department is proposing to establish the Medi-Cal Drug Rebates Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebates Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

FAMILY PACT DRUG REBATES**REGULAR POLICY CHANGE NUMBER: 50****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is a net increase due to the revised collection projections based on:

- Increased average quarterly projections based on the addition of one quarter of actual FPACT rebate collections from April 2018 through June 2018;
- Decreased estimated FPACT drug expenditures for the applicable expenditure period; and
- Increased estimated ACA Offset funding based on actual data through June 2018.

The change between FY 2018-19 and FY 2019-20, in the current estimate, is an increase due to the result of an increase to the projected FPACT pharmacy expenditures applied to FY 2019-20 projected average quarterly rebates in FY 2019-20. Additionally, the non-federal share of the FY 2019-20 FPACT drug rebate collections are not included in this policy change and are instead included in the Medi-Cal Drug Rebates Fund policy change.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 9.5% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 90.5% of the FPACT rebates.
2. Assume the ACA offset is \$1,107,000 for FY 2018-19 and \$1,160,000 for FY 2019-20.
3. Actual data from July 2013 to June 2018 is used to project rebates.
4. The Department estimates to transfer \$3.213 million FPACT rebate collections to the Medi-Cal Drug Rebates Fund in FY 2019-20.

(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2018-19	\$42,012	(\$23,327)
FY 2019-20	\$44,014	(\$24,439)

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX /50% GF	(\$2,112)	(\$1,056)	(\$1,056)
90% Title XIX / 10% GF	(\$20,108)	(\$2,011)	(\$18,097)
ACA Offset	(\$1,107)	\$0	(\$1,107)
Total	(\$23,327)	(\$3,067)	(\$20,260)

(Dollars in Thousands)

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$20,066)	(\$20,066)	(\$3,213)
ACA Offset	(\$1,160)	(\$1,160)	\$0
Total	(\$21,226)	(\$21,226)	(\$3,213)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology #4.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 50

Funding:

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

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

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1181

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$24,916,000	-\$27,408,000
- STATE FUNDS	-\$12,458,000	-\$13,704,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$24,916,000	-\$27,408,000
STATE FUNDS	-\$12,458,000	-\$13,704,000
FEDERAL FUNDS	-\$12,458,000	-\$13,704,000

DESCRIPTION

Purpose:

This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:

Welfare & Institutions Code 14100.95(a) and 14105.47(c)(1)

Interdependent Policy Changes:

Not Applicable

Background:

The Department negotiates Maximum Acquisition Cost (MAC) for diabetic testing supplies with manufacturers to make available the best price to all providers. The Department establishes the product reimbursement rates for diabetic testing products which are based on the contracted MAC. The Department also negotiates rebates with some diabetic testing supply manufacturers to provide savings to the Department. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices for the rebate amounts are sent to manufacturers.

The medical supply diabetic testing products new rebate contract terms are effective January 1, 2019 through December 31, 2021.

Reason for Change:

There is no change from the prior estimate for FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to a ten percent increase in rebates estimated to be collected due to the new contract. The Department assumes no significant shift in product utilization or service quantities.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 51

Methodology:

1. Assume the average quarterly collection is \$6,229,000.
2. Assume the medical supply rebates collected are \$24,916,000 in FY 2018-19 and \$27,408,000 in FY 2019-20.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	(\$24,916)	(\$12,458)	(\$12,458)
FY 2019-20	(\$27,408)	(\$13,704)	(\$13,704)

Funding:

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

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 4/2019
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2070

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$18,000,000	-\$168,000,000
- STATE FUNDS	-\$6,517,780	-\$61,055,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$18,000,000	-\$168,000,000
STATE FUNDS	-\$6,517,780	-\$61,055,120
FEDERAL FUNDS	-\$11,482,220	-\$106,944,880

DESCRIPTION

Purpose:

This policy change estimates the Fee-For-Service (FFS) net impact of the savings from reimbursing pharmacies based on the Actual Acquisition Cost (AAC) for Covered Outpatient Drugs (COD) and the cost associated with adopting the new Professional Dispensing Fee (PDF) methodology.

Authority:

CMS Final Rule (CMS-2345-FC), 42 CFR Part 447
 State Plan Amendment (SPA) #17-002

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare and Medicaid Services (CMS) published its Final Rule on CODs on February 1, 2016 (CMS-2345-FC). This rule implements provisions of the Affordable Care Act, pertaining to Medicaid reimbursement for CODs. The Final Rule requires states to modify the reimbursement methodology for CODs and establish a professional dispensing fee. On August 25, 2017, the SPA #17-002 was approved, with an effective date of April 1, 2017.

The Department contracted with Mercer Government Human Services Consulting (Mercer) to conduct a study of outpatient pharmacy provider costs associated with purchasing and dispensing outpatient prescription drugs to Medi-Cal beneficiaries. Mercer issued their study results and implementation alternatives report in January 2017. The Department reviewed the alternatives and selected to implement the pharmacy reimbursement and PDF methodologies to comply with the provisions in the Final Rule.

Pharmacy Reimbursement:

The Department will implement the new pharmacy reimbursement methodology by adopting CMS' National Average Drug Acquisition Cost (NADAC) as the basis for ingredient cost reimbursement. The Wholesale Acquisition Cost (WAC) + 0% will be used as the basis for reimbursement when a NADAC is not available.

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 52

The previous methodology, based on the Estimated Acquisition Cost (EAC), is determined as the lowest of 1) Average Wholesale Price (AWP) minus 17%, 2) Federal Upper Limit (FUL), or 3) Maximum Allowable Ingredient Cost (MAIC).

Professional Dispensing Fee:

Currently, the Department is reimbursing pharmacies for PDF at \$7.25 for retail and \$8.00 for Long Term Care pharmacies. The Department will replace the current PDF structure with a two-tiered PDF, based on a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume, as follows:

- Less than 90,000 claims per year = \$13.20 (requires annual provider self- attestation), or
- 90,000 or more claims per year = \$10.05

The new reimbursement methodology and PDF include reimbursements to outpatient pharmacies for drugs provided to beneficiaries under the Family Planning, Access, Care, and Treatment (FPACT) program.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to a delay in the prospective implementation from January 2019 to April 2019.

The change, in the current estimate, from FY 2018-19 to FY 2019-20, is due to:

- Adding the estimated full year net savings in FY 2019-20;
- Updating the ACA Optional FMAP percentage from 93% to 90%, beginning January 1, 2020,
- Updating the Federal Medical Assistance Percentage (FMAP) percentage for the Children's Health Insurance Program (CHIP) to 76.5%, beginning October 1, 2019, and
- Including 12 months of the Erroneous Payment Corrections (EPCs) for the retroactive period in FY 2019-20.

Methodology:

1. Mercer aggregated and measured survey data of pharmacy providers' June 2016 pharmacy purchase invoices against CMS' NADAC list based on June 2016 data, Medi-Cal's current ingredient cost reimbursement methodology, and other industry benchmarks. Mercer's fiscal impact savings analysis indicated \$132,000,000 (\$126,000,000 from NADAC adoption and \$6,000,000 from WAC) in annual projected savings to the Department.
2. To calculate the new PDF, Mercer determined a pharmacy's average cost to dispense and divided the prescription department's operational, labor, and allocated overhead costs by the total number of Medicaid and non-Medicaid prescriptions dispensed. Mercer's cost analysis of the two-tiered PDF indicated \$60,000,000 in annual projected costs to the Department.
3. On an annual accrual basis, the pharmacy savings are estimated to be:

(Dollars in Thousands)

Annual	(TF)
AAC Savings	(\$132,000)
PDF Costs	\$60,000
Net Savings	(\$72,000)

PHARMACY REIMBURSEMENT & DISPENSING FEE

REGULAR POLICY CHANGE NUMBER: 52

4. Due to required claim system changes, implementation of the new reimbursement methodology is not expected until April 2019. The Department will process Erroneous Payment Corrections (EPC) to adjust for claims payments made using the previous methodology beginning July 2019.
 - The EPC will rerun claims paid between the dates of April 1, 2017, through March 31, 2019. The EPC is estimated to occur over an 18-month period.
 - Twelve months of the EPC is estimated to occur in FY 2019-20.
5. Assume CHIP drug expenditures are funded at 88% FF / 12% GF. Beginning October 1, 2019, CHIP drug expenditures are funded at 76.5% FF / 23.5% GF.
6. The ACA Optional population is eligible for Title XIX federal reimbursement at 93% beginning January 2019 and 90% beginning January 2020.
7. On a cash basis, the savings are estimated to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
AAC Savings	(\$33,000)	(\$11,949)	(\$21,051)
PDF Costs	\$15,000	\$5,431	\$9,569
Net Savings	(\$18,000)	(\$6,518)	(\$11,482)

FY 2019-20	TF	GF	FF
AAC Savings	(\$132,000)	(\$48,830)	(\$83,170)
PDF Costs	\$60,000	\$22,196	\$37,804
Net Retroactive Savings	(\$96,000)	(\$34,421)	(\$61,579)
Net Savings	(\$168,000)	(\$61,055)	(\$106,945)

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 95% Title XIX/ 5% GF (4260-101-0001/0890)
 94% Title XIX/ 6% GF (4260-101-0001/0890)
 93% Title XIX/ 7% GF (4260-101-0001/0890)
 90% Title XIX/ 10% GF (4260-101-0001/0890)
 88% Title XXI / 12 % GF (4260-113-0001/0890)
 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 53
 IMPLEMENTATION DATE: 1/1991
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 54

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$213,254,000	-\$158,281,000
- STATE FUNDS	-\$65,384,680	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$213,254,000	-\$158,281,000
STATE FUNDS	-\$65,384,680	\$0
FEDERAL FUNDS	-\$147,869,320	-\$158,281,000

DESCRIPTION

Purpose:

This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:

Welfare & Institutions Code 14105.33
 Proposed Trailer Bill Language

Interdependent Policy Changes:

Medi-Cal Drug Rebates Fund

Background:

State supplemental drug rebates for drugs provided through fee-for-service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

The Department is proposing to establish the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebates Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to revised collection projections based on the following:

- The addition of one quarter of actual State supplemental rebate collections from April 2018 through June 2018;
- Decreased Children's Health Insurance Program (CHIP) drug rebates based on data through June 2018; and
- Increased Affordable Care Act (ACA) optional rebates based on data through June 2018.

STATE SUPPLEMENTAL DRUG REBATES**REGULAR POLICY CHANGE NUMBER: 53**

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to increased pharmacy expenditures that were applied to the FY 2019-20 projections and higher projected average quarterly collections in FY 2019-20. Additionally, the non-federal share of the FY 2019-20 state supplemental drug rebate collections are not included in this policy change and are instead included in the Medi-Cal Drug Rebates Fund policy change.

Methodology:

1. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.
2. Assume family planning drugs account for 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).
3. Assume CHIP drug rebates are estimated to be \$7,744,000 TF for FY 2018-19. These rebates are funded at 88% FF and 12% GF through September 30, 2019, and 76.5% FF and 23.5% GF beginning October 1, 2019. In FY 2019-20, CHIP rebate collections of \$6,249,000 FF is included in this policy change.
4. The optional expansion ACA population collections are estimated to be \$86,850,000 TF for FY 2018-19, funded at 94% FF and 6% GF. For FY 2019-20, the ACA collections are estimated to be \$100,263,000 TF, of which \$93,245,000 FF is budgeted in this policy change. The amount of \$7,018,000 SF is budgeted to be transferred to the GF in the Medi-Cal Drug Rebates Fund policy change.
5. The Department estimates to transfer \$67,262,000 state supplemental rebates collections to the Medi-Cal Drug Rebates Fund in FY 2019-20.

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	(\$118,446,000)	(\$59,223,000)	(\$59,223,000)
94% Title XIX/ 6% GF	(\$86,850,000)	(\$5,211,000)	(\$81,639,000)
90% Title XIX / 10% GF	(\$214,000)	(\$22,000)	(\$192,000)
88% Title XXI / 12 % GF	(\$7,744,000)	(\$929,000)	(\$6,815,000)
Total	(\$213,254,000)	(\$65,385,000)	(\$147,869,000)

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$58,787,000)	(\$58,787,000)	(\$60,244,000)
100% Title XIX ACA	(\$93,245,000)	(\$93,245,000)	(\$7,018,000)
100% Title XXI FF	(\$6,249,000)	(\$6,249,000)	\$0
Total	(\$158,281,000)	(\$158,281,000)	(\$67,262,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 5.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 53

Funding:

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

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

100% Title XXI (4260-113-0890)

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

94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)

93% ACA Title XIX FF / 5% GF (4260-101-0001/0890)

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 55

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,223,878,000	-\$1,588,306,000
- STATE FUNDS	-\$953,903,940	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,223,878,000	-\$1,588,306,000
STATE FUNDS	-\$953,903,940	\$0
FEDERAL FUNDS	-\$1,269,974,060	-\$1,588,306,000

DESCRIPTION

Purpose:

This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:

Social Security Act, section 1927 [42 U.S.C. 1396r-8]
 Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.
 Proposed Trailer Bill Language

Interdependent Policy Changes:

Medi-Cal Drug Rebates Fund

Background:

The Medicaid Drug Rebate Program, created by OBRA 1990, allows the Department to obtain price discounts for drugs. The program helps lower Medicaid spending on outpatient prescription drugs. Drug manufacturers must enter into a national Medicaid drug rebate agreement in order to obtain Medicaid coverage for their prescription drugs. Drug manufacturers are required to pay a rebate for all outpatient drugs that are dispensed and paid for by the State's Medi-Cal program.

The Department is proposing to establish the Medi-Cal Drug Rebates Fund (Fund 3331), effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebates Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase, due to the result of revised collection projections based on the net result of the following:

- The addition of a funding adjustment from FY 2017-18 drug rebates occurring in FY 2018-19,
- The addition of one quarter of actual Federal rebate collections from April 2018 through June 2018,
- Increased Children's Health Insurance Program (CHIP) rebates based on data through June

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54

- Increased Affordable Care Act (ACA) optional and ACA offset rebates based on data through June 2018.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to projecting an increase for FY 2019-20 federal drug rebates based on recent actuals and no additional prior year funding adjustments in FY 2019-20. Additionally, the non-federal share of the FY 2019-20 federal drug rebate collections are not included in this policy change and are instead included in the Medi-Cal Drug Rebates Fund policy change.

Methodology:

- Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.
- Assume family planning drugs account for 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).
- Assume CHIP drug rebate collections are estimated to be \$96,804,000 TF in FY 2018-19. These rebates are funded at 88% FF / 12% GF through September 30, 2019, and 76.5% FF / 23.5% GF beginning October 1, 2019. In FY 2019-20, CHIP rebate collections of \$78,102,000 FF is included in this policy change.
- The optional expansion ACA population collections are estimated to be \$684,386,000 TF for FY 2018-19 at 94% FF / 6% GF. For FY 2019-20, a total of \$790,079,000 TF is estimated for the optional expansion population, of which \$734,773,000 FF is budgeted in this policy change. The amount of \$55,306,000 SF is budgeted to be transferred to the GF in the Medi-Cal Drug Rebates Fund policy change.
- The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is \$116,737,000 TF for FY 2018-19 and \$121,567,000 TF for FY 2019-20.
- The FY 2017-18 funding adjustment for the January 2018 to March 2018 quarter occurred in August 2018.
- The Department estimates to transfer \$727,582,000 federal drug rebates collections to the Medi-Cal Drug Rebates Fund in FY 2019-20.

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	(\$1,323,564,000)	(\$661,782,000)	(\$661,782,000)
94% Title XIX/ 6% GF	(\$684,386,000)	(\$41,063,000)	(\$643,323,000)
90% Title XIX / 10% GF	(\$2,387,000)	(\$239,000)	(\$2,148,000)
ACA Offset	(\$116,737,000)	\$0	(\$116,737,000)
88% Title XXI / 12 % GF	(\$96,804,000)	(\$11,616,000)	(\$85,188,000)
FY 2017-18 Funding Adjustment	\$0	(\$239,204,000)	\$239,204,000
Total	(\$2,223,878,000)	(\$953,904,000)	(\$1,269,974,000)

FEDERAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 54

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$653,864,000)	(\$653,864,000)	(\$672,276,000)
100% Title XIX ACA FF	(\$734,773,000)	(\$734,773,000)	(\$55,306,000)
100% Title XXI FF	(\$78,102,000)	(\$78,102,000)	\$0
ACA Offset	(\$121,567,000)	(\$121,567,000)	\$0
Total	(\$1,588,306,000)	(\$1,588,306,000)	(\$727,582,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 7.

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 90% Title XIX / 10% GF (4260-101-0001/0890)
 100% Title XIX FFP (4260-101-0890)
 100% Title XXI FFP (4260-113-0890)
 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
 93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
 88% Title XXI / 12% GF (4260-113-0001/0890)
 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)
 65% Title XIX / 35% GF (4260-101-0001/0890)
 100% GF (4260-101-0001)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 55
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 2012

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$266,957,000	\$374,862,000
- STATE FUNDS	\$50,626,690	\$60,840,340
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$266,957,000	\$374,862,000
STATE FUNDS	\$50,626,690	\$60,840,340
FEDERAL FUNDS	\$216,330,310	\$314,021,660

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

REGULAR POLICY CHANGE NUMBER: 55

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:

Required

- 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)

Optional

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

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 88% and 76.5%. ACA Optional population is eligible for Title XIX federal reimbursement at 95% beginning January 2017, 94% beginning January 2018, and 93% beginning January 2019 and 90% beginning January 2020.

Reason for Change:

This change from the prior estimate, for FY 2018-19, is due to the following:

- Updated county implementation schedule – The prior estimate assumed costs for 32 opt-in counties to be incurred in FY 2018-19. Due to implementation delays for certain counties and revised payment lags, costs for 25 counties will be incurred in FY 2018-19.
- Updated approved interim county rates – The current estimate includes approved rates for four additional counties, for a total of 31 counties with approved rates.
- Includes the GF costs for a claims adjudication error in FY 2017-18 and the GF reimbursement in FY 2018-19.
- Updated claims data – Based on FY 2017-18 claims data for seven counties, compared to the estimated county fiscal plan, the methodology for estimating the annual cost projection was revised, and as a result, the overall annual estimate decreased.
- Includes the impact of the buprenorphine-naloxone combination product in the NTP MAT and NTP estimate. Overall estimated utilization and rate for the combination product has been revised and the cost impact is lower than previously estimated.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is primarily due to FY 2019-20 including costs for all 39 opt-in counties, compared to 25 county costs realized in FY 2018-19.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER**REGULAR POLICY CHANGE NUMBER: 55****Methodology:**

- DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Four counties implemented the waiver in FY 2016-17. For FY 2017-18, and additional seven counties (for a total of 11 counties) began providing waiver services.
- In FY 2018-19, 28 additional counties (for a total of 39 counties) will begin providing waiver services. The phase-in implementation is expected to occur through April 2019. From the 28 counties that will begin waiver services in FY 2018-19, eight counties will start the waiver under the Partnership Health Plans (PHP), and costs are not expected to be incurred in FY 2018-19.
- A total of 19 counties have not opted-in to implement DMC-ODS waiver services.
- 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. Rates for NTP services, including MAT expansion, are based on the existing State Plan rates developed by the Department.
- Effective July 1, 2018, the Department added an additional MAT, a buprenorphine–naloxone combination product, to be available under the DMC-ODS waiver. This product contains buprenorphine and naloxone, and is a safer alternative to methadone since it comes with a lower chance of addiction and dependency. In comparison to buprenorphine, the naloxone component of the combination MAT limits abuse because of the potential effects of withdrawal.

Net DMC-ODS Waiver Costs

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

DMC-ODS Waiver Net Cost	FY 2018-19	FY 2019-20
Required Services	\$60,386,000	\$93,553,000
Optional Services	\$2,823,000	\$3,208,000
Existing Services	\$245,088,000	\$328,454,000
Total	\$308,297,000	\$425,215,000

Claims Payment Error

- Payments for the DMC-ODS waiver services began in April 2017. Due to a system error, payments for all new Required and Optional services for clients with ACA optional aid codes were paid using GF as the funding match for federal funds. Payments for these clients do not fall under the provisions of Proposition 30 and therefore, should have been paid with county funds. The Department is currently working with the counties to make corrections to those claims. The system changes for payment corrections are expected to be completed in FY 2018-19 and the funds will be recouped to repay the GF.

Claims Payment Error	FY 2017-18	FY 2018-19 (Cost)	FY 2018-19 (GF recoupment)
FY 2016-17 Claims	\$32,000	\$0	(\$32,000)
FY 2017-18 Claims	\$623,000	\$0	(\$623,000)
FY 2018-19 Claims	\$0	\$6,000	(\$6,000)
Total	\$655,000	\$6,000	(\$661,000)

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

REGULAR POLICY CHANGE NUMBER: 55

8. On a cash basis, the total costs for the claims payment error and waiver services costs are estimated to be \$308,297,000 TF and \$425,215,000 TF in FY 2018-19 and FY 2019-20, respectively.

FY 2018-19	TF	GF	FF Title XIX	FF Title XXI	CF
Regular					
Current	\$163,566,000	\$44,034,000	\$81,084,000	\$1,231,000	\$37,217,000
ACA Optional	\$140,834,000	\$7,199,000	\$131,680,000	\$0	\$1,955,000
Perinatal					
Current	\$3,050,000	\$0	\$1,501,000	\$42,000	\$1,507,000
ACA Optional	\$847,000	\$55,000	\$792,000	\$0	\$0
Claims Error					
General Fund	\$0	(\$661,000)	\$0	\$0	\$661,000
Total	\$308,297,000	\$50,627,000	\$215,057,000	\$1,273,000	\$41,340,000

FY 2019-20	TF	GF	FF Title XIX	FF Title XXI	CF
Regular					
Current	\$180,775,000	\$44,887,000	\$89,399,000	\$1,570,000	\$44,919,000
ACA Optional	\$242,345,000	\$15,900,000	\$221,746,000	\$0	\$4,699,000
Perinatal					
Current	\$1,470,000	\$0	\$735,000	\$0	\$735,000
ACA Optional	\$625,000	\$53,000	\$572,000	\$0	\$0
Total	\$425,215,000	\$60,840,000	\$312,452,000	\$1,570,000	\$50,353,000

Funding:

100% GF (4260-101-0001)
 100% Title XIX FF (4260-101-0890)
 100% Title XXI FF (4260-113-0890)
 100% ACA Title XIX FF (4260-101-0890)
 94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)
 93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)
 88% Title XXI FF / 12% GF (4260-113-0001/0890)
 76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)
 50% Title XIX / 50% GF (4260-101-0001/0890)

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 60
 IMPLEMENTATION DATE: 12/2018
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1723

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$818,000	\$0
- STATE FUNDS	-\$105,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$818,000	\$0
STATE FUNDS	-\$105,000	\$0
FEDERAL FUNDS	-\$713,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:

Welfare & Institutions Code 14124.24 (g)(1)
 Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:

Not Applicable

Background:

The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and Narcotic Treatment Program (NTP).

The DMC program initially pays a claim for SUD services at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-Narcotic Treatment Program services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE).

Cost settlements for non-Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 60

Cost settlements for Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its cost settlement process to counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through certified public expenditure (CPE) as part of an all-inclusive rate. Starting from the FY 2014-15 annual cost report settlement, all amounts for administrative cost reimbursements or recoupments will be included in the Drug Medi-Cal County Administration policy change.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a savings recoupment due to updated finalized cost report settlements.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to no cost settlement payments or recoupments included in FY 2019-20.

Methodology:

1. The annual cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.
2. Final cost settlements are based on comparing actual expenditures against the audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.
3. The FY 2014-15 annual cost settlement will be recouped in FY 2018-19.

FY 2018-19	TF	GF	Title XIX	Title XXI
FY 2014-15 Settlements	(\$818,000)	(\$105,000)	(\$714,000)	\$1,000

Funding:

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

100% GF (4260-101-0001)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 10/2017
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1458

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$46,640,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,640,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$46,640,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:

ABX4 5 (Chapter 5, Statutes of 2009)
 Welfare & Institution Code 14723
 State Plan Amendment (SPA) 09-004

Interdependent Policy Changes:

Not Applicable

Background:

State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

On February 16, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the supplemental payment SPA 09-004 and Certified Public Expenditure Protocol.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to:

- Adding the remaining FY 2008-09 and FY 2009-10 payments, previously estimated to be paid in FY 2017-18, to be paid in FY 2018-19, and
- Removing the FY 2010-11 and FY 2011-12 payments from the estimate, to be paid at a later date, due to the timing of finalizing cost reports.

The change from FY 2018-19 and FY 2019-20, in the current estimate, is due to no estimated payments scheduled for FY 2019-20.

**SPECIALTY MENTAL HEALTH SVCS SUPP
REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 63**

Methodology:

1. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).
2. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.
3. The FY 2008-09 and FY 2009-10 estimates were developed using the final filed cost reports received from each county mental health plan (MHP). The remaining FY 2008-09 and FY 2009-10 supplemental payments will be paid in FY 2018-19.

(Dollars in Thousands)

FY 2018-19	FF
FY 2008-09	\$12,598
FY 2009-10	\$34,042
Total for FY 2018-19	\$46,640

Funding:

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

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 1/2017
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1957

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$17,103,000	\$20,148,000
- STATE FUNDS	\$9,365,500	\$10,888,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$17,103,000	\$20,148,000
STATE FUNDS	\$9,365,500	\$10,888,000
FEDERAL FUNDS	\$7,737,500	\$9,260,000

DESCRIPTION

Purpose:

This policy change estimates the reimbursement to counties for participating in a child and family team (CFT), providing assessments for seriously emotionally disturbed (SED) foster children, and training for mental health staff.

Authority:

AB 403 (Chapter 773, Statutes of 2015)

Interdependent Policy Changes:

Not Applicable

Background:

AB 403 is part of an effort to reform congregate care in California. AB 403 establishes a new community care licensure category that is a short-term residential therapeutic program (STRTP). STRTPs are licensed and regulated by the California Department of Social Services (CDSS). STRTPs that provide specialty mental health services (SMHS) are certified by the Department.

County mental health departments currently participate in Child and Family Teams (CFT) for children receiving intensive care coordination services once the initial mental health screening has been completed by a county social worker. AB 403 requires county mental health departments to perform the following additional workload:

- Complete a mental health assessment that determines if the child or youth has a serious emotional disturbance, or meets medical necessity criteria for SMHS for eligible beneficiaries under the age of 21 (Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)). Either a CFT or an interagency placement council (IPC) must decide that a STRTP is the appropriate level of care for the child or youth.
- A CFT will be convened for all children or youth who have an open child welfare case. The county mental health department is expected to participate in all CFTs when the child needs SMHS.

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The responsibility for SMHS for children was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. The new activities began January 2017 and the current year and budget year costs are included in this policy change.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to:

- FY 2016-17 costs are no longer estimated to be paid in this policy change,
- Updated eligible child welfare cases for CFTs,
- Updated caseload estimated for placement assessments,
- Updated the FY 2018-19 cost per hour for CFTs from \$204.00 to \$255.00, and
- Updated federal discount to 61% for training.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to:

- More prior year payments are estimated in FY 2019-20.

Methodology:

Participation in a Child and Family Team (CFT)

1. Assume mental health staff will work with each child with specialty mental health needs for two hours to determine whether or not a child or youth meets criteria to be placed in an STRTP.
2. This estimate assumes 42% of Medi-Cal EPSDT eligible children with an open child welfare case will need SMHS. Of the 42%, 11,736 are assumed to be open child welfare cases and currently receiving a CFT.

Caseload	42%	Less: Current Cases	CFT Cases (A)	Hours per Year (B)	CFT Case Hours (A x B)
Tier 1	1,372	744	628	12	7,536
Tier 2	2,794	1,515	1,279	10	12,790
Tier 3	7,704	4,176	3,528	8	28,224
Tier 4	8,383	4,544	3,839	4	15,356
Tier 5	1,396	757	639	4	2,556
Total	21,649	11,736	9,913		66,462

3. Based on filed cost reports for mental health services, the average cost for treatment planning for mental health staff to participate in the CFT is \$3.31 per minute, or \$198.60 per hour for FY 2017-18, and \$4.25 per minute or \$255.00 per hour for FY 2018-19 and FY 2019-20.

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 64

4. The estimated annual cost for participation in a child and family team in FY 2017-18, FY 2018-19, and FY 2019-20:

(Rounded)

Caseload	CFT Case Hours	FY 2017-18 Cost (Case Hours x \$198.60/hr)	FY 2018-19 Cost (Case Hours x \$255.00/hr)	FY 2019-20 Cost (Case Hours x \$255.00/hr)
Tier 1	7,536	\$1,497,000	\$1,922,000	\$1,922,000
Tier 2	12,790	\$2,540,000	\$3,261,000	\$3,261,000
Tier 3	28,224	\$5,605,000	\$7,197,000	\$7,197,000
Tier 4	15,356	\$3,050,000	\$3,916,000	\$3,916,000
Tier 5	2,556	\$508,000	\$652,000	\$652,000
Total	66,462	\$13,200,000	\$16,948,000	\$16,948,000

Placement Assessments

- Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 856 children would phase in and transition to an STRTP in FY 2017-18, 1,588 children would transition to an STRTP in FY 2018-19 and FY 2019-20, respectively.
- Assume these children and youth would need to be assessed by county mental health department prior to being placed in a STRTP.
- Assume it will take mental health staff four hours per client to complete a mental health assessment.
- The assumed Placement Assessment costs are:

FY 2017-18: $859 \times \$198.60 \times 4 = \$680,006$

FY 2018-19: $1,588 \times \$255.00 \times 4 = \$1,619,760$

FY 2019-20: $1,588 \times \$255.00 \times 4 = \$1,619,760$

Training

- Beginning FY 2018-19, CDSS is requesting funds through Federal Title IV-E authority to provide counties with Continuum of Care Reform (CCR) training. The total mental health staff training request is \$3,000,000 to be paid at 75% FMAP, and discounted to 61% for FY 2018-19 and FY 2019-20, to account for children in foster care that are not federally eligible. The federal share will come from CDSS. The Department is requesting the General Fund (GF) match for the training.

FY 2018-19 and FY 2019-20: Federal Share: $\$3,000,000 \times 0.75 \times 0.61 = \$1,373,000$ (Rounded)

FY 2018-19 and FY 2019-20: GF Match: $\$3,000,000 \times (1 - (0.75 \times 0.61)) = \$1,628,000$ (Rounded)

Funding Summary

- Based on Short Doyle/Medi-Cal paid claims data, on a cash basis for FY 2018-19, the Department will pay 62% of FY 2017-18 claims, and 37% of FY 2018-19 claims. On a cash basis for FY 2019-20, the Department will pay 1% of FY 2017-18 claims, 62% of FY 2018-19 claims, and 37% of FY 2019-20 claims. There is no lag in payment for training costs. The estimated costs, on a cash basis, is:

MHP COSTS FOR CONTINUUM OF CARE REFORM

REGULAR POLICY CHANGE NUMBER: 64

(Dollars in Thousands)

FY 2018-19	TF	CFT	Placement Assessments	Training
FY 2017-18	\$8,605	\$8,183	\$422	\$0
FY 2018-19	\$8,498	\$6,271	\$599	\$1,628
Total FY 2018-19	\$17,103	\$14,454	\$1,021	\$1,628

(Dollars in Thousands)

FY 2019-20	TF	CFT	Placement Assessments	Training
FY 2017-18	\$139	\$132	\$7	\$0
FY 2018-19	\$11,511	\$10,507	\$1,004	\$0
FY 2019-20	\$8,498	\$6,271	\$599	\$1,628
Total FY 2019-20	\$20,148	\$16,910	\$1,610	\$1,628

2. The FY 2018-19 and FY 2019-20 estimate is:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CFT	\$14,454	\$7,227	\$7,227
Placement Assessments	\$1,021	\$511	\$510
Training	\$1,628	\$1,628	\$0
Total	\$17,103	\$9,366	\$7,737

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CFT	\$16,910	\$8,455	\$8,455
Placement Assessments	\$1,610	\$805	\$805
Training	\$1,628	\$1,628	\$0
Total	\$20,148	\$10,888	\$9,260

Funding:

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

100% GF (4260-101-0001)

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1718

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$9,521,000	\$14,554,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,521,000	\$14,554,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$9,521,000	\$14,554,000

DESCRIPTION

Purpose:

This policy change estimates the costs for the following Specialty Mental Health Services (SMHS): Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC). Previously, this policy change captured costs related to clients that were part of the *Katie A.* class or subclass. Membership in the *Katie A.* class or subclass is not a requirement for receiving medically necessary services, and therefore, a child or youth need not have an open welfare case to be considered for receipt of ICC, IHBS, or TFC.

Authority:

SPA#09-004

Interdependent Policy Changes:

Not Applicable

Background:

On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services (ICC, IHBS, and TFC) under the SMHS waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. The parties met with the Special Master to develop a plan for settlement implementation.

PATHWAYS TO WELL-BEING

REGULAR POLICY CHANGE NUMBER: 65

As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive existing services in a more intensive and effective manner. In this context, these existing services are referred to as ICC, IHBS, and TFC. Reimbursement methodologies were established for ICC and IHBS effective January 1, 2013. On February 16, 2016, the reimbursement methodology was approved by the Centers for Medicare and Medicaid Services (CMS) in State Plan Amendment (SPA) #09-004 for TFC. Billing for TFC is expected to begin in October 2018. These services are an EPSDT benefit for all children and youth under the age of 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services.

The Katie A. settlement terminated in December 2014. These services and the model in which they are provided are now called “Pathways to Well-Being” services and are incorporated as SMHS.

Reason for Change:

The change from the previous estimate, for FY 2018-19, is a net decrease due to:

- The claims reimbursement for TFC was previously expected to begin in April 2018. Due to the timing of the system change implementation, and the enrollment of TFC providers as Medi-Cal approved providers, claims are expected to begin October 2018.
- The payment lags for IHBS, ICC and TFC services were revised based on updated paid claims.

The change from FY 2018-19 and FY 2019-20, in the current estimate, is due to including additional TFC payments, based on the payment lags, in FY 2019-20.

Methodology:

1. The cost estimate is based on an increase in the number of children receiving SMHS.
2. Beginning in FY 2016-17, the estimated annual cost for Medi-Cal beneficiaries under the age of 21, who are eligible for full scope Medi-Cal services and meet the medical necessity criteria for IHBS and ICC is \$21,831,000, on an accrual basis. Assume 38% of the IHBS and ICC costs are reflected in the base policy change titled SMHS for Children.
3. Assume beginning July 1, 2017, the TFC services have a cost of \$15,732,000 annual basis. Assume costs for TFC will begin in FY 2018-19, due to limited numbers of Medi-Cal certified TFC providers.
4. On an accrual basis, the estimated costs are:

(Dollars in Thousands)

Fiscal Year	IHBS and ICC Accrual	TFC Accrual	Total Accrual
2016-17	\$21,831	\$0	\$21,831
2017-18	\$21,831	\$0	\$21,831
2018-19	\$21,831	\$15,732	\$37,563
2019-20	\$21,831	\$15,732	\$37,563

5. Based on historical claims received, FY 2018-19 and FY 2019-20 assume 35% of current year IHBS, ICC, and TFC claims will be paid in the year the services occur, and 64% is paid in the second year, and 1% is paid in the third year.

PATHWAYS TO WELL-BEING
REGULAR POLICY CHANGE NUMBER: 65

6. On a cash basis for FY 2018-19, for IHBS and ICC claims, assume the Department will pay 1% of FY 2016-17 claims, 64% of FY 2017-18 claims, and 35% of FY 2018-19 claims. For TFC claims, assume 35% of FY 2018-19 claims will be paid in FY 2018-19.
7. On a cash basis for FY 2019-20, for IHBS and ICC claims, assume the Department will pay 1% of FY 2017-18 claims, and 64% of FY 2018-19 claims, and 35% of FY 2019-20 claims in FY 2019-20. For TFC claims, assume 64% of FY 2018-19 claims, and 35% of FY 2019-20 claims will be paid in FY 2019-20.

(Dollars in Thousands)

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF
2016-17	IHBS & ICC	\$21,831	0.01	\$218
Less: 38%	IHBS & ICC			(\$83)
Subtotal				\$135
2017-18	IHBS & ICC	\$21,831	0.64	\$13,972
Less: 38%	IHBS & ICC			(\$5,309)
Subtotal				\$8,663
2018-19	IHBS & ICC	\$21,831	0.35	\$7,641
Less: 38%	IHBS & ICC			(\$2,904)
Subtotal				\$4,737
2018-19	TFC	\$15,732	0.35	\$5,506
Total 2018-19 Cash Estimate				\$19,041

(Dollars in Thousands)

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF
2017-18	IHBS & ICC	\$21,831	0.01	\$218
Less: 38%	IHBS & ICC			(\$83)
Subtotal				\$135
2018-19	IHBS & ICC	\$21,831	0.64	\$13,972
Less: 38%	IHBS & ICC			(\$5,309)
Subtotal				\$8,663
2019-20	IHBS & ICC	\$21,831	0.35	\$7,641
Less: 38%	IHBS & ICC			(\$2,904)
Subtotal				\$4,737
2108-19	TFC	\$15,732	0.64	\$10,068
2019-20	TFC	\$15,732	0.35	\$5,506
Total 2019-20 Cash Estimate				\$29,109

PATHWAYS TO WELL-BEING
REGULAR POLICY CHANGE NUMBER: 65

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2018-19	\$19,041	\$9,521	\$9,520
FY 2019-20	\$29,109	\$14,554	\$14,555

Funding:

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

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2026

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$909,000	\$0
- STATE FUNDS	\$909,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$909,000	\$0
STATE FUNDS	\$909,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost to reimburse San Diego and Butte Counties for the cost of Medi-Cal Specialty Mental Health Services (SHMS) claims for services provided in FY 2009-10.

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The Department contracted with San Diego and Butte Counties to be the Mental Health Plans (MHP) for Medi-Cal beneficiaries residing in those counties. San Diego and Butte Counties submitted claims to the Department of Mental Health (DMH) for services rendered in FY 2009-10. When the DMH transitioned to the Department, it was discovered that the claims were not processed or paid.

The Department will reimburse the San Diego and Butte County MHPs with the federal share of the cost to render SMHS to Medi-Cal beneficiaries. Because the two-year limit to claim federal reimbursement has passed, federal funding is not available.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to adding back the Butte County payment to this policy change based on updated processing information. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the payments in FY 2018-19.

TRANSITIONAL SMHS CLAIMS

REGULAR POLICY CHANGE NUMBER: 66

Methodology:

1. Payments to the San Diego and Butte County MHPs are based on actual claims received from each county.
2. In FY 2018-19, assume General Funds (GF) will be used to pay claims.

Cash Basis	TF	GF
FY 2018-19	\$909,000	\$909,000

Funding:

100% GF (4260-101-0001)

LATE CLAIMS FOR SMHS

REGULAR POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1717

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$25,000	\$0
- STATE FUNDS	\$25,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,000	\$0
STATE FUNDS	\$25,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of reimbursement for Medi-Cal Specialty Mental Health Services (SMHS) claims that are submitted by county mental health plans for late eligibility determinations.

Authority:

Title 22, California Code of Regulations 50746 and 51008.5
 Welfare & Institutions Code 14680-14685.1
 Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:

Not Applicable

Background:

County mental health plans have submitted Medi-Cal SMHS claims for clients with Letters of Authorization for late eligibility determinations. Counties have 60 days to submit claims to the Department for payment when the Department of Social Services has determined eligibility for claims over one year.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. No payments are budgeted for FY 2019-20.

Methodology:

1. Late claims are based on actual claims received from the counties.
2. Assume GF will be used to pay claims in FY 2018-19 that exceed the federal claiming limit.

Cash Basis	TF	GF
FY 2018-19	\$25,000	\$25,000

Funding:

100% GF (4260-101-0001)

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 68
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1660

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,055,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,055,000	\$0
FEDERAL FUNDS	-\$1,055,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of federal fund (FF) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:

Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:

Not Applicable

Background:

During the audit and cost settlement processes, the Department identified overpayments to the Siskiyou County Mental Health Plan from improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FF to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department \$200,000 per year until it fulfills its obligation for repayment. The County repayments began August 2012. The County has submitted six payments totaling \$1,200,000.

Reason for Change:

There is no change, from the prior estimate, for FY 2018-19. The change, from FY 2018-19 to FY 2019-20, in the current estimate, is due to only reflecting the reimbursement from Siskiyou County without federal fund repayments in FY 2019-20.

Methodology:

1. The Department began making repayments to CMS in January 2012 and has repaid CMS overpayments discovered during cost settlements for FY 2006-07 through FY 2010-11 and audit settlements for FY 2005-06 through FY 2010-11.

**SISKIYOU COUNTY MENTAL HEALTH PLAN
OVERPAYMENT
REGULAR POLICY CHANGE NUMBER: 68**

2. Siskiyou County will reimburse the GF \$200,000 annually. The county has submitted payments totaling \$1,200,000.
3. In FY 2017-18, the Department completed an audit of FY 2010-11 for Siskiyou County with findings of \$1,055,000 to be recouped. The Department will continue to repay CMS for overpayments as overpayment amounts are determined.

Date of Overpayment Discovery	Due to DHCS	Paid to CMS	Due to CMS GF
1/11/2011	\$1,754,000	\$1,754,000	\$0
3/2/2011	\$116,000	\$116,000	\$0
8/4/2011	\$2,189,000	\$2,189,000	\$0
11/15/2011	\$586,000	\$586,000	\$0
12/21/2011	\$95,000	\$95,000	\$0
3/26/2012	\$443,000	\$443,000	\$0
4/15/2013	\$2,917,000	\$2,917,000	\$0
5/30/2013	\$1,131,000	\$1,131,000	\$0
4/9/2014	\$1,369,000	\$1,369,000	\$0
9/9/2015	\$270,000	\$270,000	\$0
4/4/2016	\$381,000	\$381,000	\$0
1/18/2018	\$1,055,000	\$0	\$1,055,000
Subtotal	\$12,306,000	\$11,251,000	\$0
Repayments	(\$1,200,000)	\$0	\$0
Recoupments	(\$381,000)	\$0	\$0
Total	\$10,725,000	\$11,251,000	\$1,055,000

4. The estimate for FY 2018-19 and FY 2019-20 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2018-19	\$0	\$855,000	(\$1,055,000)	\$200,000
FY 2019-20	\$0	(\$200,000)	\$0	\$200,000

Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 69
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1714

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$766,000	-\$1,494,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$766,000	-\$1,494,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$766,000	-\$1,494,000

DESCRIPTION

Purpose:

This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers.

Authority:

Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:

Not Applicable

Background:

Since January 2005, the Department has been conducting on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries. The Department recoups the disallowed claims.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to:

- Recoupments from FY 2016-17 outpatient chart reviews that were previously estimated to be received in FY 2017-18 were received in FY 2018-19.
- Increased recoupments from updating the estimate to reflect actual and draft recoupments from the FY 2017-18 inpatient and outpatient chart reviews in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to a higher projection of recoupments for FY 2018-19 inpatient reviews expected to be received in FY 2019-20. Also, the FY 2018-19 estimate is based on actual and estimated recoupments, whereas the FY 2019-20 estimate is comprised of estimated recoupments only.

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 69

Methodology:

1. The FY 2018-19 estimate includes actual and estimated recoupments from inpatient and outpatient chart reviews conducted for FYs 2016-17 and 2017-18.
2. The FY 2019-20 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2018-19.

(Dollars in Thousands)

Fiscal Year	TF	FF
FY 2018-19	(\$766)	(\$766)
FY 2019-20	(\$1,494)	(\$1,494)

Funding:

100% Title XIX (4260-101-0890)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1713

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$14,306,000	\$0
- STATE FUNDS	-\$1,649,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$14,306,000	\$0
STATE FUNDS	-\$1,649,000	\$0
FEDERAL FUNDS	-\$12,657,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:

Welfare & Institution Code 14705(c)
 Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:

Not Applicable

Background:

The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to:

- Interim cost settlements for FY 2010-11 were updated and resulted in higher net recoupments instead of repayments.
- FY 2011-12 paid claims data was corrected and resulted in revised interim cost settlements for FY 2011-12. As a result, recoupments have increased and underpayments have significantly decreased.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 70

- A final cost settlement was added for FY 2009-10,
- Updated GF payments and recoupments, and
- Adding audit settlements for FY 2007-08 through FY 2010-11.

There are no estimated underpayments or recoupments scheduled for FY 2019-20, in the current estimate.

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.
2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.
3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.
4. Cost settlements prior to 2011 Realignment may consist of General Fund (GF).

The net FF and GF to be paid in FY 2018-19 is:

(Dollars in Thousands)

Final Settlement	TF	GF	Title XIX FF	Title XXI FF
FY 2009-10	(\$38)	\$0	(\$38)	\$0
Subtotal	(\$38)	\$0	(\$38)	\$0

(Dollars in Thousands)

Interim Settlements	TF	GF	Title XIX FF	Title XXI FF
FY 2006-07	\$2	\$2	\$0	\$0
FY 2009-10	(\$159)	(\$159)	\$0	\$0
FY 2010-11	\$3,335	\$3,848	(\$71)	(\$442)
FY 2011-12	\$7,548	\$0	\$7,927	(\$379)
Subtotal	\$10,726	\$3,691	\$7,856	(\$821)

(Dollars in Thousands)

Audit Settlements	TF	GF	Title XIX FF	Title XXI FF
FY 2007-08	\$3,156	\$1,392	\$1,745	\$19
FY 2008-09	\$97	\$0	(\$1)	\$98
FY 2009-10	(\$10,569)	(\$2,473)	(\$8,376)	\$280
FY 2010-11	(\$17,678)	(\$4,259)	(\$12,931)	(\$488)
Subtotal	(\$24,994)	(\$5,340)	(\$19,563)	(\$91)
Total FY 2018-19	(\$14,306)	(\$1,649)	(\$11,745)	(\$912)

Funding:

Title XIX FFP (4260-101-0890)
 Title XXI FFP (4260-113-0890)
 100% GF (4260-101-0001)

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 12/2015
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1951

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,427,881,000	\$2,439,704,000
- STATE FUNDS	\$1,213,940,000	\$1,219,852,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,427,881,000	\$2,439,704,000
STATE FUNDS	\$1,213,940,000	\$1,219,852,000
FEDERAL FUNDS	\$1,213,941,000	\$1,219,852,000

DESCRIPTION

Purpose:

This policy change estimates the payments to fund California's remaining uninsured population.

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
 SB 815 (Chapter 111, Statutes of 2016)

Interdependent Policy Changes:

ACA DSH Reduction

Background:

Since 2005, the Designated Public Hospital and Clinic systems (DPH systems) have received partial support for health expenditures made on behalf of the uninsured through a combination of California's 1115 Waivers' Safety Net Care Pool (SNCP) and Medicaid Disproportionate Share Hospital (DSH) funding. These two funding sources have been provided through a cost-based system. The Medi-Cal 2020's redesigned Global Payment Program (GPP) includes funding from the former SNCP and the State's DSH allotment (related to the DPHs), and is designed with preset reductions to the overall funding amounts in the latter demonstration years to coincide with the Medicaid DSH reductions required in the Affordable Care Act (ACA). This safety net stabilization program will provide an innovative approach to financing care to California's remaining uninsured population served by DPH systems by unifying the DSH and the successor SNCP funding streams into a DPH-specific global payment system. The GPP incentive and utilization based program will steer funding to those who are providing actual inpatient and/or outpatient services to uninsured Californians who are most in need. Rather than continue payments to inpatient facilities based upon the current SNCP and DSH system that provides funding based on the volume of hospitalizations, the GPP would promote the right care, at the right time, in the right setting for uninsured Californians served by the DPH systems.

Effective July 1, 2015, DPHs, except State Government-operated University of California (UC) hospitals, will be receiving their allocation of the federal DSH payments through the Global Payment Program.

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 71

The ACA DSH allotment reduction was previously scheduled to go into effect on October 1, 2013. HR 2 (2015) was enacted on April 16, 2015, which delayed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. See the ACA DSH Reduction policy change for more information.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- Inclusion of Program Year (PY) 2015-16 final close out payments,
- Inclusion of PY 2016-17 final reconciliation payments, and
- Updated estimated payment data for PY 2017-18 and PY 2018-19.

The change from FY 2018-19 to FY 2019-20, in this estimate, is due to PY 2015-16 close out payments and PY 2016-17 final reconciliation payments included in FY 2018-19, and varying DSH allotments by program year.

Methodology:

1. The program year for the Global Payment Program is from July 1 to June 30, to align with the state fiscal year.
2. The Medi-Cal 2020 GPP included SNCP funding of \$236 million for Demonstration Year (DY) 2015-16. In May 2016, the Department submitted an independent report on uncompensated care to the Centers for Medicare and Medicaid Services (CMS). On July 14, 2016, CMS approved \$236 million in SNCP funding for DY 2016-17 through DY 2019-20.
3. The total federal funding for the GPP for PY 2015-16 through PY 2019-20 is estimated at:

(Dollars in Thousands)

Program Year	DPH DSH Allotment	SNCP	Total FFP
PY 2015-16	\$869,667	\$236,000	\$1,105,667
PY 2016-17	\$903,395	\$236,000	\$1,139,395
PY 2017-18	\$934,629	\$236,000	\$1,170,629
PY 2018-19	\$969,128	\$236,000	\$1,205,128
PY 2019-20	\$988,760	\$236,000	\$1,224,760

4. Assume payments are made on a quarterly basis. Three quarters are paid in the same fiscal year. The fourth quarter payment is paid the following fiscal year.
5. The PY 2015-16 final close out payment of \$3.03 million TF will be paid in FY 2018-19.
6. The PY 2016-17 final reconciliation payment of \$34.72 million TF will be paid in FY 2018-19.
7. The estimated GPP payments on a cash basis are:

GLOBAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 71

(Dollars in Thousands)

FY 2018-19	TF	IGT	FF
PY 2015-16	\$3,034	\$1,517	\$1,517
PY 2016-17	\$34,723	\$17,362	\$17,361
PY 2017-18	\$582,433	\$291,216	\$291,217
PY 2018-19	\$1,807,691	\$903,845	\$903,846
Total	\$2,427,881	\$1,213,940	\$1,213,941

FY 2019-20	TF	IGT	FF
PY 2018-19	\$602,564	\$301,282	\$301,282
PY 2019-20	\$1,837,140	\$918,570	\$918,570
Total	\$2,439,704	\$1,219,852	\$1,219,852

Funding:

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

100% Global Payment Program Special Fund (4260-601-8108)

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 8/2016
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1950

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,687,847,000	\$1,332,000,000
- STATE FUNDS	\$843,923,500	\$666,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,687,847,000	\$1,332,000,000
STATE FUNDS	\$843,923,500	\$666,000,000
FEDERAL FUNDS	\$843,923,500	\$666,000,000

DESCRIPTION

Purpose:

This policy change estimates the payments to fund the delivery system transformation and alignment incentive program, known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME).

Authority:

SB 815 (Chapter 111, Statutes of 2016)

AB 1568 (Chapter 42, Statutes of 2016)

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Not Applicable

Background:

California will fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. Projects will be reported on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. To promote greater stability, 50% of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55% by January 2019; and 60% by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed \$7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems (DPH) and district/municipal public hospitals (DMPH) to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to \$1.4 billion annually for the DPH systems and up to \$200 million annually for the DMPH systems for the first three years of the demonstration. The pool will then phase down by 10% in the fourth year of the demonstration and by an additional 15% in the fifth year of the demonstration.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 72

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to the remaining DY 2016-17 supplemental payments shifted from FY 2017-18 to FY 2018-19 and the inclusion of additional high performance pool payments for DY 2017-18 in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the phase down of the annual allotments for DY 2018-19 and DY 2019-20 and no supplemental payments in FY 2019-20.

Methodology:

1. Assumes two semi-annual reports are due: the first report will be due in March for the July to December period and the second report is due in September for the January to June period.
2. Starting in DY 2016-17, if an entity does not meet the project metric target by the annual report due date, then the entity will not be able to claim the full allocation. The entity will have the opportunity to claim up to 90% of the unearned funds for up to two consecutive years by over-performing in other project metrics through the supplemental payment. The remaining 10% of the unearned funds will go to a high performance pool in the subsequent DY and can be claimed through the supplemental payment for the subsequent DY.
3. The remaining DY 2016-17 supplemental payments are estimated to be paid in FY 2018-19.
4. Starting in DY 2017-18, for both DMPHs and DPHs, based on the current hospitals' plans, assume the first semi-annual payment will be 50% of the annual DY allotment. The annual payment will include the remaining 50% of the annual DY allotment plus any unclaimed allotment funds from the first semi-annual payment period, if all metrics are achieved.
5. The DY 2017-18 payments include high performance pool payments from prior year allocations.
6. In DY 2018-19, the annual allocation to DMPHs and DPHs will be phased down by 10%. In FY 2018-19, the first semi-annual payment for DY 2018-19 is estimated based on the 10% phased down allocation. In FY 2019-20, the annual payment for DY 2018-19 is estimated based on the 10% phased down allocation.
7. In DY 2019-20, the annual allocation to DMPHs and DPHs will be phased down by an additional 15%. In FY 2019-20, the first semi-annual payment for DY 2019-20 is estimated based on the additional 15% phased down allocation.

PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 72

(Dollars in Thousands)

FY 2018-19	TF	IGT	FF
DY 2016-17			
DPH	\$12,559	\$6,279	\$6,279.73
DMPH	\$0	\$0	\$0
Total	\$12,559	\$6,279	\$6,280
DY 2017-18			
DPH	\$804,052	\$402,026	\$402,026
DMPH	\$151,236	\$75,618	\$75,618
Total	\$955,288	\$477,644	\$477,644
DY 2018-19			
DPH	\$630,000	\$315,000	\$315,000
DMPH	\$90,000	\$45,000	\$45,000
Total	\$720,000	\$360,000	\$360,000
Total FY 2018-19	\$1,687,847	\$843,923	\$843,924

(Dollars in Thousands)

FY 2019-20	TF	IGT	FF
DY 2018-19			
DPH	\$630,000	\$315,000	\$315,000
DMPH	\$90,000	\$45,000	\$45,000
Total	\$720,000	\$360,000	\$360,000
DY 2019-20			
DPH	\$535,500	\$267,750	\$267,750
DMPH	\$76,500	\$38,250	\$38,250
Total	\$612,000	\$306,000	\$306,000
Total FY 2019-20	\$1,332,000	\$666,000	\$666,000

Funding:

50% Title XIX FF (4260-101-0890)

50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1953

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$839,722,000	\$646,730,000
- STATE FUNDS	\$419,861,000	\$323,365,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$839,722,000	\$646,730,000
STATE FUNDS	\$419,861,000	\$323,365,000
FEDERAL FUNDS	\$419,861,000	\$323,365,000

DESCRIPTION

Purpose:

This policy change estimates the costs related to Medi-Cal 2020 Waiver Whole Person Care (WPC) Pilots.

Authority:

Welfare & Institutions Code Section 14184.60
 California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Not Applicable

Background:

Under the Medi-Cal 2020 Waiver, the Centers for Medicare and Medicaid Services (CMS) approved funding for WPC Pilot programs for a five-year period beginning January 1, 2016.

The WPC Pilots allow the following to act as a Lead Entity serving a county, or a region consisting of more than one county, to integrate services for their high-risk, high-utilizing beneficiaries to promote an integrated health system that is designed to maximize health care value and is sustainable over the long-term:

- City
- County
- City and county
- Health or hospital authority
- Consortium of any of the above entities
- Federally Recognized Tribe
- Tribal Health Program

Pilots allow city, county, state, tribal, and federal entities as well as Medi-Cal managed care plans, hospitals, and provider organizations to align communication and integrate services to prevent

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

REGULAR POLICY CHANGE NUMBER: 73

fragmentation of the delivery system that can result in duplicative or inappropriate care for Medi-Cal beneficiaries.

Proposals for WPC Pilots include specific strategies to:

- Increase and strengthen care coordination and integration for high-risk, high-utilizing beneficiaries, and develop an infrastructure that will ensure local collaboration among the entities participating in the WPC Pilots over the long term.
- Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries and reduce inappropriate emergency department utilization.
- Improve data collection and sharing among local entities to support ongoing case management, monitoring, and strategic program improvements.

WPC Pilots may also focus on Housing & Supportive Services which include (but are not limited to):

- Access to housing
- Tenancy-based care management services
- County Housing Pools

The Department approved a total of 25 local Whole Person Care Pilot programs that included 23 individual counties, one consortium of two counties, and one city.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a lower than projected amount of rollover funds into program year (PY) 3. The change in FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the removal of Plumas County from the WPC Pilot as of July 1, 2018, and the projected amount of rollover funds into PY 4.

Methodology:

1. First Round Lead Entities submitted applications with annual budgets in June 2016. The Department determined the program awards in the second quarter of FY 2016-17 for approved participating entities. The payments began in FY 2016-17 and are assumed to continue through FY 2020-21.
2. Second Round Lead Entities submitted applications with annual budgets in March 2017. The Department determined the program awards in the fourth quarter of FY 2016-17 for entities approved to participate in the second round. The payments for second round entities began in FY 2017-18 and are assumed to continue through FY 2020-21.
3. Payments are made through an Intergovernmental Transfer (IGT) process.
4. For First Round Lead Entities, PYs correspond to calendar years. PY 1 began January 1, 2016.
5. For Second Round Lead Entities, PY 1 is January – June 2017, and PY 2 is July 2017 – December 2017. The remaining program years, PY 3 – PY 5, are then aligned with First Round Lead Entities and correspond to calendar years. PY 3 began January 2018.

MEDI-CAL 2020 WHOLE PERSON CARE PILOTS**REGULAR POLICY CHANGE NUMBER: 73**

6. PY 3 payments will be made in November 2018 and June 2019.
7. PY 4 payments will be made in November 2019 and June 2020.
8. Lead entities may roll over unused funds from the prior PY. The rollover process impacts actual expenditures in current year and projected expenditures in budget year.

(Dollars in Thousands)

	TF	IGT*	FF
FY 2018-19	\$839,722	\$419,861	\$419,861

(Dollars in Thousands)

	TF	IGT*	FF
FY 2019-20	\$646,730	\$323,365	\$323,365

Funding:

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

*Whole Person Care Pilot Special Fund (4260-601-8107)

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74
 IMPLEMENTATION DATE: 1/2017
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 1954

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$115,244,000	\$149,110,000
- STATE FUNDS	\$57,622,000	\$74,555,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$115,244,000	\$149,110,000
STATE FUNDS	\$57,622,000	\$74,555,000
FEDERAL FUNDS	\$57,622,000	\$74,555,000

DESCRIPTION

Purpose:

This policy change estimates the dental-related costs for the Medi-Cal 2020 Waiver. These costs include the estimated incentive payments for the provision of preventive services, caries risk assessment and disease management, continuity of care, and funding for the Local Dental Pilot Projects (LDPPs).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Not Applicable

Background:

Through the Medi-Cal 2020 Waiver, the Department is implementing and overseeing four dental efforts (domains), which are collectively referred to as the Dental Transformation Initiative (DTI) program.

The four domains of the DTI program are as follows:

- (1) Increase Preventive Services Utilization for Children,
- (2) Caries Risk Assessment and Disease Management,
- (3) Increase the Continuity of Care, and
- (4) LDPPs

The Increase Preventive Services Utilization for Children domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department offers incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. A reassessment of this Domain and the applicable benchmarks will take place between years two and three in order to evaluate program effectiveness.

The Caries Risk Assessment and Disease Management domain enables eligible Medi-Cal Dental

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74

program enrolled dentists to receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under, based upon the beneficiary's risk level as determined by the dentist via the caries risk assessment. The key elements of this program are to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures. This domain has been implemented on a pilot basis in select counties based on the percentage of restorative to preventive services, representative sampling across the state, and likelihood of provider participation.

The Increase the Continuity of Care domain aims to encourage the continuity of care among Medi-Cal beneficiaries age 20 and under. This domain has been implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state.

The Department requires the selected LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three abovementioned programs. The Department issued payments to pilot providers (i.e. the entity or entities providing the pilot proposal application) only on the basis of an approved application. Fifteen LDPPs were approved; however, two LDPP were unable to execute their contracts.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to lower than estimated usage in Domain 2, and a change in methodology in calculating Domain 3 incentive payments, and some LDPPs not executing their contracts. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to anticipated increased participation in the DTI for the remaining program years and the reallocation of LDPP funds.

Methodology:

Domain 1: Increase Preventive Services Utilization for Children

1. The implementation date for Domain 1 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, count towards the domains performance metrics and incentive payments. Incentive payments are paid on a semi-annual basis.. The timing of the payments assumes the incentives will be completed by the first payment of the following fiscal year. Therefore, FY 2018-19 includes incentive payments for CY 2018 and the remainder of CY 2017 and FY 2019-20 includes incentive payments for CY 2019 and the remainder of CY 2018.
2. Service Office Locations are reimbursed for services in accordance with the Schedule of Maximum Allowances (SMA). In addition, qualified service office locations may receive incentive payments for preventive services equating to a payment of 37.5% of the SMA for every qualifying preventive service provider to users above the 1% benchmark and 75% of the SMA for every qualifying preventive service provided to users above a 2% benchmark set by the Department.
3. A factor to account for changes in statewide Medi-cal eligibles has been applied based on caseload trends.
4. The Department assumes that there will be a 15% decrease in provider payments after the re-baselining of providers in program year 2018.

Total Domain 1 costs are estimated to be:

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74

Fiscal Year	TF	GF	FF
FY 2018-19	\$60,244,000	\$30,122,000	\$30,122,000
FY 2019-20	\$76,925,000	\$38,462,000	\$38,462,000

Domain 2: Caries Risk Assessment and Disease Management

5. This four year incentive program implemented on January 1, 2017. The Department uses the most recent complete calendar year (CY) for Caries Risk Assessment CDT code data to determine the utilization.
6. Domain 2 has three levels of risk assessment; Low, Moderate and High Risk. Low Risk children are able to obtain these services twice a year, Moderate Risk three times per year, and High Risk four times per year. High Risk children also have the option of receiving an interim caries arresting medication twice per year. The participation is projected using the last six months of data along with a factor based on caseload trends to account for changes in statewide Medi-cal eligibles.
7. Payments are made on a monthly basis. Therefore, FY 2018-19 includes incentive payments for the second six months of CY 2018 and first six months of CY 2019 while FY 2019-20 will include incentive payments for the second six months of CY 2019 and the first six months of CY 2020.

Total Domain 2 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2018-19	\$3,654,000	\$1,827,000	\$1,827,000
FY 2019-20	\$4,078,000	\$2,039,000	\$2,039,000

Domain 3: Increase the Continuity of Care

8. The implementation date for Domain 3 was July 1, 2016; however, claims data from January 1, 2016, through June 30, 2016, count towards the domain's performance metrics and incentive payments as compared to prior year's data. Payments are made once a year starting in July 2017. Therefore, FY 2018-19 will include incentive payments for CY 2017 and runout for CY 2016, while FY 2019-20 includes incentive payments for FY 2018 and runout for FY 2017
9. This incentive program is available to service office locations that provide examinations to an enrolled Medi-Cal beneficiary for two, three, four, five, and six year continuous periods.
10. A factor to account for changes in statewide Medi-cal eligibles has been applied based on caseload trends.
11. This five year incentive program is only available for services performed on child beneficiary participants age 20 and under. The Department assumes that the beneficiaries from the baseline year for the selected pilot county will return to the same provider at the same rate from year one through year five.
12. There will be a projected 2.25% increase in exams utilization each year for newly entering Domain 3 participants.
13. Incentive payment amounts are made available in tiers based on the length of time a beneficiary maintains continuity of care with the same service office location. In each subsequent year of continuity, the dollar amount of the incentive payment for an exam of the same child within that period is increased.

MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

REGULAR POLICY CHANGE NUMBER: 74

Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2018-19	\$11,876,000	\$5,938,000	\$5,938,000
FY 2019-20	\$18,054,000	\$9,027,000	\$9,027,000

Domain 4: Local Dental Pilot Projects

14. The implementation for this domain was April 15, 2017. Payments are invoiced quarterly beginning FY 2017-18.

15. Fifteen LDPPs were approved; however, two LDPPs have been withdrawn.

16. Assume financing for LDPPs is contingent upon the structure and design of approved proposals. The LDPPs domain's annual funding shall not exceed twenty-five percent of the DTI annual funding limits. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal Waiver Special Terms and Conditions (STCs).

Total Domain 4 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2018-19	\$39,470,000	\$19,735,000	\$19,735,000
FY 2019-20	\$50,053,000	\$25,027,000	\$25,027,000

17. On a cash basis, the FY 2018-19 and FY 2019-20 total demonstration costs are:

FY 2018-19	TF	GF	FF
Domain 1	\$60,244,000	\$30,122,000	\$30,122,000
Domain 2	\$3,654,000	\$1,827,000	\$1,827,000
Domain 3	\$11,876,000	\$5,938,000	\$5,938,000
Domain 4	\$39,470,000	\$19,735,000	\$19,735,000
Total	\$115,244,000	\$57,622,000	\$57,622,000

FY 2019-20	TF	GF	FF
Domain 1	\$76,925,000	\$38,462,000	\$38,462,000
Domain 2	\$4,078,000	\$2,039,000	\$2,039,000
Domain 3	\$18,054,000	\$9,027,000	\$9,027,000
Domain 4	\$50,053,000	\$25,027,000	\$25,027,000
Total	\$149,110,000	\$74,555,000	\$74,555,000

*Totals may not add due to rounding

Funding:

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

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 75
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1153

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$110,930,000	\$0
- STATE FUNDS	\$110,930,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$110,930,000	\$0
STATE FUNDS	\$110,930,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION**Purpose:**

This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
 AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:

Not Applicable

Background:

Stabilization funding is calculated as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
 - a. The NDPHs' aggregate payment increase, and
 - b. The sum of \$0.544 million and 0.64% of total stabilization funding.
- Private Hospitals will receive total funds payment equal to the difference between:
 - a. The Private Hospitals' aggregate payment increase, and
 - b. The sum of \$42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.
- Distressed Hospitals will receive total funds payments equal to the lesser of \$23.5 million or 10% of total stabilization funding, with a minimum of \$15.3 million.
- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs' certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 75

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to the shift of the DY 2008-09 final reconciliation from FY 2017-18 to FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the DY 2008-09 and DY 2009-10 final reconciliations in FY 2018-19.

Methodology:

1. Stabilization funding is calculated after the final reconciliation of the DPH interim payments is completed.
2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.
3. Stabilization funding to NDPHs, Private Hospitals, and Distressed Hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.
4. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the BTR.
5. The MH/UCD final reconciliation calculation takes into account claiming for Designated State Health Programs as well as payments to DPHs and Distressed Hospitals.
6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.
7. Final reconciliations will result in updated stabilization amounts for NDPH and Private Hospitals. These updated stabilization amounts will not be paid out.
8. Distressed Hospital payments are calculated as part of the MH/UCD waiver final reconciliation. These payments were previously distributed based on negotiations with the Office of the Selective Provider Contracting Program, formerly CMAC. The Department will now distribute these payments. Distressed Hospital payments for 2005-06 and 2006-07 were paid prior to FY 2013-14. Until the distribution methodology for Distressed Hospital payments is finalized, Distressed Hospital payments for DY 2007-08 through DY 2009-10 will not be paid out.
9. The DY 2008-09 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2018-19.
10. The DY 2009-10 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2018-19.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 75

The estimated stabilization payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
DY 2008-09 DPHs	\$55,400	\$55,400	\$0
DY 2009-10 DPHs	\$55,530	\$55,530	\$0
Total	\$110,930	\$110,930	\$0

Funding:

100% GF (4260-101-0001)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 76
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1578

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$104,616,000	\$198,363,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$104,616,000	\$198,363,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$104,616,000	\$198,363,000

DESCRIPTION**Purpose:**

This policy change estimates the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:

AB 342 (Chapter 723, Statutes of 2010)

AB 1066 (Chapter 86, Statutes of 2011)

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:

Not Applicable

Background:

The LIHP was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The MCE program is not subject to a federal funding cap. The HCCI covered those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs), and
- IGTs for county-owned Federally Qualified Health Centers (IGT-FQHCs).

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 76

The Department has used the CI cost claiming protocol for the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) as the basis for payments made on claims for dates of service from November 1, 2010, through September 30, 2011. This protocol is permitted by the Special Terms and Conditions of the Section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

On August 13, 2012, the Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGT-FQHC on February 5, 2013, retroactive to November 1, 2010.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to not completing any final reconciliations for LIHP counties in FY 2017-18. FY 2018-19 includes the prior estimated FY 2017-18 final reconciliations for LIHP invoice counties while shifting the reconciliation for LIHP cost report counties to FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to the varying final reconciliation results for the LIHP invoice counties and the LIHP counties that used cost reports. The current estimate reflects reconciliation of LIHP invoice counties occurring in FY 2018-19, and the reconciliation of LIHP cost report counties occurring in FY 2019-20.

Methodology:

1. Assume the remaining DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2018-19.
2. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2019-20.

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	FF
2010-11 (CPEs)	\$33,850	\$33,850
2011-12 (CPEs)	\$29,916	\$29,916
2012-13 (CPEs)	\$21,387	\$21,387
2013-14 (CPEs)	\$19,463	\$19,463
Total FY 2018-19	\$104,616	\$104,616

(Dollars in Thousands)

FY 2019-20	TF	FF
2010-11 (CPEs)	(\$3,238)	(\$3,238)
2011-12 (CPEs)	(\$15,078)	(\$15,078)
2012-13 (CPEs)	\$40,954	\$40,954
2013-14 (CPEs)	\$175,725	\$175,725
Total FY 2019-20	\$198,363	\$198,363

Funding:

100% Title XIX (4260-101-0890)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 77
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1572

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$36,060,000	\$231,547,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$36,060,000	\$231,547,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$36,060,000	\$231,547,000

DESCRIPTION**Purpose:**

This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:

AB 342 (Chapter 723, Statutes of 2010)

AB 1066 (Chapter 86, Statutes of 2011)

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:

Not Applicable

Background:

The LIHP, effective November 1, 2010, through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the HCCI. The MCE covered eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those eligible individuals with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service from November 1, 2010, through September 30, 2011. This protocol is permitted by the Special Terms and Conditions of the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

BTR - LOW INCOME HEALTH PROGRAM - HCCI**REGULAR POLICY CHANGE NUMBER: 77**

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. CMS approved this change retroactive to October 1, 2011. CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013, retroactive to November 1, 2010.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at \$360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and \$180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

However, local spending under the HCCI has not reached \$360 million. The Department obtained CMS approval through two amendments to the BTR Medicaid Demonstration waiver to reallocate the unused HCCI funds from DY 2010-11 through DY 2013-14 to the Safety Net Care Pool (SNCP) uncompensated care component. The total reallocation amount for DY 2010-11 through DY 2013-14 is \$222 million in federal funds.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to not completing any final reconciliations for LIHP counties in FY 2017-18. FY 2018-19 includes the prior estimated FY 2017-18 final reconciliations for LIHP invoice counties while shifting the reconciliation for LIHP cost report counties to FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to the varying final reconciliation results for the LIHP invoice counties and the LIHP counties that used cost reports. The current estimate reflects reconciliation of LIHP invoice counties occurring in FY 2018-19, and the reconciliation of LIHP cost report counties occurring in FY 2019-20.

Methodology:

1. Assume the remaining DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted invoices for payment will occur in FY 2018-19.
2. Assume the DY 2010-11 through DY 2013-14 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2019-20.

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	FF
DY 2010-11	\$9,555	\$9,555
DY 2011-12	\$10,348	\$10,348
DY 2012-13	\$11,096	\$11,096
DY 2013-14	\$5,061	\$5,061
Total FY 2018-19	\$36,060	\$36,060

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 77

(Dollars in Thousands)

FY 2019-20	TF	FF
DY 2010-11	\$22,546	\$22,546
DY 2011-12	\$192,933	\$192,933
DY 2012-13	\$10,915	\$10,915
DY 2013-14	\$5,153	\$5,153
Total FY 2019-20	\$231,547	\$231,547

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 78
 IMPLEMENTATION DATE: 9/2007
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1154

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$21,940,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,940,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$21,940,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD).

Authority:

SB 1448 (Chapter 76, Statutes of 2006)
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

Not Applicable

Background:

Under the MH/UCD, \$180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10.

The federal funds available will reimburse the HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their certified public expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP). The Special Terms and Conditions (STC) of the MH/UCD waiver allowed the Department to reallocate unspent Coverage Initiative (CI) funding to counties who have additional expenditures.

The Demonstration, which would have ended on August 31, 2010, was extended until October 31, 2010. The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE**REGULAR POLICY CHANGE NUMBER: 78****Reason for Change:**

The change in FY 2018-19, from the prior estimate, is an increase due to shifting all FY 2017-18 reconciliation payments to FY 2018-19. All final reconciliation payments are expected to be completed in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the payments in FY 2018-19.

Methodology:

1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	\$8,204
Contra Costa County/Contra Costa Health Services	\$15,250
County of Orange	\$16,872
County of San Diego, Health and Human Services Agency	\$13,040
County of Kern, Kern Medical Center	\$10,000
Los Angeles County Department of Health Services	\$54,000
San Francisco Department of Public Health	\$24,370
San Mateo County	\$7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	\$20,700
Ventura County Health Care Agency	\$10,000
Total	\$180,000

2. Remaining reconciliation payments for DY 2007-08 under the MH/UCD HCCI for the counties that submitted invoices for payment will occur in FY 2018-19.
3. Assume DY 2007-08 through DY 2009-10 final reconciliations for the counties that submitted cost reports for payment will occur in FY 2018-19.

The estimated HCCI reconciliation payments on a cash basis are:

FY 2018-19	TF	FF
DY 2007-08	\$20,534,000	\$20,534,000
DY 2008-09	\$698,000	\$698,000
DY 2009-10	\$708,000	\$708,000
Total FY 2018-19	\$21,940,000	\$21,940,000

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1072

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,989,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,989,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,989,000	\$0

DESCRIPTION**Purpose:**

This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
 MH/UCD

Interdependent Policy Changes:

Not Applicable

Background:

Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a SNCP was established to support the provision of services to the uninsured. The SNCP makes available \$586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional \$180 million per DY for implementing a healthcare coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual \$100,000,000 of the SNCP federal financial participation (FFP) for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

MH/UCD—SAFETY NET CARE POOL**REGULAR POLICY CHANGE NUMBER: 79**

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed \$586 million.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each DY may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR demonstration. A modified SNCP was continued in the BTR demonstration.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to the shift of the DY 4 final reconciliation from FY 2017-18 to FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the DY 4 and DY 5 final reconciliations in FY 2018-19.

Methodology:

1. The final reconciliation for DY 2008-09 and DY 2009-10 will occur in FY 2018-19.

The estimated DPH payments/recoupments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	FF
DY 2008-09	(\$6,723)
DY 2009-10	\$9,712
Total	\$2,989

Funding:

100% Health Care Support Fund (4260-601-7503)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1769

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$363,000	\$369,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$363,000	\$369,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$363,000	\$369,000

DESCRIPTION

Purpose:

This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Pursuant to the Special Terms and Conditions (STCs) of the BTR waiver, for the period covering April through December of 2013, IHS facilities may claim for services provided to uninsured individuals and optional benefits eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009).

On December 24, 2013, CMS approved the extension of IHS payments for the period covering January through December 2014. On December 30, 2014, CMS approved the extension of IHS payments for the period covering January through October 2015. Under the extensions, IHS facilities may claim for eliminated optional Medi-Cal benefits, but not for services provided to uninsured individuals.

The BTR was extended for two months, until December 31, 2015. Effective January 1, 2016, CMS approved the Medi-Cal 2020 Demonstration that allows the State to continue to claim federal financial participation for eliminated optional Medi-Cal benefits provided by Indian Health Service tribal health facilities.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG REGULAR POLICY CHANGE NUMBER: 80

Covered Services for Uninsured Individuals (April 5, 2013 to December 31, 2013)

Until December 31, 2013, IHS facilities were eligible to receive payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who were not enrolled in a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

Covered Services for Medi-Cal Enrollees (April 5, 2013 to December 31, 2020)

For Medi-Cal enrolled individuals, IHS facilities may receive payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology

Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For the period covering April through December of 2013, services provided to non-IHS eligible individuals are also eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan include:

- Acupuncture³
- Audiology
- Chiropractic
- Dental^{1,4}
- Incontinence creams and washes
- Optician/optical lab⁵
- Podiatry
- Psychology²
- Speech therapy

¹AB 82 (Chapter 23, Statutes of 2013) restores certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration does not affect calendar year 2013. For calendar year 2014, eliminated dental services will be claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and will no longer be claimable under this program.

²SBX1 1 (Chapter 4, Statutes of 2013) restores psychology services, effective January 1, 2014.

³SB 833 (Chapter 30, Statutes of 2016) restores acupuncture services, effective July 1, 2016.

⁴SB 97 (Chapter 52, Statutes of 2017) restores full adult dental benefits, effective January 1, 2018.

⁵SB 97 also restores the optician/optical lab benefit, no sooner than January 1, 2020 contingent upon an act from the legislature. The Department proposes to restore the optician/optical lab benefit, effective January 1, 2020.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG REGULAR POLICY CHANGE NUMBER: 80

Reason for Change:

The change in FY 2018-19, from the prior estimate, and from FY 2018-19 to FY 2019-20, in the current estimate, is due to outstanding claims for CY 2017 recouped in FY 2018-19.

Methodology:

1. Recoupments for CY 2017 in the amount of \$6,000 TF were made in July 2018.
2. Assume the remaining three quarters of CY 2018 will be paid in FY 2018-19.
3. Assume the first quarter of CY 2019 will be paid in FY 2018-19.
4. Assume the remaining three quarters of CY 2019 will be paid in FY 2019-20.
5. Assume the first quarter of CY 2020 will be paid in FY 2019-20.
6. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2018, the rate is \$427. Assume the rate is \$427 for CY 2019 and CY 2020.
7. IHS claims are paid for each encounter. Assume the encounters are 864 for CY 2018, CY 2019, and CY 2020.

Calendar Year 2018	864 encounters x	\$427 =	\$368,928 FF
Calendar Year 2019	864 encounters x	\$427 =	\$368,928 FF
Calendar Year 2020	864 encounters x	\$427 =	\$368,928 FF

8. Assume IHS payments will be made as follows on a cash basis:

FY 2018-19	TF	FF
Calendar Year 2017	(\$6,000)	(\$6,000)
Calendar Year 2018	\$277,000	\$277,000
Calendar Year 2019	\$92,000	\$92,000
Total	\$363,000	\$363,000

FY 2019-20	TF	FF
Calendar Year 2019	\$277,000	\$277,000
Calendar Year 2020	\$92,000	\$92,000
Total	\$369,000	\$369,000

Funding:

100% Health Care Support Fund (4260-601-7503)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 10/2016
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1952

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$37,727,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$37,727,000	\$0
FEDERAL FUNDS	\$37,727,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the new California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020). General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Medi-Cal 2020 Dental Transformation Initiative

Background:

The Centers for Medicare & Medicaid Services (CMS) approved the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD)
<ul style="list-style-type: none"> • Song-Brown Health Care Workforce Training • Steven M. Thompson Physician Corp Loan Repayment Program (STLRP) • Mental Health Loan Assumption Program (MHLAP)

MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

REGULAR POLICY CHANGE NUMBER: 81

The annual limit the State-Only programs may claim for Medi-Cal 2020 DSHP is \$75 million in FFP each Demonstration Year (DY) for a five year total of \$375 million.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to a decrease in claiming amounts.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to no DSHP claims are expected in FY 2019-20.

Methodology:

1. Assume \$37.727 million FFP will be claimed in FY 2018-19 for CCS, GHPP, MIA-LTC, and BCCTP.
2. Program allocations are updated based on actual claims.
3. On a cash basis, the total DSHP payments are estimated to be:

FY 2018-19	TF	GF	FF
CCS	\$0	(\$12,981,000)	\$12,981,000
GHPP	\$0	(\$18,718,000)	\$18,718,000
MIA-LTC	\$0	(\$5,341,000)	\$5,341,000
BCCTP	\$0	(\$687,000)	\$687,000
Total	\$0	(\$37,727,000)	\$37,727,000

Funding:

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 82
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1459

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$6,205,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$6,205,000	\$0
FEDERAL FUNDS	\$6,205,000	\$0

DESCRIPTION**Purpose:**

This policy change estimates the impact of the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:

Welfare & Institutions Code 14166.221
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:

Not Applicable

Background:

Under the MH/UCD, \$180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, \$360 million of the funding was unused. On February 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to the CMHS DY 5 final reconciliation shifted from FY 2017-18 to FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the CMHS final reconciliation in FY 2018-19.

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 82

Methodology:

1. The Department may claim these funds using the certified public expenditures from State-Only funded programs: Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).
2. AB 1653 (Chapter 218, Statutes of 2010) allowed the State to retain up to \$420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. \$135.083 million of the total \$420 million was applied to this policy change and paid in FY 2010-11.
3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011.
4. The MH/UCD demonstration required settled and audited cost reports in order to complete the final reconciliation for CMHS. The claimable time period for DY 2009-10 (DY 5) for CMHS is February 2010 through August 2010. This spans five months in FY 2009-10 and two months in FY 2010-11. Final reconciliation of DY 2009-10 will be completed when FY 2009-10 and FY 2010-11 mental health cost reports are settled and audited.
5. The Department is assuming completion of the CMHS reconciliation in FY 2018-19.

The General Fund savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	ARRA
DY 5 CMHS Final Reconciliation	\$0	(\$6,205)	\$5,038	\$1,167
Total	\$0	(\$6,205)	\$5,038	\$1,167

Funding:

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 9/2018
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 2035

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$108,229,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$108,229,000	\$0
FEDERAL FUNDS	-\$108,229,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the expenditure to settle the Centers for Medicare and Medicaid Services' (CMS) Federal Fiscal Year (FFY) 2013 and prior deferred claims and negative Payment Management System (PMS) subaccount balances.

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)

Interdependent Policy Changes:

Not Applicable

Background:

CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral notice to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable PMS subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn. Unpaid deferred claims and reporting issues resulted in negative PMS subaccount balances.

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current and PMS subaccounts into balance. The Department is working with CMS to resolve the specific items to reduce the General Fund (GF) liability for the remaining deferred claims and negative PMS subaccount balances.

CMS DEFERRALS & NEGATIVE BALANCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 83

While the repayment of remaining deferred claims is not subject to interest, the repayment for any remaining negative PMS subaccount balances is subject to interest. The Department must begin repayments for the negative PMS subaccount balance in regular, quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 2020) or within three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to updated PMS negative account balances.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the remaining repayments are expected to occur in FY 2018-19.

Methodology:

1. The Department repaid \$162,700,000 to CMS in FY2017-18.
2. Assume the remaining repayments will be made in FY 2018-19 totaling \$108,229,000.

(Dollars in Thousands)

FY 201819	TF	GF	FF
Repayments	\$0	\$108,229	(\$108,229)

3. The Department will continue to reconcile the remaining CMS deferred and disallowed claims.

Funding:

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

LIHP MCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 12/2018
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 2108

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$7,832,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$7,832,000	\$0
FEDERAL FUNDS	-\$7,832,000	\$0

DESCRIPTION**Purpose:**

This policy change budgets the return of federal funds to the Centers for Medicare and Medicaid Services (CMS) that were related to expenditures claimed incorrectly under the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) program.

Authority:

SB 335 (Chapter 286, Statutes of 2011)

SB 920 (Hernandez, Statutes of 2012)

California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

Not Applicable

Background:

The Low Income Health Program (LIHP) was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The MCE program is not subject to a federal funding cap. The HCCI covered those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs that used Certified Public Expenditures (CPEs) to claim federal funding.

SB 335, through the enactment of Welfare and Institutions Code (WIC), Section 14169.7.5, established the LIHP MCE Out-of-Network (OON) Emergency Care Services Fund (LIHP Fund 3201), effective July 1, 2011, to December 31, 2013. The Department was to disburse moneys from the fund to the LIHPs as revenue transfers solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required post stabilization care provided by private hospitals that are outside the LIHP coverage network.

LIHP MCE REPAYMENT

REGULAR POLICY CHANGE NUMBER: 84

In September 2017, CMS formally denied approval of the LIHP MCE OON Emergency Care Services payments, and as a result, the revenue transfers must be returned to the DPHs pursuant to WIC section 14169.7.5(d).

A portion of the revenue transfers were deposited into the LIHP Fund 3201 in FY 2011-12. From the transfers that were available in LIHP Fund 3201, the Department distributed \$7,832,000 to the Los Angeles County (LAC) LIHP. The LAC LIHP received the Department's \$7,832,000 distribution and spent \$7,832,000 of its own funding to pay a total of \$15,664,000 to private hospitals for LIHP MCE OON payments. The LAC LIHP then certified these expenditures, drawing down \$7,832,000 in Federal Financial Participation (FFP) through the separate BTR LIHP MCE program. Since the LIHP MCE OON payments was formally denied, the LAC LIHP must return the \$7,832,000 in incorrectly claimed FFP to CMS.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume a one-time payment to CMS for \$7,832,000 will occur in December 2018.

(Dollars in Thousands)

FY 2018-19	TF	Reimbursement	FF
LIHP MCE Repayment	\$0	\$7,832	(\$7,832)

Funding:

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

Reimbursement GF (4260-601-0995)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 4/2014
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1766

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$7,705,868,000	\$7,982,402,000
- STATE FUNDS	\$3,852,934,000	\$3,991,201,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	68.16 %	68.07 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,453,548,400	\$2,548,781,000
STATE FUNDS	\$1,226,774,180	\$1,274,390,480
FEDERAL FUNDS	\$1,226,774,190	\$1,274,390,480

DESCRIPTION

Purpose:

This policy change estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:

SB 1008 (Chapter 33, Statutes of 2012)
 SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings are generated from a reduction in inpatient and LTC institutional services.

The CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from

CCI-MANAGED CARE PAYMENTS**REGULAR POLICY CHANGE NUMBER: 88**

capitation rate payments as of January 1, 2018.

Reason for Change:

There is an overall net decrease from the prior estimate for FY 2018-19 due to lower eligibles in the Full Dual Opt-In, Non-Full Dual Non Institutional, and Home and Community Based Services (HCBS) categories.

FY 2019-20 costs increased from FY 2018-19 in the current estimate due to slightly higher projected eligibles in the Opt-Out/Excluded and Non-Full Dual Non Institutional categories and the addition of two new health care plans, Aetna and United, in San Diego County. Additionally, FY 2019-20 budget rates are assumed equal to CY 2018 assumed rates, plus a growth factor resulting in an increase in rates from CY to BY.

Methodology:

1. All dual eligibles have phased in to the CCI as of July 2016.
2. Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all CCI dual eligibles who are excluded from Cal Medi-Connect (CMC) (including those in non-CMC Dual Eligible Special Needs Plans (D-SNP)) had their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange County. Orange County began August 1, 2015.
3. Paid rates vary throughout the fiscal year depending on the most recently available approved rates. CY 2016, FY 2016-17, CY 2017, FY 2017-18, CY 2018, and FY 2018-19 rates will be paid in FY 2018-19, while CY 2018, FY 2018-19, CY 2019, and FY 2019-20 rates will be paid in FY 2019-20.
4. Estimated below is the overall impact of the CCI demonstration in FY 2018-19 and FY 2019-20.

(Dollars in Thousands)

FY 2018-19	TF	GF	FFP	Reimb.	HTF
CCIManaged Care Payments:					
Base managed care payments	\$7,707,068	\$3,852,934	\$3,853,534	\$0	\$600
Prop 56 ICF/DD Supplemental Payments	(\$1,200)		(\$600)		(\$600)
Total Managed Care Payments	\$7,705,868	\$3,852,934	\$3,852,934	\$0	\$0
CCISavings and Deferral :					
Total Savings (In the Base)	(\$7,745,224)	(\$3,872,612)	(\$3,872,612)	\$0	
CCIAdmin Costs, HCO Costs	\$17,039	\$8,520	\$8,520	\$0	
Retro MC Rate Adjustments	\$729,774	\$346,119	\$321,645	\$62,014	
CCIQuality Withhold Repayments	\$8,260	\$4,130	\$4,130	\$0	
Health Insurer Fee	\$6,016	\$3,008	\$3,008	\$0	
Total of CCI PCs including pass through	\$721,733	\$342,098	\$317,624	\$62,014	

*Totals may differ due to rounding.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 88

(Dollars in Thousands)

FY 2019-20	TF	GF	FFP	Reimb.	HTF
CCI-Managed Care Payments:					
Base managed care payments	\$7,984,322	\$3,991,201	\$3,992,161	\$0	\$960
Prop 56 - ICF/DD Supplemental Payments	(\$1,920)		(\$960)		(\$960)
Total Managed Care Payments	\$7,982,402	\$3,991,201	\$3,991,201	\$0	\$0
CCI-Savings and Deferral :					
Total Savings (In the Base)	(\$8,029,634)	(\$4,014,817)	(\$4,014,817)	\$0	
CCI-Admin Costs	\$12,223	\$6,112	\$6,112	\$0	
Retro MC Rate Adjustments	\$0	\$0	\$0	\$0	
CCI-Quality Withhold Repayments	\$16,822	\$8,411	\$8,411	\$0	
Health Insurer Fee	\$6,016	\$3,008	\$3,008	\$0	
Total of CCI PCs including pass through	(\$12,171)	(\$6,085)	(\$6,085)	\$0	

*Totals may differ due to rounding.

Funding:

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

Healthcare Treatment Fund Prop. 56 (4260-101-3305)

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

REGULAR POLICY CHANGE NUMBER: 89
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1961

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,172,871,000	\$187,902,000
- STATE FUNDS	\$662,808,800	\$57,317,090
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,172,871,000	\$187,902,000
STATE FUNDS	\$662,808,800	\$57,317,090
FEDERAL FUNDS	\$1,510,062,200	\$130,584,910

DESCRIPTION

Purpose:

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

Authority:

SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:

MCO Enrollment Tax Mgd. Care Plans
 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:

SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014 and September 30, 2015. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee.

The MCO Enrollment tax is effective July 1, 2016 through July 1, 2019.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a slight decrease due to updated payment data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the MCO Enrollment tax ending as of July 1, 2019. Costs for FY 2019-20 are for the June 2018 monthly capitation payment.

Methodology:

1. The MCO Enrollment tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.
2. Enrollment for managed care plans are based on the number of Medi-Cal enrollees, alternate health care service plans (AH CSP) enrollees, and "all-other" enrollees as defined in SBx2 2.

**MCO ENROLLMENT TAX MGD. CARE PLANS-INCR.
CAP.RATES
REGULAR POLICY CHANGE NUMBER: 89**

3. The enrollee count is multiplied by a tiered rate to determine total tax revenue.
4. Increased capitation rates due to the MCO Enrollment tax are initially paid from the General Fund (GF). The GF is then reimbursed by MCO Enrollment tax revenue through a funding adjustment. The reimbursement is budgeted in the MCO Enrollment Tax Mgd. Care Plans-Funding Adjustment policy change.
5. The June monthly capitation payment for Non-COHS will be paid in July of the following fiscal year. The May and June monthly capitation payment for COHS will be paid in July of the following fiscal year.
6. The costs of capitation rate increases related to the imposition of the MCO Enrollment tax are expected to be:

(Dollars in Thousands)

	TF	GF (MCO Tax)	FF
FY 2018-19	\$2,172,871	\$662,809	\$1,510,062
FY 2019-20	\$187,902	\$57,317	\$130,585

Funding:

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

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

94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)

93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)

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

MANAGED CARE RATE RANGE IGTs

REGULAR POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 7/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1054

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$1,697,426,000	\$0
- STATE FUNDS	\$494,080,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,697,426,000	\$0
STATE FUNDS	\$494,080,000	\$0
FEDERAL FUNDS	\$1,203,346,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for the purpose of providing capitation rate increases to the managed care plans.

Authority:

Welfare & Institutions Code 14164 and 14301.4

Interdependent Policy Changes:

Managed Care IGT Admin. And Processing Fee

Background:

An IGT is a transfer of funds from a public entity to the State. The non-federal share is matched with federal funds and used to make payments.

The actuarially sound capitation rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

The Department's rate range IGT program has grown significantly as more plans and providers have decided to participate. As Medi-Cal managed care significantly expands, the Department seeks to maintain the safety net and access to care by continuing and expanding plan and public providers' ability to leverage additional federal funding through the rate range IGT program. As of the June 30, 2018 rating period, the managed care rate range IGT program will be discontinued.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is updated funding levels to incorporated more recent payment data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the discontinuation of the existing rate range program, as of the June 30, 2018 rating period.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 90

Methodology:COHS:

The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; and Orange, Napa, and Yolo counties were effective retroactive to July 1, 2010. The IGTs for Marin, Mendocino, and Ventura Counties were effective retroactive to July 1, 2011.

The COHS expansion counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were effective retroactive to September 1, 2013.

Two Plan Model:

An IGT for Los Angeles County was effective October 2006.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and Fresno, Stanislaus, and Tulare Counties were effective retroactive to October 1, 2011.

Geographic Managed Care:

The IGTs for Sacramento and San Diego Counties were retroactive to January 2012.

Regional:

The Regional Model consists of three IGT programs, which are program specific counties. These programs are: (1) San Benito County, (2) Imperial County, and (3) Regional (Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Imperial, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba). The programs were effective retroactive to November 1, 2013.

SB 78 (Chapter 33, Statutes of 2013) extended the gross premium tax through June 30, 2013. SB 78 also provides for a 3.9375% statewide tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

(Dollars in Thousands)

Family Planning

FY 2018-19	IGT*	T19 FF	T21 FF	FF	Total FF	TF
FY 2017-18	\$494,080	\$1,040,153	\$134,925	\$28,268	\$1,203,346	\$1,697,426
Total 2018-19	\$494,080	\$1,040,153	\$134,925	\$28,268	\$1,203,346	\$1,697,426

Funding:

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

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

Reimbursement GF (4260-610-0995)*

ACA 95% FFP/5% GF (IGT) (4260-101-0890)

ACA 94% FFP/6% GF (IGT) (4260-101-0890)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 1/2016
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1788

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$884,722,000	\$264,478,000
- STATE FUNDS	\$480,419,540	\$126,796,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$884,722,000	\$264,478,000
STATE FUNDS	\$480,419,540	\$126,796,250
FEDERAL FUNDS	\$404,302,460	\$137,681,750

DESCRIPTION

Purpose:

This policy change estimates retroactive managed care capitation rate adjustments.

Authority:

Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:

Not applicable

Background:

This policy change accounts for retroactive:

- Martin Luther King, Jr. (MLK) rate adjustments,
- Prior period retro managed care base payments, and
- Coordinated Care Initiative (CCI) full dual and non-full dual payments.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to:

- A cost shift for
 - FY 2016-17 Non-Full Duals from FY 2017-18 to FY 2018-19,
 - FY 2017-18 Non-Full Duals from FY 2017-18 to FY 2018-19,
 - CY 2015 Full Duals from FY 2017-18 to FY 2018-19, and
- Updated CY 2017 Full Duals rates.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to updated payments and recoupment timeframes. As of FY 2019-20, the Department anticipates this policy change to include six months of CY 2019 Full Dual retro payments and prior period retro managed care base payments attributable to the FY 2018-19 rating period.

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 92

Methodology:

- The Department estimates the following retroactive managed care capitation rate adjustments in FY 2018-19 and FY 2019-20:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	GF Reimb.	HTF-P56
MLK (FY 2017-18)	\$17,978	\$5,644	\$12,334		
Retro Payments (FY 2017-18)	\$139,290	\$67,805	\$71,485		
CCI Full Duals (CY 2015)					
MLTSS	\$15,297	\$7,649	\$7,648		
MLTSS Reimb.	\$674	\$674			
CCI Full Duals (CY 2017)					
CMC	\$7,201	\$3,601	\$3,600		
CMC Reimb.	\$11,349			\$11,349	
MLTSS	\$214,351	\$106,016	\$107,176		\$1,160
MLTSS Reimb.	\$23,800	\$23,800			
CCI Full Duals (CY 2018, 6 mons.)					
CMC	\$5,720	\$2,860	\$2,860		
CMC Reimb.					
MLTSS	\$227,524	\$113,762	\$113,762		
MLTSS Reimb.					
CCI Non-Full Duals (CY 2015-16)					
SFY 2015-16	\$33,213	\$16,607	\$16,607		
SFY 2015-16 Reimb.	\$13,864			\$13,864	
CCI Non-Full Duals (CY 2016-17)					
SFY 2016-17	\$70,410	\$35,205	\$35,205		
SFY 2016-17 Reimb.	\$32,803			\$32,803	
CCI Non-Full Duals (CY 2017-18)					
SFY 2017-18	\$69,570	\$34,785	\$34,785		
SFY 2017-18 Reimb.	\$3,998			\$3,998	
Subtotal-CCI	\$729,774	\$344,959	\$321,642	\$62,014	\$1,160
Prop 56 ICF-DD Supplemental Pymts.	(\$2,320)		(\$1,160)		(\$1,160)
Total FY 2018-19*	\$884,722	\$418,408	\$404,301	\$62,014	\$0

*Difference due to rounding.

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 92

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
MLK (FY 2018-19)	\$18,956	\$5,967	\$12,989
Retro Payments (FY 2018-19)	\$146,254	\$71,195	\$75,059
CCI Full Duals (CY 2019)			
CMC	\$10,382	\$5,191	\$5,191
MLTSS	\$88,886	\$44,443	\$44,443
Total FY 2019-20	\$264,478	\$126,796	\$137,682

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)
88% Title XXI FF / 12% GF (4260-113-0001/0890)
ACA 95/5 (2017) (4260-101-0890)
ACA 94/6 (2018) (4260-101-0890)
ACA 93/7 (2019) (4260-101-0890)
100% Title XIX Federal Share Only (4260-101-0890)
100% Reimbursement GF (4260-610-0995)

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 4/2019
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 2060

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$835,015,000	\$1,513,188,000
- STATE FUNDS	\$248,950,230	\$457,482,290
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$835,015,000	\$1,513,188,000
STATE FUNDS	\$248,950,230	\$457,482,290
FEDERAL FUNDS	\$586,064,770	\$1,055,705,710

DESCRIPTION

Purpose:

This policy change estimates Managed Care Enhanced Payment Program (EPP) Directed Payments for Designated Public Hospitals (DPHs) including University of California Health Systems (UCs).

Authority:

SB 171 (Chapter 768, Statutes of 2017)
 AB 205 (Chapter 738, Statutes of 2017)
 Code of Federal Regulations (CFR) Section 438.6 9 (c)

Interdependent Policy Changes:

N/A

Background:

The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, CFR section 438.6 (c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, with the FY 2017-18 rating period, the Department will direct MCPs to reimburse California's 21 DPHs for network contracted services delivered by DPH systems. The total funding available for the enhanced network contracted payments is limited to a predetermined amount (pool). The EPP Directed Payment Program is divided into two primary sub-pools:

- Capitated sub-pool value is based on a pre-determined pool amount. Actual enhanced payments will be increased by a uniform percentage based on actual monthly DPH member assignment for network contracted services.
- Fee-For-Service (FFS) sub-pool value is based on a pre-determined pool amount. Actual enhanced payments will be increased by a uniform dollar amount based on actual utilization of network contracted services.

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 93

On June 29, 2018, the Department submitted a proposal to CMS requesting a continuation of the EPP Directed Payment for FY 2018-19 rating period. This policy changes assumes CMS approval of this proposal.

Reason for Change:

This is a new policy change.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to the timing of payments. Payments in FY 2018-19 consist of capitated sub-pool amounts. Payments in FY 2019-20 consist of both FFS and capitated sub-pool amounts.

Methodology:

1. The value of the entire public hospital EPP pool is \$1,476,870,000 TF for rating period FY 2017-18 on an accrual basis.
2. Assume the estimated value of the entire FY 2018-19 EPP pool is \$1,541,109,000 TF for rating period FY 2018-19 on an accrual basis.
3. Enhanced payments will be issued to MCPs based on actual public hospital utilization for network contracted services.
4. The FY 2017-18 Capitated sub-pool payments are anticipated to be made in April 2019.
5. The FY 2017-18 FFS sub-pool payments will be issued in two separate payment periods and are anticipated to occur in September 2019 and March 2020.
6. The FY 2018-19 Capitated sub-pool payments are anticipated to be made in April 2020.
7. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	ACA
FY 2017-18				
Title XIX	\$451,312	\$225,656	\$225,656	\$0
ACA 2017 95/5	\$175,001	\$8,750	\$0	\$166,251
ACA 2018 94/6	\$175,001	\$10,500	\$0	\$164,501
Title XXI	\$33,701	\$4,044	\$29,657	\$0
Total FY 2018-19	\$835,015	\$248,950	\$255,313	\$330,752

FY 2019-20	TF	GF	FF	ACA
FY 2018-19				
Title XIX	\$817,853	\$408,926	\$408,926	\$0
ACA 2018 94/6	\$317,131	\$19,028	\$0	\$298,103
ACA 2019 93/7	\$317,131	\$22,199	\$0	\$294,932
Title XXI 88/12	\$61,073	\$7,329	\$53,744	\$0
Total FY 2019-20	\$1,513,188	\$457,482	\$462,670	\$593,036

MANAGED CARE PUBLIC HOSPITAL EPP

REGULAR POLICY CHANGE NUMBER: 93

Funding:

100% State GF (4260-101-0001)

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

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

94% Title XIX ACA FF / 6% GF (4260-101-0890)

93% Title XIX ACA FF / 7% GF (4260-101-0890)

88% Title XXI FF / 12% GF (4260-611-0890)

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 98
 IMPLEMENTATION DATE: 5/2017
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 2031

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$8,260,000	\$16,822,000
- STATE FUNDS	\$4,130,000	\$8,411,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,260,000	\$16,822,000
STATE FUNDS	\$4,130,000	\$8,411,000
FEDERAL FUNDS	\$4,130,000	\$8,411,000

DESCRIPTION

Purpose:

This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative.

Authority:

SB 1008 (Chapter 33, Statutes of 2012)

SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable.

Background:

In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. By enrolling these eligibles into coordinated care delivery models, the CCI aligns financial incentives, streamlines beneficiary-centered care delivery, and rebalances the current health care system away from avoidable institutionalized services.

The CCI mandatorily enrolls dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings are generated from a reduction in inpatient and LTC institutional services. Beginning January 1, 2018, IHSS has not been included in CCI.

The CCI has been implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

As part of CCI, a quality withhold will be applied to the Cal MediConnect (CMC) capitation rate. The withheld amounts will be repaid subject to plan performance consistent with established quality thresholds. The quality withhold started at 1% in CY 2014 and CY 2015, increasing to 2% in CY 2016 and 3% in CY 2017 and beyond until new contracts are established. Repayments of withholds will be based on performance measures.

CCI-QUALITY WITHHOLD REPAYMENTS

REGULAR POLICY CHANGE NUMBER: 98

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to updated actuals regarding repayments based on plan performance. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to FY 2018-19 budgeting for CY 2016 repayments and FY 2019-20 budgeting for CY 2017 repayments. Final payment rates and the withhold repayment percentages for CY 2017 are unknown at this time. As such, the estimated amount for FY 2019-20 is based on CY 2016 final withhold repayment percentages and the total quality withhold amount to date for CY 2017.

Methodology:

1. Withheld amounts will be repaid subject to performance consistent with established quality thresholds. Thresholds are based on a combination of certain core quality withhold measures as well as state-specified quality measures.
2. CMS and the State will evaluate plan performance according to the specified metrics in order to determine how much of the withheld amount a plan will be repaid for a given year.
3. Quality withholds for CY 2016 will be repaid in January 2019.
4. Assume quality withholds for CY 2017 repaid in FY 2019-20.

FY 2018-19	TF	GF	FF
Quality Withhold Repayment (CY 2016)	\$8,260,000	\$4,130,000	\$4,130,000

FY 2019-20	TF	GF	FF
Quality Withhold Repayment (CY 2017)	\$16,822,000	\$8,411,000	\$8,411,000

Funding:

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

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 5/2013
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1605

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$4,981,000	\$0
- STATE FUNDS	\$4,981,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,981,000	\$0
STATE FUNDS	\$4,981,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:

SB 208 (Chapter 714, Statutes of 2010)
AB 85 (Chapter 24, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) were transitioned from fee-for-service (FFS) to managed care. Additionally, SPDs that 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. Prior to June 1, 2011, the DPHs in applicable counties utilized Certified Public Expenditures to reimburse allowable costs associated with inpatient services. In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

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 (OE).

State law requires DPHs to be reimbursed at no less than the costs of providing services to the OE population. Through an IGT, Public Providers have historically provided the non-federal share portion of the adjusted capitation rates related to the costs for this population. As of June 30, 2017, the existing DPH reimbursement program has been discontinued.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 99

Reason for Change:

There is no change from the prior estimate for FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the discontinuation of the DPH GF reimbursement and associated IGT program. All closeout reconciliations associated with this program are expected to be completed in FY 2018-19.

Methodology:

1. The FY 2016-17 reconciliation is expected to occur in FY 2018-19 to close out the DPH reimbursement program.

(Dollars in Thousands)

	FY 2018-19
FY 2016-17-Closeout Reconciliation	\$4,981
GF	\$4,981
Net Impact	\$4,981

Funding:

Reimbursement (4260-601-0995)

100% State GF (4260-101-1001)

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1907

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,652,000	\$85,506,000
- STATE FUNDS	\$265,200	\$8,550,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,652,000	\$85,506,000
STATE FUNDS	\$265,200	\$8,550,600
FEDERAL FUNDS	\$2,386,800	\$76,955,400

DESCRIPTION

Purpose:

This policy change estimates the local assistance cost of a Health Home Program (HHP).

Authority:

AB 361 (Chapter 642, Statutes of 2013)
 SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:

Not Applicable

Background:

The Medicaid Health Home State Plan Option is afforded to states under the Affordable Care Act (ACA). The ACA allows states to create Medicaid Health Homes to coordinate the full range of physical and behavioral health services, community-based long-term services and supports, and other community-based services that beneficiaries with chronic conditions require.

AB 361 authorizes the Department to create a HHP for beneficiaries with chronic conditions. The HHP will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

SB 75 establishes the HHP Fund. The HHP Fund will be used to pay for the non-federal share of HHP costs.

ACA Section 2703 allows geographic phasing of HHP services. The Department plans to implement the HHP in three phases, by counties and conditions:

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 100

	July 2018	January 2019	July 2019	January 2020
Group 1	Eligible Chronic Physical Conditions	Eligible Serious Mental Illnesses (SMIs)		
Group 2		Eligible Chronic Physical Conditions	Eligible SMIs	
Group 3			Eligible Chronic Physical Conditions	Eligible SMIs

- Group 1 represents San Francisco County. Local programs in this group for members with eligible chronic physical conditions implemented in July 2018. Local programs in this group for members with SMIs implement in January 2019.
- Group 2 represents the following two counties: Riverside and San Bernardino. Local programs in this group for members with eligible chronic physical conditions implement in January 2019. Local programs in this group for members with SMIs implement in July 2019.
- Group 3 represents 26 counties: Alameda, Del Norte, Humboldt, Fresno, Imperial, Kern, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, Monterey, Napa, Orange, Sacramento, San Diego, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Siskiyou, Tulare, and Yolo. Local programs in this group for members with eligible chronic physical conditions implement in July 2019. Local programs in this group for members with SMIs implement in January 2020.

Reason for Change:

The change from the prior estimate for FY 2018-19 is due to updated supplemental payment timing for HHP Group 2.

The change from FY 2018-19 to FY 2019-20, is an increase due to HHP Group 3 phasing in on July 1, 2019.

Methodology:

1. Assume the program began July 2018. Enrollment will phase-in based on county and condition.
2. Assume approximately 20% of the Targeted Engagement List (TEL) members and 3% of eligibles members not on the TEL will enroll in HHP.
3. The supplemental capitation rates for FY 2018-19 will be paid on a plan and rating region basis for both dual and non-dual HHP members. The average weighted rate across all plans and rating regions for FY 2018-19 is \$508.46 per member per month. The average weighted rate across all plans and rating regions for FY 2019-20 is \$489.05
4. Assume 9,093 member months for FY 2018-19 and 256,214 member months for FY 2019-20.

HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 100

5. Assume the following payment lags for each HHP Group:
- HHP Group 1 supplemental payments are expected to begin in January 2019.
 - HHP Group 2 supplemental payments are expected to begin in March 2019.
 - HHP Group 3 supplemental payments are expected to begin in October 2019.
6. Assume the June 2019 and June 2020 capitation payments will be deferred to the following fiscal years.
7. The Department will receive 90% federal reimbursement for this program in FY 2018-19. The remaining 10% will be funded by non-GF sources. Funding adjusts to 50% non-GF and 50% Federal Fund two years after each implementation date.
8. On an accrual basis, the costs for FY 2018-19 and FY 2019-20 are expected to be:

FY 2018-19: 9,093 x \$508.46 = \$4,623,427 TF
 FY 2019-20: 256,214 x \$489.05 = \$125,301,457 TF

9. On a cash basis, the costs for FY 2018-19 and FY 2019-20 are expected to be:

(Dollars in Thousands)

	TF	FF	HHP Fund
FY 2018-19	\$2,652,000	\$2,387,000	\$265,000
FY 2019-20	\$85,806,000	\$76,955,000	\$8,551,000

Funding:

90% Title XIX FF (4260-101-0890)

10% HHP Fund (4260-601-0942)

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

REGULAR POLICY CHANGE NUMBER: 102
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1781

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$571,000	\$0
- STATE FUNDS	\$285,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$571,000	\$0
STATE FUNDS	\$285,500	\$0
FEDERAL FUNDS	\$285,500	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:

MCO Tax Mgd. Care Plans - Funding Adjustment
 MCO Tax Managed Care Plans

Background:

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

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to having only one retro payment scheduled in FY 2018-19 for CY 2015 CCI Non-Full Dual. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to having no additional retro payments after FY 2018-19.

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

REGULAR POLICY CHANGE NUMBER: 102

Methodology:

1. The MCO tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.
2. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.
3. The FY 2015-16 premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.
4. Capitation rate increases due to the MCO tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.
5. The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

	TF	GF (MCO Tax)	FF
FY 2018-19	\$571,000	\$285,500	\$285,500

Funding:

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

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 11/2017
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1947

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$237,000	\$0
- STATE FUNDS	\$118,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$237,000	\$0
STATE FUNDS	\$118,500	\$0
FEDERAL FUNDS	\$118,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the overall net impact of training and development costs of Medi-Cal palliative care, as well as the Department providing technical assistance to Medi-Cal managed care plans for delivering palliative care services.

Authority:

SB 1004 (Chapter 574, Statutes of 2014)
 Palliative Care Training Contract #: 17-94429
 Medi-Cal Managed Care Plan Palliative Care Program Development Contracts

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare and Medicaid Services (CMS) defines palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.” Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

SB 1004 requires the Department to:

- Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.
- Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services.
- Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis.
- Define palliative care services.
- Provide access to curative care for beneficiaries eligible for palliative care.

PALLIATIVE CARE SERVICES IMPLEMENTATION

REGULAR POLICY CHANGE NUMBER: 103

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to some training and development costs shifting from FY 2017-18 to FY 2018-19. Additionally, the projected savings have been eliminated as initial data does not support the prior estimate.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the completion of payments for training and development costs.

Methodology:

1. Palliative care training began in October 2017.
2. The Department estimates initial training of providers will cost \$87,000 TF in FY 2018-19.
3. The Department estimates \$150,000 TF in FY 2018-19 for Medi-Cal managed care plans to develop their palliative care program and operational plan.
4. Implementation of palliative care services began in January 2018.
5. The FY 2018-19 estimate for this program is:

	TF	GF	FF
FY 2018-19	\$237,000	\$118,000	\$119,000

Funding:

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

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 104
 IMPLEMENTATION DATE: 2/2020
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 2061

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,754,616,000
- STATE FUNDS	\$0	\$556,174,890
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,754,616,000
STATE FUNDS	\$0	\$556,174,890
FEDERAL FUNDS	\$0	\$1,198,441,110

DESCRIPTION

Purpose:

This policy change estimates increased payments to managed care plans (MCPs) designed to provide additional support for counties and/or public entities serving Medi-Cal beneficiaries.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2018, the Department implemented a new voluntary Managed Care Health Care Financing Program which increases payments to counties and/or public entities servicing Medi-Cal beneficiaries. Participation is voluntary and the increased payment levels will be evaluated annually.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to changes in the expected FY 2018-19 rating period CMS approval date.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to all FY 2018-19 rating period payments for the Managed Care Health Care Financing program anticipated to occur in FY 2019-20.

Methodology:

1. The Managed Care Health Care Financing Program begins with the FY 2018-19 rating period.
2. Based on preliminary participation levels for FY 2018-19, it is estimated total payments will be \$1,754,616,000 TF.
3. Payments for the FY 2018-19 rating period are anticipated to occur in FY 2019-20.

MANAGED CARE HEALTH CARE FINANCING PROGRAM

REGULAR POLICY CHANGE NUMBER: 104

4. Anticipated costs on a cash basis are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Title XIX	\$1,004,480	\$502,240	\$502,240
Title XXI	\$94,110	\$11,293	\$82,817
ACA 94/6	\$328,013	\$19,681	\$308,332
ACA 93/7	\$328,013	\$22,961	\$305,052
Total	\$1,754,616	\$556,175	\$1,198,441

Funding:

GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-101-0890)

ACA 94% FFP/6% GF (2018)

ACA 93% FFP/7% GF (2019)

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 9/2019
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 2062

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$640,000,000
- STATE FUNDS	\$0	\$190,807,720
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$640,000,000
STATE FUNDS	\$0	\$190,807,720
FEDERAL FUNDS	\$0	\$449,192,280

DESCRIPTION

This policy change estimates managed care directed payments to fund Quality Incentive Pool (QIP) payments by managed care plans (MCPs) to Designated Public Hospitals (DPHs) including the University of California Health Systems (UCs), based on their performance on designated performance metrics.

Authority:

SB 171 (Chapter 768, Statutes of 2017)
 AB 205 (Chapter 768, Statutes of 2017)

Interdependent Policy Changes:

N/A

Background:

The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, CFR section 438.6 (c) provides State's flexibility to implement delivery system and provider payment initiatives under MCPs contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department will direct MCPs to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization to DPHs. The QIP payments will be linked to delivery of services under the MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments the DPHs must achieve specified improvement targets, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for the QIP payments are limited to a predetermined amount (pool).

On June 29, 2018, the Department submitted a proposal to CMS requesting continuation of the QIP Directed Payment for the FY 2018-19 rating period.

MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 105

Reason for Change:

The change from the prior estimate for FY 2018-19, and the change between FY 2018-19 and FY 2019-20, is due to a delay in implementation.

Methodology:

1. The value of the FY 2017-18 QIP is \$640 million total fund.
2. FY 2017-18 QIP payments will be evaluated based on defined QIP reported requirements. Assume the entire QIP FY 2017-18 payments will occur in FY 2019-20.
3. On a cash basis, the estimated FY 2017-18 QIP payments are:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	ACA
FY 2017-18				
Title XIX	\$345,909	\$172,955	\$172,955	\$0
ACA 2017 95/5	\$134,130	\$6,707	\$0	\$127,424
ACA 2018 94/6	\$134,130	\$8,048	\$0	\$126,082
Title XXI	\$25,831	\$3,100	\$22,731	\$0
FY 2019-20	\$640,000	\$190,808	\$195,686	\$253,506

Funding:

100% State GF (4260-101-0001)

100% Title XIX FFP (4260-611-0890)

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

94% Title XIX ACA FF / 6% GF (4260-101-0890)

88% Title XXI FF / 12% GF (4260-611-0890)

CAPITATED RATE ADJUSTMENT FOR FY 2019-20

REGULAR POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1338

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$384,038,000
- STATE FUNDS	\$0	\$183,363,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$384,038,000
STATE FUNDS	\$0	\$183,363,800
FEDERAL FUNDS	\$0	\$200,674,200

DESCRIPTION

The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2019-20.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Managed care capitation rates will be rebased in FY 2019-20 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types.

This policy change shows the increase in capitation rates from FY 2018-19 to FY 2019-20.

Reason for Change:

The change in classic capitation rates from FY 2018-19 to FY 2019-20 is a 2.86% average rate increase, excluding Optional Expansion (OE) rates.

CAPITATED RATE ADJUSTMENT FOR FY 2019-20

REGULAR POLICY CHANGE NUMBER: 106

Methodology:

(Dollars in Thousands)

	Cost by Plan	Rate Adjustment	Rate Increase
COHS	\$3,995,724	2.86%	\$114,471
GMC	\$1,510,304	2.86%	\$43,268
Regional	\$729,706	2.86%	\$20,905
Two Plan	\$7,169,378	2.86%	\$205,394
Total	\$13,405,112		\$384,038

Funding:

FY 2019-20	COHS	GMC	Regional	Two Plan	Total
Title XIX 50/50 FFP (4260-101-0001/0890)	\$104,360,000	\$39,754,000	\$19,226,000	\$190,047,000	\$353,387,000
State GF (4260-101-0001)	\$236,000	\$121,000	\$55,000	\$581,000	\$993,000
Family Planning 90/10 GF (4260-101-0001-0890)	\$1,092,000	\$480,000	\$244,000	\$2,322,000	\$4,138,000
Title XXI 88/12 (4260-101-0001/0890)	\$2,196,000	\$728,000	\$345,000	\$3,111,000	\$6,380,000
Title XXI 76.5/23.5 (4260-101-0001/0890)	\$6,588,000	\$2,185,000	\$1,035,000	\$9,332,000	\$19,140,000
Total Funds	\$114,472,000	\$43,268,000	\$20,905,000	\$205,393,000	\$384,038,000
FF	\$60,135,000	\$22,621,000	\$10,928,000	\$106,990,000	\$200,674,000
GF	\$54,337,000	\$20,647,000	\$9,977,000	\$98,403,000	\$183,364,000

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1782

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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

Authority:

SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:

MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 MCO Tax Managed Care Plans

Background:

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

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

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to having only one retro payment scheduled in FY 2018-19 for CY 2015 CCI Non-Full Dual. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to having no additional retro payments after FY 2018-19.

Methodology:

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

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 107

2. The FY 2015-16 premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue. This policy change does not assume a FY 2016-17 tax.
3. The share that offsets GF cost for the Medi-Cal program is then determined.
4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.
5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.
6. The MCO tax fund transfers to the GF are expected to be:

	TF	GF	MCO Tax*
FY 2018-19	\$0	(\$285,500)	\$285,500

Funding:

100% State GF (4260-101-0001)

*3156 MCO (Non-GF) (4260-601-3156)

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 109
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1601

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

Authority:

Welfare & Institutions Code section 14301.4
 AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

The counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Per Welfare & Institutions (W&I) Code 14301.4, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. As specified in section 14301.4, the assessment fee is limited to those IGTs made by a transferring entity to provide the nonfederal share of rate range increases. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to W&I Code sections 14168.7, 14182.15, and 14301.5.

MANAGED CARE IGT ADMIN. & PROCESSING FEE**REGULAR POLICY CHANGE NUMBER: 109**

The 20% assessment fees are collected at the same time as the rate range IGTs. As of June 30, 2018 rating period, the collection of the IGT assessment fees discontinued.

Pending CMS approval of State Plan Amendment (SPA) 17-009, the Department will make new Medi-Cal Graduate Medical Education (GME) supplemental payments to Designated Public Hospitals (DPHs) systems participating in the Medi-Cal managed care program. The Department submitted SPA 17-009 to CMS in March 2017 of FY 2016-17 with an effective date of January 1, 2017. CMS approval of SPA 17-009 is anticipated in the second quarter of FY 2018-19. The Department will budget the Graduate Medical Education Payments to DPHs and their affiliated governmental entities; IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed to the IGTs in order to reimburse the Department for support costs associated with administering the program. Fees assessed in excess of the support costs will result in a savings to the General Fund.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease in reimbursement due to lower IGT amounts received from funding entities. FY 2018-19 fees from GME supplemental payments are now anticipated to be paid in FY 2018-19. Fees from FY 2016-17 and FY 2017-18 GME supplemental payments were adjusted to reflect a revised payment methodology.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the discontinuation of managed care rate range IGT assessment fees as of the June 30, 2018 rating period. Fees from GME supplemental payments will continue to be budgeted in this PC.

Methodology:

1. The fee will be 20% of each IGT, unless exempt W&I Code section 14301.4 or 14301.5
2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.
3. Assume beginning in FY 2018-19, the fee for GME supplemental payments will be 5% of the aggregate nonfederal share, which is calculated at 50% FMAP of the Total Funds from the Graduate Medical Educations Payments to the DPHs policy change.

	IGT amount subject to the fee	20% Admin & Processing Fee	Support Cost Reimbursement to the GF	Local Assistance Reimbursement to the GF
FY 2018-19 (Non-GME)				
FY 2017-18	\$449,512	\$89,902	\$251	\$89,651
Total FY 2018-19	\$449,512	\$89,902	\$251	\$89,651

	IGT amount subject to the fee	5% GMC Admin Fee	Local Assistance Reimbursement to the GF
FY 2018-19 (GME)			
FY 2016-17	\$86,282	\$4,314	\$4,314
FY 2017-18	\$177,742	\$8,887	\$8,887
FY 2018-19	\$183,074	\$9,154	\$9,154
Total FY 2018-19	\$447,098	\$22,355	\$22,355

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 109

FY 2019-20 (GME)	IGT amount subject to the fee	5% GMC Admin Fee	Local Assistance Reimbursement to the GF
FY 2019-20	\$188,567	\$9,428	\$9,428
Total FY 2019-20	\$188,567	\$9,428	\$9,428

(Dollars in Thousands)

Fiscal Year	Local Assistance Reimbursement to the GF
FY 2018-19	\$112,006
FY 2019-20	\$9,428

Funding:

100% State GF (4260-101-0001)

Reimbursement (4260-601-0995)

DPH Graduate Medical Education Special Fund (4260-601-8113)

MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 110
 IMPLEMENTATION DATE: 2/2019
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 2063

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates reimbursements to the General Fund (GF) by Intergovernmental Transfer (IGT) from allowable public entities for Medi-Cal payment contributions and administration and processing fees.

Authority:

Welfare & Institution Code 14164 and 14301.4

Interdependent Policy Changes:

None

Background:

Effective July 1, 2017, rating period, this policy change consolidates voluntary IGT reimbursements to the GF and administration and processing fees from allowable public entities servicing Medi-Cal managed care beneficiaries.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease to both expenditures and reimbursements due to a cost shift in FY 2018-19 to FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase to both expenditures and reimbursements due to the shift of FY 2018-19 reimbursements to FY 2019-20.

Methodology:

1. Data from FY 2016-17 and FY 2017-18 are used to estimate the annual commitment from allowable public entities.
2. Annual administration and processing fees are calculated based on the estimated FY 2017-18 participation.

**MANAGED CARE REIMBURSEMENTS TO THE GENERAL
FUND**
REGULAR POLICY CHANGE NUMBER: 110

3. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

	FY 2018-19
Reimbursement	
FY 2017-18	\$315,907
Total	\$315,907
GF	(\$315,907)
FY 2018-19 Net Impact	\$0

	FY 2019-20
Reimbursement	
FY 2017-18	\$407,894
FY 2018-19	\$974,768
FY 2018-19 Support Cost To GF	(\$251)
Total	\$1,382,411
GF	(\$1,382,411)
FY 2019-20 Net Impact	\$0

Funding:

Reimbursement (4260-601-0995)

100% State GF (4260-101-0001)

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER: 111
 IMPLEMENTATION DATE: 11/2016
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1962

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION**Purpose:**

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

Authority:

SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:

MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
 MCO Enrollment Tax Managed Care Plans

Background:

SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014 and September 30, 2015. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee.

The MCO Enrollment tax is effective July 1, 2016 through July 1, 2019. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a slight decrease due to updated payment data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the MCO Enrollment tax ending as of July 1, 2019. Costs for FY 2019-20 are for the June 2018 monthly capitation payment.

Methodology:

1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees, alternate health care service plans (AH CSP) enrollees, and "all-other" enrollees as defined in SBx2 2.

MCO ENROLLMENT TAX MGD. CARE PLANS-FUNDING ADJ.

REGULAR POLICY CHANGE NUMBER: 111

2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.
3. The MCO Enrollment tax fund transfers is based on 35% of the Medi-Cal share of tax.
4. The MCO Enrollment tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

	TF	GF	MCO Tax
FY 2018-19	\$0	(\$660,295)	\$660,295
FY 2019-20	\$0	(\$223,020)	\$223,020

Funding:

MCO Tax 2016 (Non-GF) (4260-601-3293)

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 112
 IMPLEMENTATION DATE: 11/2016
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1960

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of funds collected from the enrollment tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2016.

Authority:

SBx2 2 (Chapter 2, Statutes of 2016)

Interdependent Policy Changes:

MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates
 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

Background:

SBx2 2 was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between October 1, 2014, and September 30, 2015. The tax is tiered based on whether the enrollee is a Medi-Cal, alternate health care service plans, or other enrollee.

The MCO Enrollment tax is effective July 1, 2016, through July 1, 2019. This policy change estimates GF savings resulting from the imposition of the MCO enrollment tax.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to updated payment data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the MCO Enrollment tax ending as of July 1, 2019. Costs for FY 2019-20 are for the June 2018 monthly capitation payment.

Methodology:

1. The MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month period between October 1, 2014, and September 30, 2015.

MCO ENROLLMENT TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 112

2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans. Non-Medi-Cal health plans include Alternate Health Care Service Plans (AHCSF).
3. The following taxing tier structure is used to determine the MCO Enrollment Tax for FY 2018-19:

Medi-Cal			
Enrollees	Rate	Average Enrollment/Entity	
0-2,000,000	\$45.00	39,161,294	\$1,762,259,000
2,000,001-4,000,000	\$21.00	21,180,988	\$444,801,000
Over 4,000,000	\$1.00	48,831,000	\$48,831,000

Non-Medi-Cal (including AHCSF)			
Enrollees	Rate	Average Enrollment/Entity	
0-4,000,000	\$8.50	25,757,753	\$218,941,000
4,000,001-8,000,000	\$3.50	16,832,337	\$58,913,000
Over 8,000,000	\$1.00	30,244,000	\$30,244,000

The total FY 2018-19 Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis is:
\$2,562,919,000

4. The impact of the increase in capitation payments related to the tax is included in the MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.
5. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

	TF	GF	MCO Tax
FY 2018-19	\$0	(\$1,866,610)	\$1,866,610
FY 2019-20	\$0	(\$583,412)	\$583,412

Funding:

MCO Tax 2016 (Non-GF) (4260-601-3293)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 113
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1585

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,906,393,000	-\$1,442,173,000
- STATE FUNDS	-\$549,831,860	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,906,393,000	-\$1,442,173,000
STATE FUNDS	-\$549,831,860	\$0
FEDERAL FUNDS	-\$1,356,561,140	-\$1,442,173,000

DESCRIPTION

Purpose:

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

Authority:

Social Security Act Section 1927(b) as amended by Section 2501(c) of the Affordable Care Act (ACA) Proposed Trailer Bill Language

Interdependent Policy Changes:

Medi-Cal Drug Rebates Fund

Background:

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

The Department is proposing to establish the Medi-Cal Drug Rebate Fund (Fund 3331) effective July 1, 2019. The non-federal share of Medi-Cal federal and state supplemental drug rebates will be deposited into Fund 3331. See the Medi-Cal Drug Rebates Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to revised collection projections based on the net result of the following:

- One additional quarter of actual managed care rebate collections from April 2018 through June 2018;
- Increased ACA optional based on data through June 2018;
- Decreased ACA Offset rebates;
- Decreased Children's Health Insurance Program (CHIP) rebates based on data through June 2018;

MANAGED CARE DRUG REBATES**REGULAR POLICY CHANGE NUMBER: 113**

- Decreased Medi-Cal managed care eligibles data used to project the estimated rebates, and
- Decreased estimated managed care rebates based on updated managed care claims data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to resuming the historical trend in FY 2019-20 and updated Federal Medical Assistance Percentages (FMAPs) for the CHIP and ACA optional populations. Additionally, the non-federal share of the FY 2019-20 managed care drug rebate collections are not included in this policy change and are instead included in the Medi-Cal Drug Rebates Fund policy change.

Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.
2. Assume family planning drugs account for 0.18% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% General Fund (GF).
3. Assume CHIP drug rebate collections are estimated to be \$89,060,000 TF in FY 2018-19. These rebates are funded at 88% FF / 12% GF through September 30, 2019, and 76.5% FF / 23.5% GF beginning October 1, 2019. In FY 2019-20, CHIP rebate collections of \$71,854,000 FF is included in this policy change.
4. Collections for the optional expansion ACA population are estimated to be \$774,276,000 TF for FY 2018-19, funded with 94% FF and 6% GF. For FY 2019-20, a total of \$798,510,000 TF is estimated for the optional expansion population, of which \$742,614,000 FF is budgeted in this policy change. The amount of \$55,896,000 SF is budgeted to be transferred to the GF in the Medi-Cal Drug Rebates Fund policy change.
5. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is \$56,260,000 TF for FY 2018-19 and \$61,424,000 TF for FY 2019-20.
6. The Department estimates to transfer \$639,218,000 managed care drug rebates collections to the Medi-Cal Drug Rebates Fund in FY 2019-20.

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	(\$985,021,000)	(\$492,511,000)	(\$492,510,000)
94% Title XIX / 6% GF	(\$774,276,000)	(\$46,456,000)	(\$727,820,000)
90% Title XIX / 10% GF	(\$1,776,000)	(\$178,000)	(\$1,598,000)
ACA Offset	(\$56,260,000)	\$0	(\$56,260,000)
88% Title XXI / 12 % GF	(\$89,060,000)	(\$10,687,000)	(\$78,373,000)
Total	(\$1,906,393,000)	(\$549,832,000)	(\$1,356,561,000)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 113

FY 2019-20	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$566,281,000)	(\$566,281,000)	(\$583,322,000)
100% Title XIX ACA FF	(\$742,614,000)	(\$742,614,000)	(\$55,896,000)
100% Title XXI FF	(\$71,854,000)	(\$71,854,000)	\$0
ACA Offset	(\$61,424,000)	(\$61,424,000)	\$0
Total	(\$1,442,173,000)	(\$1,442,173,000)	(\$639,218,000)

*The Fund 3331 Transfer column is for informational purposes only. See Methodology# 6.

Funding:

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

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

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)

93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)

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

76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 10/2007
ANALYST: Joy Oda
FISCAL REFERENCE NUMBER: 1152

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$242,884,000	-\$7,318,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$242,884,000	-\$7,318,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$242,884,000	-\$7,318,000

DESCRIPTION

Purpose:

This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:

SPA 05-21

Interdependent Policy Changes:

Not Applicable

Background:

As approved on April 25, 2006 through SPA 05-21, effective for dates of service on or after July 1, 2005, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

DPH INTERIM & FINAL RECONS**REGULAR POLICY CHANGE NUMBER: 114****Reason for Change:**

The change in FY 2018-19, from the prior estimate, is due to:

- Final reconciliations did not occur in FY 2017-18 due to cost report appeals. FY 2007-08 and FY 2008-09 reconciliations shifted from FY 2017-18 to FY 2018-19. In addition, FY 2013-14 reconciliations shifted to be paid in FY 2019-20.
- FY 2009-10 and FY 2014-15 reconciliations shifted to FY 2019-20, and
- Updated cost reports for FY 2007-08.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the varying reconciliation estimates from the different reconciliation years.

Methodology:

1. DPH's final reconciliation for all years will be the difference between the Federal Medical Assistance Percentage (FMAP) rate of the audited costs and the respective payments.
2. The estimated final reconciliation payments and recoupments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	FF	ACA FF
2007-08 Final Reconciliation	\$82,847	\$82,847	\$0
2008-09 Final Reconciliation	\$160,037	\$160,037	\$0
Total	\$242,884	\$242,884	\$0

(Dollars in Thousands)

FY 2019-20	TF	FF	ACA FF
2009-10 Final Reconciliation	\$46,782	\$46,782	\$0
2013-14 Final Reconciliation	(\$4,148)	(\$11,812)	\$7,664
2014-15 Final Reconciliation	(\$49,952)	(\$29,389)	(\$20,563)
Total	(\$7,318)	\$5,581	(\$12,899)

Funding:

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

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

RATE INCREASE FOR FQHCS/RHCS/CBRCs

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 10/2005
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 88

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$218,078,000	\$255,462,000
- STATE FUNDS	\$82,162,520	\$97,694,560
PAYMENT LAG	0.9180	0.9349
% REFLECTED IN BASE	49.11 %	0.65 %
APPLIED TO BASE		
TOTAL FUNDS	\$101,879,500	\$237,279,000
STATE FUNDS	\$38,383,880	\$90,740,970
FEDERAL FUNDS	\$63,495,660	\$146,538,050

DESCRIPTION**Purpose:**

This policy change estimates the rate increase for all Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology and the rate increase for Cost-Based Reimbursement Clinics (CBRCs).

Authority:

Section 1833 of the Social Security Act
Welfare & Institutions Code, section 14170 and 14132.100

Interdependent Policy Changes:

Not Applicable

Background:

The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either 1) the average of the clinic's 1999 and 2000 cost-based rate or, 2) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index (MEI) and is effective October 1st of each year.

The Department reimburses the CBRCs, owned or operated by Los Angeles County at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The interim rate is adjusted July 1st of each year.

Reason for Change:

The change from the prior estimate, FY 2018•19, is an increase due to a higher estimated rate increase calculated from the prior three fiscal years of actuals. The change from FY 2018•19 to FY 2019•20, in the current estimate, is an increase due to a projected rate increase of 3.28% with a projected increase in visits.

RATE INCREASE FOR FQHCS/RHCS/CBRC

REGULAR POLICY CHANGE NUMBER: 115

Methodology:

1. The projected visits are based on the average percent increase of the last 3 years actual visit counts.
2. The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent for calendar year 2017 was 3.39%, 3.28% for calendar year 2018, and 3.28% for calendar year 2019.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2017	18,388,163	\$155.45	$\$155.45 \times (1+3.39\%) = \160.72
2018	19,488,398	\$160.72	$\$160.72 \times (1+3.28\%) = \166.00
2019	20,654,464	\$166.00	$\$166.00 \times (1+3.28\%) = \171.45

3. The estimated expenditures are the increased rate multiplied by the number of projected visits. The projected annual expenditures due to the rate increase are:

(Dollars in Thousands)

Federal Rate Year	Expenditures	Exp. with Increase	Rate Increase
2017	\$2,858,440	\$2,955,346	\$96,906
2018	\$3,132,175	\$3,235,074	\$102,899
2019	\$3,428,641	\$3,541,208	\$112,567

4. The July 1, 2018 CBRC rate increase of \$43,998,000 is based on the FY 2014-15 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2016-17. The estimated payment increase is determined by the difference between the calculated estimated payments and the total payments per the Paid Claims Summary Reports for FY 2016-17.
5. The July 1, 2019 CBRC rate increase of \$24,140,000 is based on the FY 2015-16 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2017-18. The estimated payment increase is determined by the difference between the calculated estimated payments and the total payments per the Paid Claims Summary reports for FY 2017-18.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CY 2018 Increase	\$109,039	\$40,927	\$68,112
CY 2019 Increase	\$109,039	\$41,236	\$67,803
FY 2018-19 Total	\$218,078	\$82,163	\$135,915
FY 2019-20	TF	GF	FF
CY 2019 Increase	\$127,731	\$48,305	\$79,426
CY 2020 Increase	\$127,731	\$49,390	\$78,341
FY 2019-20 Total	\$255,462	\$97,695	\$157,767

*Totals may differ due to rounding.

RATE INCREASE FOR FQHCS/RHCS/CBRCS

REGULAR POLICY CHANGE NUMBER: 115

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$156,293,000	\$78,147,000	\$78,146,000
94% Title XIX ACA / 6% GF	\$30,893,000	\$1,854,000	\$29,039,000
93% Title XIX ACA / 7% GF	\$30,892,000	\$2,162,000	\$28,730,000
FY 2018-19 Total	\$218,078,000	\$82,163,000	\$135,915,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$183,085,000	\$91,543,000	\$91,542,000
93% Title XIX ACA / 7% GF	\$36,188,000	\$2,533,000	\$33,655,000
90% Title XIX ACA / 10% GF	\$36,189,000	\$3,619,000	\$32,570,000
FY 2019-20 Total	\$255,462,000	\$97,695,000	\$157,767,000

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
 100% Title XIX ACA (4260-101-0890)
 94% Title XIX / 6% ACA (4260-101-0001/0890)
 93% Title XIX / 7% ACA (4260-101-0001/0890)
 90% Title XIX / 10% ACA (4260-101-0001/0890)

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 1/2019
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 2081

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$172,631,000	\$187,109,000
- STATE FUNDS	\$55,217,000	\$62,621,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$172,631,000	\$187,109,000
STATE FUNDS	\$55,217,000	\$62,621,000
FEDERAL FUNDS	\$117,414,000	\$124,488,000

DESCRIPTION

Purpose:

This policy change estimates the Quality Assurance Fee (QAF) revenues and the cost of rate increases for certain Ground Emergency Medical Transportation (GEMT) services.

Authority:

SB 523 (Chapter 773, Statutes of 2017)

Interdependent Policy Changes:

Not Applicable

Background:

SB 523 requires the Department to impose a GEMT QAF on all ground emergency medical transports. The QAF revenues will be used 1) to pay for DHCS staffing and administrative costs to implement the QAF program, capped at \$1,003,000 for FY 2018-19, and \$374,000 for each year thereafter, 2) to pay for health care coverage in each FY in the amount of 10 percent of the annual QAF collection amount, and 3) to be used, along with a federal match, to provide an add-on to the reimbursement rates for base ground emergency transport services.

The Department collected gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF will be assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

The Department is required to provide an add-on to the Medi-Cal FFS payment schedule for codes A0427 Advanced Life Support (ALS) Emergency, A0429 Basic Life Support (BLS) Emergency, and A0433 ALS2 using available QAF revenue, effective July 1, 2018. The add-on increase was calculated to be \$220.80, and will remain the same for subsequent applicable FYs, to the extent that FFP is available. On July 11, 2018, SPA 18-004 was submitted to the Centers for Medicare and Medicaid Services (CMS) and is expected to be approved in November 2018.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 116

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to a revised QAF revenue estimate based on additional transport data submitted by providers and updated funding split assumptions. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to lower administration costs resulting in a higher QAF amount available in FY 2019-20. In addition, a full year of managed care add-ons are estimated to be paid in FY 2019-20.

Methodology:

FY 2018-19 add-on

1. The effective date for the FY 2018-19 add-on is July 1, 2018.
2. Assume the GEMT QAF revenue will be \$70,009,000 in FY 2018-19.
3. \$1,003,000 will be transferred from the MEMTF to the GF for administration costs.
4. The transfer from the MEMTF to the GF for the 10 percent set aside for health care coverage is estimated to be \$6,901,000 for FY 2018-19.
5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2018-19 is estimated to be \$192,814,000 TF, of which \$30,334,000 TF is for FFS and \$162,480,000 TF is for Managed Care GEMT transport services.
6. The FY 2018-19 FFS add-on payments are expected to implement in January 2019. The Erroneous Payment Correction (EPC) for the period of July 2018 through December 2018 is expected to implement in April 2019.
7. The FY 2018-19 Managed Care payments are expected to be implemented with the FY 2018-19 capitation rates.
 - a. Assume 11 months of the FY 2018-19 managed care payments for the County Organized Health Systems (COHS) and Non-COHS models will be paid in FY 2018-19 and 1 month will be paid in FY 2019-20.
8. On a cash basis, with payment lags applied, total FY 2018-19 GEMT add-on payments are estimated to be \$172,631,000 TF, of which \$23,691,000 TF is for FFS and \$148,940,000 TF is for Managed Care GEMT transport services.

FY 2019-20 add-on

9. The effective date for the FY 2019-20 add-on is July 1, 2019.
10. Assume the GEMT QAF revenue will be \$70,009,000 in FY 2019-20.
11. \$374,000 will be transferred from the MEMTF to the GF for administration costs.
12. The transfer from the MEMTF to the GF for the 10 percent set aside for health care coverage is estimated to be \$6,964,000 for FY 2019-20.

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF**REGULAR POLICY CHANGE NUMBER: 116**

13. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2019-20 is estimated to be \$186,577,000 TF, of which \$30,241,000 TF is for FFS and \$156,336,000 TF is for Managed Care GEMT transport services.
14. The FY 2019-20 FFS add-on payments are expected to implement in July 2019.
15. The FY 2019-20 Managed Care payments are expected to be implemented with the FY 2019-20 capitation rates.
- a. Assume 11 months of the FY 2019-20 managed care payments for the County Organized Health Systems (COHS) and Non-COHS models will be paid in FY 2019-20 and 1 month will be paid in FY 2020-21.
16. On a cash basis, with payment lags applied, total FY 2019-20 GEMT add-on payments are estimated to be \$187,109,000 TF, of which \$30,262,000 TF is for FFS and \$154,847,000 TF for Managed Care GEMT transport services.
17. The cash basis estimate is summarized as follows:

(Dollars in Thousands)

FY 2018-19	TF	GF	MEMTF	FF
Healthcare Coverage – GF Offset	\$0	(\$6,901)	\$6,901	\$0
FFS Add-On (lagged)	\$23,691	\$0	\$9,701	\$13,990
Managed Care Add-On	\$148,940	\$0	\$45,516	\$103,424
Total	\$172,631	(\$6,901)	\$62,118	\$117,414

(Dollars in Thousands)

FY 2019-20	TF	GF	MEMTF	FF
Healthcare Coverage – GF Offset	\$0	(\$6,964)	\$6,964	\$0
FFS Add-On (lagged)	\$30,262	\$0	\$12,543	\$17,719
Managed Care Add-On	\$156,847	\$0	\$50,078	\$106,769
Total	\$187,109	(\$6,964)	\$69,585	\$124,488

GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

REGULAR POLICY CHANGE NUMBER: 116

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	MEMTF	FF
100% GF (4260-101-0001)	(\$6,901)	(\$6,901)	\$0	\$0
MEMTF (4260-601-3323)	\$62,118	\$0	\$62,118	\$0
ACA Title XIX FF (4260-101-0890)	\$61,445	\$0	\$0	\$61,445
Title XIX FF (4260-101-0890)	\$50,188	\$0	\$0	\$50,188
Title XXI FF (4260-113-0890)	\$5,781	\$0	\$0	\$5,781
Total	\$172,631	(\$6,901)	\$62,118	\$117,414

(Dollars in Thousands)

FY 2019-20	TF	GF	MEMTF	FF
100% GF (4260-101-0001)	(\$6,964)	(\$6,964)	\$0	\$0
MEMTF (4260-601-3323)	\$69,585	\$0	\$69,585	\$0
ACA Title XIX FF (4260-101-0890)	\$63,512	\$0	\$0	\$63,512
Title XIX FF (4260-101-0890)	\$55,571	\$0	\$0	\$55,571
Title XXI FF (4260-113-0890)	\$5,405	\$0	\$0	\$5,405
Total	\$187,109	(\$6,964)	\$69,585	\$124,488

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 7/2008
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1329

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$163,939,000	\$107,027,000
- STATE FUNDS	\$61,765,490	\$40,929,870
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$163,939,000	\$107,027,000
STATE FUNDS	\$61,765,490	\$40,929,870
FEDERAL FUNDS	\$102,173,510	\$66,097,130

DESCRIPTION

Purpose:

This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) according to the prospective payment system (PPS), Indian Health Services/Memorandum of Agreement (IHS/MOA), and the reimbursement to Cost-Based Reimbursement Clinics (CBRCs).

Authority:

Welfare & Institutions Code, sections 14132 and 14170
 Social Security Act, 1902 (bb)(5)

Interdependent Policy Changes:

Not Applicable

Background:

Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department must provide payment to the clinics equal to the difference between each clinic's final PPS rate and the expenditures already reimbursed by an interim payment and third party payors (i.e. managed care entities, Medicare, etc.) in order to calculate the final settlement with the clinic.

The Department reimburses the CBRCs, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs. The Department pays an interim rate to the clinics, which is adjusted once the audit reports are finalized. The adjusted interim rate is used for subsequent fiscal year claims. The FY 2015-16 audited levels were used to update the CBRC rates as of July 1, 2018. The Department is scheduled to complete the CBRC reconciliation audit for FY 2016-17 in FY 2018-19, and will complete FY 2017-18 audit levels in FY 2019-20. Interim rates will be adjusted to the FY 2016-17 audit levels beginning in FY 2019-20.

Currently, there are 1093 active FQHCs, 277 active RHCs, 25 active CBRCs, and 79 active IHS/MOA.

FQHC/RHC/CBRC RECONCILIATION PROCESS**REGULAR POLICY CHANGE NUMBER: 117****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is a decrease due to a lower retroactive rate adjustment average for FQHCs. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the recovery of overpayments in FY 2017-18. This impacted the three-year average for FY 2019-20.

Methodology:

1. FY 2018-19 FQHC and RHC reconciliations are based on a three-year average of actual settlements from July 2016 through June 2018. FY 2019-20 reconciliations are based on a three-year average of actual and estimated settlements from July 2016 through June 2019. FY 2016-17 and FY 2017-18 FQHC reconciliations include settlements for IHS.
2. The estimated FQHC retroactive rate adjustment for FY 2018-19 of \$19,933,000 and \$21,197,000 for FY 2019-20 is based on a three-year average of the previous year's implemented and paid Erroneous Payment Corrections (EPC). The Department calculates the three-year average by summing the number of EPCs for 2016-17, 2017-18, and FY 2018-19. The change from the prior year estimate is attributed to a slight increase in EPC's implemented and paid. Currently, the fiscal intermediary processes EPCs quarterly.
3. The LA CBRC reconciliation for FY 2018-19 reconciliation is based on settlement of 95% of the FY 2016-17 audited settlements. The FY 2019-20 reconciliation is based on 95% of the projected FY 2017-18 settlements calculated utilizing an average percentage between the CBRC and interim payments over revenues for FY 2012-13 and FY 2015-16 audited settlements, and FY 2016-17 reported settlements. The change from the prior year estimate is due to less visits billed.

	FY 2018-19	FY 2019-20
FQHCs Reconciliation	\$31,176,000	(\$215,000)
RHCs Reconciliation	\$15,529,000	\$4,823,000
FQHC Retroactive Rate Adjustment	\$19,933,000	\$21,198,000
LA CBRCs Reconciliation	\$97,301,000	\$81,220,000
Total	\$163,939,000	\$107,026,000

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$117,493,000	\$58,747,000	\$58,746,000
94% Title XIX ACA / 6% GF	\$22,223,000	\$1,393,000	\$21,830,000
93% Title XIX ACA / 7% GF	\$22,223,000	\$1,626,000	\$21,597,000
FY 2018-19 Total	\$163,939,000	\$61,766,000	\$102,173,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$76,704,000	\$38,352,000	\$38,352,000
93% Title XIX ACA / 7% GF	\$15,161,000	\$910,000	\$14,251,000
90% Title XIX ACA / 10% GF	\$15,161,000	\$1,516,000	\$13,645,000
FY 2019-20 Total	\$107,026,000	\$40,778,000	\$66,248,000

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 117

Funding:

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

94% Title XIX ACA / 6% GF (4260-101-0001/0890)

93% Title XIX ACA / 7% GF (4260-101-0001/0890)

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

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 8/2014
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1508

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$158,585,000	\$224,879,000
- STATE FUNDS	\$79,292,500	\$112,439,500
PAYMENT LAG	0.9382	0.9562
% REFLECTED IN BASE	14.52 %	12.80 %
APPLIED TO BASE		
TOTAL FUNDS	\$127,180,900	\$187,505,500
STATE FUNDS	\$63,590,470	\$93,752,770
FEDERAL FUNDS	\$63,590,470	\$93,752,780

DESCRIPTION

Purpose:

This policy change estimates the cost of the AB 1629 rate increases and add-ons for Freestanding Skilled Nursing Facilities, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facilities, Level-B (FSSA/NF-B).

Authority:

AB 1629 (Chapter 875, Statutes of 2004)
 ABX1 19 (Chapter 4, Statutes of 2011)
 AB 1489 (Chapter 631, Statutes of 2012)
 AB 119 (Chapter 17, Statutes of 2015)
 SB 3 (Chapter 4, Statutes of 2016)
 SB 97 (Chapter 52, Statutes of 2017)
 SB 219 (Chapter 482, Statutes of 2017)
 SPA 17-020

Interdependent Policy Changes:

Funding Adjust.—ACA Opt. Expansion
 Funding Adjust.—OTLICP

Background:

AB 1629 requires the Department to implement a facility-specific rate methodology and impose a Quality Assurance Fee (QAF) on FS/NF-B, FSSA/NF-B, and Freestanding Pediatric Subacute (FS/PSA) facilities. The QAF is used to offset the General Fund (GF) portion of the reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

To determine the QAF amount assessed to these facilities, the Department uses two-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 118

as the federal safe harbor limit, which is 6%, effective October 1, 2011. Changes in the amount of licensing and certification fees for FS/NF-B and FSSA/NF-B facilities, assessed by the California Department of Public Health (CDPH), affect the amount of QAF that can be collected in order to remain within the federal safe harbor limit.

The rate methodology provides for facility-specific cost-based per diem payments for AB 1629 facilities based upon allowable audited costs and additional reimbursement for the projected Medi-Cal cost of complying with new state or federal mandates, referred to as “add-ons.” The AB 1629 program add-ons are negotiated on an annual basis, and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific per-diem rates. These new mandated costs are budgeted for separately, as it will take two years to be reflected in the regular facility specific reimbursement rates.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the QAF collections will be deposited directly into the fund, rather than the state GF, and will be used to offset provider reimbursement rate expenditures. AB 1489 implemented a 3% increase to the weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payments (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The QASP is tied to demonstrated quality of care improvements and paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The fund is comprised of penalties assessed on FS/NF-Bs and FSSA/NF-Bs that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2013-14 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning rate-year (RY) 2015-16, the annual weighted average rate increase was set at 3.62%, and the GF appropriation for the QASP will continue at the FY 2014-15 amount of \$43 million, rather than setting aside a portion of the annual rate increase. AB 119 also changes the annual weighted average rate increase from a cap to a mandatory set percentage increase. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-020, effective August 1, 2017, to clarify that the rate increase provided through July 31, 2020 is at 3.62%, which aligns with current statute, rather than up to a 3.62% increase.

The Department submitted SPA 18-0050 to Centers for Medicare and Medicaid Services (CMS) on September 28, 2018, to revise the building construction and estimated building value used to calculate the Fair Rental Value cost category of the reimbursement rate methodology for FS/NF-B and FSSA/NF-B facilities. Overall, the change will be cost neutral, but will provide a more appropriate level of reimbursement for new facility construction.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to:

- Revised methodology to estimate the FS/NF-B and FSSA/NF-B facility rate increases,
- Delayed implementation of the 2017-18 retroactive rate payments to FY 2018-19,
- Revised Fee-for-Service (FFS) utilization based on data through July 2018,
- Revised 2017-18 and 2018-19 rates based on updated rates information, and
- Updated 2018-19 add-ons.

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The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to:

- Including seven months of the 2018-19 rates in FY 2018-19 and 12 months in FY 2019-20,
- The addition of the 2019-20 rates in FY 2019-20,
- Including fewer years of retroactive rate payments in FY 2019-20, and
- Higher add-ons in 2019-20.

Methodology:

1. The effective date for the rate increase and add-ons is August 1st.
2. Assume a 3.62% rate increase for the 2018-19 rate year, and a 3.62% rate increase for the 2019-20 rate year.
3. The 2018-19 rates and add-ons will be implemented in December 2018. The 2018-19 retroactive rate payment will cover August 2018 through November 2018, and will be implemented in April 2019.
4. The 2019-20 rates and add-ons will be implemented in October 2019. The 2019-20 retroactive rate payment will cover August 2019 through September 2019, and will be implemented in January 2020.
5. The estimated managed care rate adjustment impact for 2018-19 and 2019-20 is included in the 2018-19 and 2019-20 managed care capitation rates, respectively.
6. The add-on descriptions are listed below:
 - SB 3 Minimum Wage Increases: For employers who employ 26 or more employees.
 - i. \$10.50 per hour, effective January 2017.
 - ii. \$11.00 per hour, effective January 2018.
 - iii. \$12.00 per hour, effective January 2019.
 - iv. \$13.00 per hour, effective January 2020.
 - Standards of Participation: Effective November 28, 2016, CMS required SNFs to meet new health and safety standards in order to participate in the Medicare and Medicaid programs.
 - i. Phase I – Antimicrobial Stewardship
 - ii. Phase II – Infection Control
 - iii. Phase III – Infection Preventionist Staff
 - SNF Staffing Ratio: Effective July 1, 2018, SB 97 requires SNFs to have a minimum number of direct care service hours of 3.5 per patient day.
 - Lesbian, Gay, Bisexual, and Transgender (LGBT) training: Effective August 1, 2018, SB 219 requires SNFs to implement an LGBT training program.

AB 1629 ANNUAL RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 118

7. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FFP
FFS (Rate Increase)	\$125,018	\$62,509	\$62,509
RY 2017-18 Retro	\$19,891	\$9,945	\$9,946
RY 2018-19 Retro	\$35,900	\$17,950	\$17,950
Add-Ons	(\$22,224)	(\$11,112)	(\$11,112)
Managed Care	\$0	\$0	\$0
Total	\$158,585	\$79,292	\$79,293

(Dollars in Thousands)

FY 2019-20	TF	GF	FFP
FFS (Rate Increase)	\$220,587	\$110,294	\$110,293
RY 2019-20 Retro	\$14,038	\$7,019	\$7,019
Add-Ons	(\$9,746)	(\$4,873)	(\$4,873)
Managed Care	\$0	\$0	\$0
Total*	\$224,879	\$112,440	\$112,439

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 119
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1162

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$80,227,000	\$153,537,000
- STATE FUNDS	\$40,113,500	\$76,768,500
PAYMENT LAG	0.7404	0.8661
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$59,400,100	\$132,978,400
STATE FUNDS	\$29,700,040	\$66,489,200
FEDERAL FUNDS	\$29,700,040	\$66,489,200

DESCRIPTION

Purpose:

This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:

SPA 05-21

Interdependent Policy Changes:

DPH Interim Rate
 Funding Adjust. — ACA Opt. Expansion

Background:

As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in the hospitals' costs. The interim per diem rate consists of 100% federal funding.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to a decrease in estimated users and utilization per user based on updated DPH actual data through July 2018.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to an increased growth rate for community-based DPHs by 4.29% and by 6.21% for county DPHs in FY 2019-20 based on updated DPH actual data through July 2018.

DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 119

Methodology:

1. The DPHs received new FY 2018-19 interim rates in mid-July 2018, effective July 1, 2018. These rates were based on FY 2016-17 costs trended to FY 2018-19. Assume the FY 2019-20 interim rates will be implemented in July 2019.
2. For FY 2018-19:
 - An Erroneous Payment Correction (EPC) is expected to occur in February 2019 for the time period from July 1, 2018 through July 13, 2018.
 - Assume a 7.79% interim rate increase for county DPHs.
 - Assume a 4.40% interim rate increase for community-based DPHs.
 - An additional cost of \$80,227,000 TF is estimated for the FY 2018-19 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$59,400,000 TF.
3. For FY 2019-20:
 - Assume a 6.21% interim rate increase for county DPHs.
 - Assume a 4.29% interim rate increase for community-based DPHs.
 - An additional cost of \$153,537,000 TF is estimated for the FY 2019-20 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$132,978,000 TF.
4. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/ 50% FFP and are budgeted as 50% GF / 50% FFP. The full adjustment is shown in the DPH Interim Rate policy change.

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust. — ACA Opt. Expansion policy change

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 1/2019
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 2077

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$64,834,000	\$64,834,000
- STATE FUNDS	\$30,975,970	\$31,204,980
PAYMENT LAG	0.8730	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$56,600,100	\$64,834,000
STATE FUNDS	\$27,042,020	\$31,204,980
FEDERAL FUNDS	\$29,558,060	\$33,629,020

DESCRIPTION**Purpose:**

This policy change estimates the costs of a rate increase for Fee-for-Service (FFS) home health agency and private duty nursing (PDN) services, effective July 1, 2018.

Authority:

SB 856 (Chapter 30, Statutes of 2018)
 SPA 18-0037

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 the home health agency rate increases.

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.

Pursuant to SB 856, the Department shall develop the structure and parameters for rate increases to be made for home health providers of medically necessary in-home services for children and adults in the Medi-Cal Fee-for-Service (FFS) system or through Home and Community Based Services (HCBS) waivers. Home Health and PDN services are an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

On September 17, 2018, the Centers for Medicare and Medicaid Services approved State Plan Amendment (SPA) 18-0037 for federal approval to provide a rate increase to certain home health services.

PROP 56 - HOME HEALTH RATE INCREASE**REGULAR POLICY CHANGE NUMBER: 120****Reason for Change:**

There is no change, from the prior estimate, for FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to:

- Updating the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP) to 76.5%, beginning October 1, 2019, and
- Updating the ACA Optional FMAP from 93% to 90%, beginning January 1, 2020.

Methodology:

1. The Department will increase certain FFS and HCBS waiver home health agency and PDN services rates by 50%, effective for dates of service on and after July 1, 2018. Providers in the Medi-Cal FFS delivery systems, as well as the impacted HCBS waivers will receive these rate increases.
2. The rate adjustments are estimated to be implemented in January 2019. The Erroneous Payment Correction (EPC) for the retroactive period from July 2018 to December 2018 is estimated to occur in April 2019.
3. The total costs budgeted in the Medi-Cal and Family Health Estimates are estimated to be:

FY 2018-19	TF	GF	SF	FF	CF
Medi-Cal	\$64,834,000	\$0	\$30,976,000	\$33,858,000	\$0
CCS-State Only	\$8,699,000	\$4,349,000	\$0	\$0	\$4,350,000
Total	\$73,533,000	\$4,349,000	\$30,976,000	\$33,858,000	\$4,350,000

FY 2019-20	TF	GF	SF	FF	CF
Medi-Cal	\$64,834,000	\$0	\$31,205,000	\$33,629,000	\$0
CCS-State Only	\$8,699,000	\$4,349,000	\$0	\$0	\$4,350,000
Total	\$73,533,000	\$4,349,000	\$31,205,000	\$33,629,000	\$4,350,000

4. The Medi-Cal costs in this policy change are as follows:

Fiscal Year	TF	SF	FF	Title XXI FF	ACA FF
FY 2018-19	\$64,834,000	\$30,976,000	\$30,611,000	\$2,083,000	\$1,164,000
FY 2019-20	\$64,834,000	\$31,205,000	\$30,611,000	\$1,879,000	\$1,139,000

PROP 56 - HOME HEALTH RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 120

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$61,222,000	\$30,611,000	\$30,611,000
94% Title XIX / 6% SF (4260-101-3305 / 0890)	\$622,000	\$37,000	\$585,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$623,000	\$44,000	\$579,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$2,367,000	\$284,000	\$2,083,000
Total FY 2018-19	\$64,834,000	\$30,976,000	\$33,858,000

FY 2019-20	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$61,222,000	\$30,611,000	\$30,611,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$623,000	\$44,000	\$579,000
90% Title XIX / 10% SF (4260-101-3305 / 0890)	\$622,000	\$62,000	\$560,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$592,000	\$71,000	\$521,000
76.5% Title XXI / 23.5% SF (4260-101-3305 / 4260-113-0890)	\$1,775,000	\$417,000	\$1,358,000
Total FY 2019-20	\$64,834,000	\$31,205,000	\$33,629,000

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 7/2014
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1185

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$25,931,000	\$0
- STATE FUNDS	\$9,552,080	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,931,000	\$0
STATE FUNDS	\$9,552,080	\$0
FEDERAL FUNDS	\$16,378,920	\$0

DESCRIPTION

Purpose:

This policy change budgets the retroactive adjustments to scheduled Dental Managed Care (DMC) rates in prior years.

Authority:

Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:

Not Applicable

Background:

The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in the Medi-Cal dental services program to implement the new annual rates through an amendment or change order to the contract.

In the event there is any delay in a determination of rate changes, the amendment or change order may not be processed in time to permit payment of new rates commencing July 1, the payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to retroactive payments for FY 2016-17. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to no scheduled retroactive payments in FY 2019-20.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 121

Methodology:

1. Assume the DMC retroactive rate adjustment to be made in FY 2018-19 for FY 2016-17 is \$25,930,384 TF.

Funding:

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$18,588,000	\$9,294,000	\$9,294,000
ACA 95% FFP/5% GF (2017)	\$3,280,000	\$164,000	\$3,116,000
ACA 100% FFP (2016)	\$3,279,000	\$0	\$3,279,000
88% Title XXI / 12% GF	\$784,000	\$94,000	\$690,000
Total	\$25,931,000	\$9,552,000	\$16,379,000

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122
 IMPLEMENTATION DATE: 8/2007
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1046

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$26,874,000	\$25,131,000
- STATE FUNDS	\$13,437,000	\$12,565,500
PAYMENT LAG	0.9326	0.9307
% REFLECTED IN BASE	43.94 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,050,100	\$23,389,400
STATE FUNDS	\$7,025,070	\$11,694,710
FEDERAL FUNDS	\$7,025,070	\$11,694,710

DESCRIPTION

Purpose:

This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part (DP) Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, DP Adult Subacute, DP Pediatric Subacute (DP/PSA), Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding Pediatric Subacute facilities (FS/PSA). It also estimates the additional reimbursement for the projected Medi-Cal costs of complying with new State or federal mandates, referred to as “add-ons.”

Authority:

ABX4 5 (Chapter 5, Statutes of 2009)
 AB 97 (Chapter 3, Statutes of 2011)
 ABX1 19 (Chapter 4, Statutes of 2011)
 SB 239 (Chapter 657, Statutes of 2013)
 AB 119 (Chapter 17, Statutes of 2015)
 ABX2 1 (Chapter 3, Statutes of 2016)
 SB 3 (Chapter 4, Statutes of 2016)
 SB 219 (Chapter 483, Statutes of 2017)

Interdependent Policy Changes:

Funding Adjust. – ACA Opt. Expansion
 Funding Adjust. – OTLICP

Background:

Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122

continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

Effective June 1, 2011, AB 97 required the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, AB 97 extends this requirement to the other LTC facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

Effective September 1, 2013, Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas are exempted from the rate freeze.

The Department also received CMS approval to exempt DP Adult Subacute and DP/PSA from the rate freeze based on access and utilization analyses.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and rate freeze at the 2008-2009 levels, required by AB 97, with respect to DP/NF-Bs facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. As a result, the Department was to implement the AB 97 payment reductions and rate freezes retroactive to June 1, 2011. On December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and 10% payment reduction, effective October 1, 2013.

Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013. Additionally, effective August 1, 2016, ABX2 1 requires the Department to reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%, for which the Department obtained CMS approval on July 5, 2016.

SB 219 created a Lesbian, Gay, Bisexual, and Transgender (LGBT) bill of rights and staff training requirement for LTC facilities, including Skilled Nursing Facilities and Intermediate Care Facilities.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to:

- Revised FFS utilization based on data through July 2018,
- Updated FY 2018-19 rates based on audited data,
- Updated RY 2018-19 add-ons,
- Removing supplemental payments for FS Pediatric Subacute facilities through Proposition 56 funds. These costs are now budgeted in the Prop 56 FS-PSA Supplemental Payments policy change.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net decrease due to:

- A full year of the RY 2018-19 rate adjustments in FY 2019-20, and
- Less retroactive payments in FY 2019-20.

Methodology:

1. The effective date for the rate adjustments is August 1st of each rate year. The expected RY 2018-19 and RY 2019-20 implementation dates are as follows:

Facility	RY 2018-19	RY 2019-20
DP/NF-B	11/1/2018	11/1/2019
Rural Swing Beds (non-exempt)	11/1/2018	11/1/2019
Rural Swing Beds (exempt)	11/1/2018	11/1/2019
DP Adult Subacute	11/1/2018	11/1/2019
NF-A	11/1/2018	11/1/2019
ICF/DDs	11/1/2018	11/1/2019
DP Pediatric Subacute	9/1/2018	9/1/2019
FS Pediatric Subacute	9/1/2018	9/1/2019

2. Payments in FY 2018-19 include retroactive payments for 2017-18 and 2018-19. Payments for FY 2019-20 include retroactive payments for 2019-20.
3. Add-ons reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are negotiated on an annual basis and take two years to be reflected in the regular facility specific reimbursement rates, with the exception of DP Adult Subacute facilities, which take three years for add-ons to be reflected in their rates.
4. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze.
5. **DP Adult Subacute and DP Pediatric Subacute facilities:** These two facility types will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for these two facilities would negatively impact access to care. Therefore, the Department will develop reimbursement rates for these facility types as described in the State Plan.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122

6. **DP/NF-B facilities:** Effective August 1, 2016, ABX2 1 requires the Department to forgo the AB 97 retroactive recoupment for the rate reduction and rate freeze that would have been applied to the reimbursement for services provided by DP/NF-Bs between June 1, 2011 and September 30, 2013.
7. **Rural Swing Bed Rates:** The impact of the rate freeze and exemption for Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas is captured in the FFS base trends.
8. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities:** Effective August 1, 2016, ABX2 1 requires the Department to restore the AB 97 payment reduction and reimburse ICF/DDs at the 2008-09 rate levels, increased by 3.7%.

Restore AB 97	Increase 3.7%	Total
\$5,791,000	\$19,330,000	\$25,121,000

9. ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee (QAF) beginning January 1, 2012. Effective October 1, 2011, the QA fee cap is 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.
10. AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020.
11. The estimated managed care rate adjustment impacts for rate year 2018-19 and rate year 2019-20 are included in the managed care capitation rates.
12. The add-on descriptions are listed below:
 - SB 3 Minimum Wage Increases: For employers who employ 26 or more employees.
 - i. \$10.50 per hour, effective January 2017.
 - ii. \$11.00 per hour, effective January 2018.
 - iii. \$12.00 per hour, effective January 2019.
 - iv. \$13.00 per hour, effective January 2020.
 - Payroll-Based Journal: Effective July 1, 2016, CMS requires facilities to submit direct care staffing information based on payroll data.
 - Standards of Participation: Effective November 28, 2016, CMS required SNFs to meet new health and safety standards in order to participate in the Medicare and Medicaid programs.
 - i. Phase I – Antimicrobial Stewardship
 - ii. Phase II – Infection Control
 - iii. Phase III – Infection Preventionist Staff
 - Lesbian, Gay, Bisexual, and Transgender (LGBT) training: Effective August 1, 2018, SB 219 requires SNFs to implement an LGBT training program.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122

13. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

Fee-for-Service	FY 2018-19	FY 2019-20
Rate Adjustment (17-18)		
DP/NF-B	(\$428,000)	\$0
Rural Swing Beds (non-exempt)	\$1,000	\$0
Rural Swing Beds (exempt)	\$113,000	\$0
DP Adult Subacute	\$4,491,000	\$0
NF-A	\$26,000	\$0
ICF/DDs	\$4,644,000	\$0
DP Pediatric Subacute	\$379,000	\$0
FS Pediatric Subacute	\$2,000	\$0
Rate Adjustment (18-19)		
DP/NF-B	\$5,581,000	\$8,371,000
Rural Swing Beds (non-exempt)	\$0	\$1,000
Rural Swing Beds (exempt)	\$22,000	\$33,000
DP Adult Subacute	\$1,409,000	\$2,114,000
NF-A	\$42,000	\$63,000
ICF/DDs	\$1,433,000	\$2,150,000
DP Pediatric Subacute	\$391,000	\$470,000
FS Pediatric Subacute	\$100,000	\$120,000
Rate Adjustment (18-19)		
DP/NF-B	\$0	\$5,001,000
Rural Swing Beds (non-exempt)	\$0	\$1,000
Rural Swing Beds (exempt)	\$0	\$26,000
DP Adult Subacute	\$0	\$1,742,000
NF-A	\$0	\$13,000
ICF/DDs	\$0	\$1,537,000
DP Pediatric Subacute	\$0	\$319,000
FS Pediatric Subacute	\$0	\$17,000
Retro Rate Adjustments		
DP/NF-B	\$1,914,000	\$1,875,000
Rural Swing Beds (non-exempt)	\$0	\$0
Rural Swing Beds (exempt)	\$65,000	\$10,000
DP Adult Subacute	\$2,400,000	\$653,000
NF-A	\$27,000	\$5,000
ICF/DDs	\$4,020,000	\$576,000
DP Pediatric Subacute	\$229,000	\$32,000
FS Pediatric Subacute	\$11,000	\$2,000
Total FFS	\$26,874,000	\$25,131,000
Managed care	\$0	\$0
Total Cost	\$26,874,000	\$25,131,000

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 122

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 123
 IMPLEMENTATION DATE: 11/2012
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1612

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$11,972,000	\$13,000,000
- STATE FUNDS	\$5,986,000	\$6,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,972,000	\$13,000,000
STATE FUNDS	\$5,986,000	\$6,500,000
FEDERAL FUNDS	\$5,986,000	\$6,500,000

DESCRIPTION

Purpose:

This policy change estimates the Fee-for-Service (FFS) augmentation payments and the offset of General Fund (GF) expenditures for Medi-Cal emergency medical air transportation service reimbursements.

Authority:

AB 2173 (Chapter 547, Statutes of 2010), Government Code 76000.10
 AB 215 (Chapter 392, Statutes of 2011)
 AB 1410 (Chapter 718, Statutes of 2017)
 SPA 17-019

Interdependent Policy Changes:

Not Applicable

Background:

AB 2173 imposed an additional penalty of \$4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill required the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Medical Air Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds are used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund is matched with federal funds and used to provide augmentation payments for eligible Medi-Cal emergency medical air transportation services.

The augmentation payment amount is per transport and calculated annually; therefore, a State Plan Amendment (SPA) is required annually. The SPA for FY 2017-18 was approved on December 8, 2017.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT**REGULAR POLICY CHANGE NUMBER: 123**

On October 23, 2018, SPA 18-0030 was approved for FY 2018-19.

AB 1410 renamed the EMATA Fund to the Emergency Medical Air Transportation and Children's Coverage (EMATCC) Fund, effective January 1, 2018. AB 1410 extends the \$4 penalty for vehicle code violations until January 1, 2020, extends supplemental payments to June 30, 2021, and extends the EMATA sunset date to January 1, 2022.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to lower utilization, resulting in lower augmentation payments, and a decrease in GF transfer amounts based on decreasing penalty assessment revenue.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to increased augmentation payments in FY 2019-20.

Methodology:

1. Implementation date began November 2012.
2. The FY 2018-19 estimated payments include:
 - FFS augmentation payments for the second half of FY 2017-18, and the first half of FY 2018-19,
 - GF transfer from the second half of FY 2017-18 collections is expected to be \$795,000, and
 - GF transfer from the first half of FY 2018-19 collections is expected to be \$795,000.
3. The FY 2019-20 estimated payments include:
 - FFS augmentation payments for the second half of FY 2018-19, and the first half of FY 2019-20,
 - GF transfer from the second half of FY 2018-19 collections is expected to be \$795,000, and
 - GF transfer from the first half of FY 2019-20 collections is expected to be \$795,000.
4. Based on estimated fee collections, the estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2018-19	TF	GF	EMATCC	FFP
GF Offset	\$0	(\$1,590)	\$1,590	\$0
Augment Payment	\$11,972	\$0	\$5,986	\$5,986
Total	\$11,972	(\$1,590)	\$7,576	\$5,986

(Dollars in Thousands)

FY 2019-20	TF	GF	EMATCC	FFP
GF Offset	\$0	(\$1,590)	\$1,590	\$0
Augment Payment	\$13,000	\$0	\$6,500	\$6,500
Total	\$13,000	(\$1,590)	\$8,090	\$6,500

Funding:

100% GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

EMATA / EMATCC Fund (4260-101-3168)

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 124
 IMPLEMENTATION DATE: 1/2019
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 2098

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$14,246,000	\$14,246,000
- STATE FUNDS	\$6,811,980	\$6,880,060
PAYMENT LAG	0.8250	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,753,000	\$14,246,000
STATE FUNDS	\$5,619,880	\$6,880,060
FEDERAL FUNDS	\$6,133,070	\$7,365,940

DESCRIPTION**Purpose:**

This policy change estimates the costs of a rate increase for fee-for-service (FFS) Pediatric Day Health Care (PDHC) facilities, effective July 1, 2018.

Authority:

SB 840 (Chapter 29, Statutes of 2018)
 SB 856 (Chapter 30, Statutes of 2018)
 SPA 18-0037

Interdependent Policy Changes:

Not Applicable

Background:

PDHC is an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service when rendered by a PDHC facility licensed by the Department. PDHC is a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning, and social interaction, designed to optimize the individuals medical status and developmental functioning so that he or she can remain within the family.

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 PDHC rate increase.

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.

Pursuant to SB 840 and SB 856, the Department shall develop the structure and parameters for a rate increase in 2018-19 for PDHC facilities.

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE**REGULAR POLICY CHANGE NUMBER: 124**

The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0037 on September 17, 2018, which increased PDHC rates, effective July 1, 2018.

Reason for Change:

The change in FY 2018-19, from the previous estimate, is an increase based on the estimated utilization of PDHC services.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to:

- Updating the Federal Medical Assistance Percentage (FMAP) for the Children's Health Insurance Program (CHIP) to 76.5%, beginning October 1, 2019, and
- Updating the ACA Optional FMAP from 93% to 90%, beginning January 1, 2020.

Methodology:

1. The current Medi-Cal FFS reimbursement rate for PDHC services is \$29.41 per hour.
2. The reimbursement rate for EPSDT PDHC support service rates will increase by 50 percent, effective July 1, 2018.
3. The PDHC rate increase is expected to be implemented in January 2019. An Erroneous Payment Correction (EPC) for the retroactive period of July 2018 through December 2018 is expected to be implemented in April 2019.
4. The FY 2018-19 and FY 2019-20 costs budgeted in the Medi-Cal and Family Health Estimates are estimated to be:

FY 2018-19	TF	GF	SF	Title XIX FF	Title XXI FF	ACA FF	CF
Medi-Cal	\$14,246,000	\$0	\$6,812,000	\$6,716,000	\$689,000	\$29,000	\$0
CCS-State Only	\$2,006,000	\$1,003,000	\$0	\$0	\$0	\$0	\$1,003,000
Total	\$16,252,000	\$1,003,000	\$6,812,000	\$6,716,000	\$689,000	\$29,000	\$1,003,000

FY 2019-20	TF	GF	SF	Title XIX FF	Title XXI FF	ACA FF	CF
Medi-Cal	\$14,246,000	\$0	\$6,880,000	\$6,716,000	\$621,000	\$29,000	\$0
CCS-State Only	\$2,006,000	\$1,003,000	\$0	\$0	\$0	\$0	\$1,003,000
Total	\$16,252,000	\$1,003,000	\$6,880,000	\$6,716,000	\$621,000	\$29,000	\$1,003,000

5. The Medi-Cal costs in this policy change are as follows:

FY 2018-19	TF	SF	Title XIX FF	Title XXI FF	ACA FF
Rate Increase	\$7,123,000	\$3,406,000	\$3,358,000	\$344,500	\$14,500
Retro Rate Increase	\$7,123,000	\$3,406,000	\$3,358,000	\$344,500	\$14,500
Total	\$14,246,000	\$6,812,000	\$6,716,000	\$689,000	\$29,000

FY 2019-20	TF	SF	Title XIX FF	Title XXI FF	ACA FF
Rate Increase	\$14,246,000	\$6,880,000	\$6,716,000	\$621,000	\$29,000

PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

REGULAR POLICY CHANGE NUMBER: 124

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$13,432,000	\$6,716,000	\$6,716,000
94% Title XIX / 6% SF (4260-101-3305 / 0890)	\$15,000	\$1,000	\$14,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$16,000	\$1,000	\$15,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$783,000	\$94,000	\$689,000
Total FY 2018-19	\$14,246,000	\$6,812,000	\$7,434,000

FY 2019-20	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$13,432,000	\$6,716,000	\$6,716,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$16,000	\$1,000	\$15,000
90% Title XIX / 10% SF (4260-101-3305 / 0890)	\$16,000	\$2,000	\$14,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$195,000	\$23,000	\$172,000
76.5% Title XXI / 23.5% SF (4260-101-3305 / 4260-113-0890)	\$587,000	\$138,000	\$449,000
Total FY 2019-20	\$14,246,000	\$6,880,000	\$7,366,000

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 125
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 96

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$16,585,000	\$17,176,000
- STATE FUNDS	\$8,292,500	\$8,588,000
PAYMENT LAG	0.9245	0.9143
% REFLECTED IN BASE	4.98 %	4.38 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,569,300	\$15,016,200
STATE FUNDS	\$7,284,630	\$7,508,090
FEDERAL FUNDS	\$7,284,630	\$7,508,090

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:

Funding Adjust.—ACA Opt. Expansion
 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 per diem rates for Nursing Facility – Level B (NF-B), which include Distinct Part (DP) or Freestanding; Nursing Facility – Level A (NF-A); Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 125

Pursuant to AB 97 (Chapter 3, Statutes of 2011) rate freezes and payment reductions were implemented for NF-As and DP/NF-Bs, and Freestanding Pediatric Subacute rates, effective June 1, 2011. 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.

ICF/DD, ICF/DD-H, and ICF/DD-N facilities—Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to restore the AB 97 payment reduction and reimburse ICF/DDs at the 2008-09 rate levels, increased by 3.7%.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to:

- Updated actual hospice payment data through July 2018;
- A delay in the Rate Year (RY) 2017-18 hospice rates, excluding the Routine Home Care (RHC) and Service Intensity Add-On (SIA) from May 2018 to July 2018;
- The RY 2016-17 hospice services and RY 2017-18 room and board rates no longer being budgeted in this policy change;
- A decrease in the RY 2018-19 room and board rates due to updated claims data; and
- A decrease in the utilization estimate for the RHC and SIA retroactive claims.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to:

- The retroactive payments for the period from January 2016 through April 2018 for the RHC tiered rates and SIA occurring in FY 2018-19; and
- A full year of RY 2018-19 RHC tiered rates and RY 2018-19 hospice services included in FY 2019-20.

Methodology:

1. The estimated weighted increase for hospice service rates, excluding RHC and SIA, for RY 2018-19 and RY 2019-20 is 1.80%.
2. RY 2017-18 hospice services rates, excluding RHC and SIA, were implemented on June 25, 2018. The EPC for the retroactive period of October 2017 through June 2018 occurred in October 2018.
3. RY 2018-19 hospice services rates, excluding RHC and SIA, are assumed to be implemented in January 2019. The EPC for the retroactive period of October 2018 to December 2018 is estimated to occur in June 2019.
4. Effective January 1, 2016, the CMS final hospice rule changes the payment methodology for RHC 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.
5. The CMS final hospice rule also establishes a 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.
6. The RY 2015-16, RY 2016-17, and RY 2017-18 RHC tiered rates and SIA were implemented on April 23, 2018. Retroactive claims for the period January 2016 through April 2018 will require providers to resubmit claims for payments. Payments for the retroactive period are expected to be paid in FY 2018-19 as claims are reprocessed.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 125

7. The RY 2018-19 RHC tiered rates and SIA are expected to be implemented January 2019. The retroactive payment for the period of October 2018 through December 2018 is expected to be implemented in June 2019.
8. The RY 2019-20 hospice rates, including the RHC and SIA, are expected to be implemented in January 2020. The retroactive payment for the period of October 2019 through December 2019 is expected to be implemented in June 2020.
9. Hospice room and board rates will continue at 95% of the facility's rates, whether frozen or unfrozen. The weighted increase for hospice room and board rates for RY 2017-18 and RY 2018-19 is estimated to be 4.69%.

Cash Basis	FY 2018-19	FY 2019-20
Hospice Services (17-18)	\$28,000	\$28,000
RHC & SIA Payments (17-18)	\$3,707,000	\$3,707,000
Hospice Services (18-19)	\$14,000	\$28,000
RHC & SIA Payments (18-19)	\$1,355,000	\$2,712,000
Room & Board (18-19)	\$4,029,000	\$4,395,000
RHC & SIA Retro	\$6,746,000	
Hospice Services Retro (17-18)	\$21,000	
Hospice Services Retro (18-19)	\$685,000	
Hospice Services (19-20)		\$14,000
RHC & SIA Payments (19-20)		\$1,378,000
Room & Board (19-20)		\$4,218,000
Hospice Services Retro (19-20)		\$696,000
TOTAL	\$16,585,000	\$17,176,000

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 126
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1996

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$7,690,000	\$3,743,000
- STATE FUNDS	-\$6,212,030	-\$2,292,450
PAYMENT LAG	0.8633	0.9735
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,638,800	\$3,643,800
STATE FUNDS	-\$5,362,840	-\$2,231,700
FEDERAL FUNDS	\$12,001,620	\$5,875,510

DESCRIPTION

Purpose:

This policy change estimates funding adjustments to reflect inpatient hospital payments to Alameda Hospital and San Leandro Hospital based on their designation as a Designated Public Hospital (DPH) effective July 1, 2016.

Authority:

SB 815 (Chapter 111, Statutes of 2016)
 AB 1568 (Chapter 42, Statutes of 2016)
 State Plan Amendment (SPA) 16-032

Interdependent Policy Changes:

Not Applicable

Background:

Through SB 815, the designation of Alameda Hospital and San Leandro Hospital changed from a Non-Designated Public Hospital (NDPH) to a DPH, effective July 1, 2016. As a result, inpatient hospital payment methodologies for the two hospitals will change from a Diagnosis Related Group (DRG) methodology to a cost based payment methodology based on Certified Public Expenditures (CPEs).

The DRG payment methodology is calculated at 50% federal financial participation (FFP) and 50% General Fund (GF), while the DPHs receive 100% FFP reimbursements based on CPEs. Therefore, an adjustment to shift from 50% FFP / 50% GF to 100% FFP is made.

The Centers for Medicare & Medicaid Services approved SPA 16-032 on September 11, 2017, effective July 1, 2016, which allows for the two hospitals' designations to be changed to DPHs.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to an additional five months included in the erroneous payment correction (EPC), and updated payment data.

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE**REGULAR POLICY CHANGE NUMBER: 126**

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to FY 2018-19 includes nine months of payments, while FY 2019-20 includes a full year of payments and EPCs for retroactive periods.

Methodology:

1. Assume the FY 2017-18 DPH CPE interim rate will decrease by 2.87% and DRG payments will increase by 3.59%.
2. Assume the FY 2018-19 DPH CPE interim rate will increase by 27.50% and DRG payments will increase by 4.66%.
3. Assume the FY 2019-20 DPH CPE interim rate will increase by 6.21% and DRG payments will increase by 4.47%
4. The DRG payment methodology is paid at 50% GF and 50% FFP.
5. The cost based CPE payment methodology is paid at 50% FFP and 50% CPE.
6. Assume the net ACA optional population adjustments are included in FY 2016-17, FY 2017-18, FY 2018-19, and FY 2019-20. Funding for the ACA optional population is represented as 100% FFP for DRGs and 100% FFP for CPEs based on costs certified by the hospitals through December 2016. Beginning January 2017, the FFP reduces to 95% FFP / 5% GF, 94% FFP / 6% GF beginning January 2018, and 93% FFP / 7% GF beginning January 2019. Beginning January 2020, the FFP further reduces to 90% FFP / 10% GF.
7. The change in payment methodology from DRG to cost based CPEs occurred in late September 2018. The FY 2018-19 GF savings total \$6,212,000, which includes a \$4,566,000 EPC for the time period from July 2016 through September 2018 to be implemented in June 2019. The FY 2019-20 GF savings total \$2,293,000.
8. The funding adjustment on an annual basis is estimated as follows:

FY 2018-19	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	(\$6,313,000)	(\$2,534,000)	(\$2,467,000)	(\$1,312,000)
CPE	\$12,037,000	\$0	\$7,529,000	\$4,508,000
Alameda Hospital Total	\$5,724,000	(\$2,534,000)	\$5,062,000	\$3,196,000
San Leandro Hospital				
DRG	(\$11,526,000)	(\$3,678,000)	(\$3,453,000)	(\$4,395,000)
CPE	\$13,492,000	\$0	\$6,861,000	\$6,631,000
San Leandro Hospital Total	\$1,966,000	(\$3,678,000)	\$3,408,000	\$2,236,000
FY 2018-19 Total	\$7,690,000	(\$6,212,000)	\$8,470,000	\$5,432,000

ALAMEDA HOSP & SAN LEANDRO HOSP INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 126

FY 2019-20	TF	GF	FF	ACA FF
Alameda Hospital				
DRG	(\$2,291,000)	(\$929,000)	(\$895,000)	(\$467,000)
CPE	\$5,159,000	\$0	\$3,272,000	\$1,887,000
Alameda Hospital Total	\$2,868,000	(\$929,000)	\$2,377,000	\$1,420,000
San Leandro Hospital				
DRG	(\$4,184,000)	(\$1,364,000)	(\$1,253,000)	(\$1,567,000)
CPE	\$5,059,000	\$0	\$2,622,000	\$2,437,000
San Leandro Hospital Total	\$875,000	(\$1,364,000)	\$1,369,000	\$870,000
FY 2019-20 Total	\$3,743,000	(\$2,293,000)	\$3,746,000	\$2,290,000

Funding:

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

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

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

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

94% Title XIX ACA / 6% GF (4260-101-0001/0890)

93% Title XIX ACA / 7% GF (4260-101-0001/0890)

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

PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 127
 IMPLEMENTATION DATE: 9/2018
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2107

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$5,953,000	\$0
- STATE FUNDS	\$2,976,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,953,000	\$0
STATE FUNDS	\$2,976,500	\$0
FEDERAL FUNDS	\$2,976,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the adjustment to the Periodontal Maintenance rate for Skilled Nursing Facilities or Intermediate Care Facilities as a result of a Centers for Medicare & Medicaid Services (CMS) policy. An erroneous payment correction (EPC) will be issued for the time period of July 1, 2016, through May 15, 2018.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The reimbursement rate for Periodontal Maintenance was revised through state law processes from \$130 to \$55 as of July 15, 2016. Due to a revision of federal interpretation of rate setting, a State Plan Amendment (SPA) has been submitted to CMS on June 29, 2018, to approve this rate under federal law. The state paid the lower rate of \$55 since adoption of the new policy in July 2016, but CMS has indicated the department must pay the higher rate of \$130 until the effective date of the SPA. The SPA currently contemplates an effective date no earlier than May 15, 2018.

Reason for Change:

This is a new policy change. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease as all adjustment payments expect to be paid in FY 2018-19.

Methodology:

1. The rate change from \$130 to \$55 is a difference of \$75.
2. A total of 78,224 periodontal maintenance procedures were paid from July 15, 2016, through May 15, 2018.

PERIODONTAL MAINTENANCE REIMB RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 127

3. A total of \$5,953,000 will be reimbursed in FY 2018-19.

	TF	FF	GF
FY 2018-19	\$5,953,000	\$2,976,500	\$2,976,500

Funding:

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

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 128
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1938

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$2,506,000	\$2,506,000
- STATE FUNDS	\$1,253,000	\$1,253,000
PAYMENT LAG	0.8130	1.0000
% REFLECTED IN BASE	3.90 %	3.51 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,957,900	\$2,418,000
STATE FUNDS	\$978,960	\$1,209,020
FEDERAL FUNDS	\$978,960	\$1,209,020

DESCRIPTION

Purpose:

This policy change estimates the costs associated with fee increases for newborn screening provided to Medi-Cal beneficiaries under the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP).

Authority:

Health & Safety Code Section 124977
 SB 1095 (Chapter 393, Statutes of 2016)

Interdependent Policy Changes:

Not Applicable

Background:

Pursuant to Health & Safety Code Section 124977, the Newborn Screening (NBS) Program fee shall be periodically adjusted to fully support GDSP.

SB 1095 requires GDSP to expand statewide screening of newborns for diseases that are detectable in blood samples as soon as practicable, but no later than two years after the diseases are adopted by the federal Recommended Uniform Screening Panel (RUSP). Pompe disease and Mucopolysaccharidosis Type I were added to the RUSP in 2015 and 2016, respectively. Beginning August 2018, GDSP began screening all babies in California for the two new disorders.

Effective July 2018, a fee increase of \$12.00 per specimen was implemented for increased appropriation for staff, equipment, consumables, reagents, contract costs for maintenance and operation of the NBS computer system and the Screening Information System (SIS), DNA sequencing, follow-up activities, confirmatory testing, and increased contract costs due to inflation. The Department has accounted for start-up costs.

GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 128

Reason for Change:

The change from FY 2018-19, from the prior estimate, is a decrease due to the \$17.55 and \$9.95 fee increases being fully incorporated in the FFS base and no longer budgeted in this policy change.

There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. The Department implemented a \$12.00 fee increase for the GDSP NBS program in July 2018. The annual cost is \$2,506,000 TF.
2. The estimated number of births in California is 478,419 for FY 2018-19 and FY 2019-20. GDSP assumes approximately 99% of newborns will be screened by the NBS Program each year.
3. Assume approximately 45% of newborns screened are from the Medi-Cal population.
4. Assume 98% of Medi-Cal claims submitted are paid.
5. The estimated costs for FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$2,506	\$1,253	\$1,253
FY 2019-20	\$2,506	\$1,253	\$1,253

Funding:

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

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 129
 IMPLEMENTATION DATE: 8/2013
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1784

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 AB 119 (Chapter 17, Statutes of 2015)
 SB 833 (Chapter 30, Statutes of 2016)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1762 (Chapter 230, Statutes of 2003) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA and ICF-DDs fees collected are deposited into the fund, rather than the state GF, which are used for LTC provider reimbursement rate expenditures.

**LONG TERM CARE QUALITY ASSURANCE FUND
EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 129**

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and Quality and Accountability Supplemental Payments (QASP) Program through July 31, 2020. Beginning rate-year 2015-16, the annual weighted average rate increase is 3.62%. Further, the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure to the QASP Program.

SB 833 established a continuous appropriation for the LTCQAF, to allow moneys from the fund to be appropriated without further legislative action.

A withhold process was applied to collections for the AB 1629 QAF assessed on Skilled Nursing Facilities and the QAF assessed on ICF-DDs. The withheld portion is transferred to the LTCQAF, and subsequently to the GF, providing savings once the transfer occurs. The withheld QAF payments are budgeted in the QAF Withhold Transfer policy change.

Reason for Change:

The change for FY 2018-19, from the prior estimate, and the change from FY 2018-19 to FY 2019-20, in the current estimate, is due to updated actual collections and transfer data through August 2018. Additionally, FY 2018-19 includes the QAF withhold transfers for prior years.

Methodology:

1. Based on LTC QA fee collection data from July 2016 through June 2018, the average annual LTC QA fee revenue on a cash basis is \$477,993,000. Based on four years of FFS utilization data, the average growth rate for ICF-DDs and nursing facilities is 1.88% and 2.00%, respectively.
2. Based on collections and transfer data through August 2018, assume \$593.02 million will be transferred to the GF in FY 2018-19, and \$503.27 million in FY 2019-20.
3. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs for prior years is \$306.74 million. These transfers are expected to occur in FY 2018-19.

**LONG TERM CARE QUALITY ASSURANCE FUND
EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 129**

4. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

FY 2018-19	TF	GF	LTCQAF
FY 2016-17	\$0	(\$124,754)	\$124,754
FY 2017-18	\$0	(\$110,257)	\$110,257
FY 2018-19	\$0	(\$358,008)	\$358,008
Subtotal	\$0	(\$593,019)	\$593,019
Withhold Transfers	\$0	(\$306,740)	\$306,740
Total	\$0	(\$899,759)	\$899,759

(Dollars in Thousands)

FY 2019-20	TF	GF	LTCQAF
FY 2016-17	\$0	(\$6,413)	\$6,413
FY 2017-18	\$0	(\$5,668)	\$5,668
FY 2018-19	\$0	(\$126,043)	\$126,043
FY 2019-20	\$0	(\$365,144)	\$365,144
Total	\$0	(\$503,268)	\$503,268

Funding:

Long Term Care Quality Assurance Fund (4260-601-3213)
100% GF (4260-101-0001)

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 130
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1161

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$384,598,010	-\$421,868,360
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$384,598,010	-\$421,868,360
FEDERAL FUNDS	\$384,598,010	\$421,868,360

DESCRIPTION

Purpose:

This policy change estimates the technical adjustment in funding to reimburse Designated Public Hospitals (DPHs) at 100% federal financial participation (FFP).

Authority:

SPA 05-21

Interdependent Policy Changes:

DPH Interim Rate Growth

Background:

As approved on April 25, 2006 through SPA 05-21, effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The Medi-Cal Estimate FFS base expenditures are calculated at 50% FFP and 50% GF. Since the DPH interim rate receives a 100% FFP, an adjustment to shift from 50% GF to 100% FFP is made.

In addition, the Medi-Cal Estimate makes funding adjustments to inpatient services for the applicable Federal Medical Assistance Percentage (FMAP) for the Affordable Care Act (ACA) optional population. As a result, this policy change will also make adjustments for the ACA optional population to shift from 5% GF / 95% FFP to 100% FFP beginning January 2017 through December 2017, 6% GF / 94% FFP to 100% FFP beginning January 2018 through December 2018, 7% GF / 93% FFP to 100% FFP beginning January 2019, and 10% GF / 90% FFP to 100% FFP beginning January 2020.

DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 130

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to updated DPH actual data through July 2018.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the increased growth rate for community-based DPHs by 4.29%, and by 6.21% for county DPHs in FY 2019-20 based on updated DPH actual data through July 2018.

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)

	Expenditures	GF to FF Shift
FY 2018-19	\$1,316,279	\$384,598
FY 2019-20	\$1,402,340	\$421,868

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$687,448)	(\$343,724)	(\$343,724)
100% Title XIX FF (4260-101-0890)	\$1,316,279	\$0	\$1,316,279
94% Title XIX ACA / 6% GF (4260-101-0890 / 0001)	(\$314,416)	(\$18,865)	(\$295,551)
93% Title XIX ACA / 7% GF (4260-101-0890 / 0001)	(\$314,415)	(\$22,009)	(\$292,406)
Total Funds	\$0	(\$384,598)	\$384,598

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$729,324)	(\$364,662)	(\$364,662)
100% Title XIX FF (4260-101-0890)	\$1,402,340	\$0	\$1,402,340
93% Title XIX ACA / 7% GF (4260-101-0890 / 0001)	(\$336,508)	(\$23,555)	(\$312,953)
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$336,508)	(\$33,651)	(\$302,857)
Total Funds	\$0	(\$421,868)	\$421,868

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 131
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1580

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$194,418,000	-\$194,418,000
- STATE FUNDS	-\$97,209,000	-\$97,209,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	92.83 %	92.83 %
APPLIED TO BASE		
TOTAL FUNDS	-\$13,939,800	-\$13,939,800
STATE FUNDS	-\$6,969,880	-\$6,969,880
FEDERAL FUNDS	-\$6,969,890	-\$6,969,890

DESCRIPTION

Purpose:

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

Authority:

AB 1183 (Chapter 758, Statutes of 2008)
 AB 97 (Chapter 3, Statutes of 2011)
 SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:

Funding Adjust.—OTLICP

Background:

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

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

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 131

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

Reason for Change:

The change for FY 2018-19, from the prior estimate, is a decrease due to a decrease in the monthly Pharmacy recoupment amounts, resulting in an extended recoupment schedule. There is no change, in the current estimate, from FY 2018-19 to FY 2019-20.

Methodology:

1. **Managed Care:** There are no retroactive savings for managed care payments recouped and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes and will take place on a prospective basis. The following services are not subject to a reduction:
 - Pharmacy, and
 - Specialty physician services.
2. **FFS:** The Department implements the FFS payment reductions in three phases.
 - **Phase I:** Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.
 - PDHC program was first exempted on October 25, 2012, from the 10% payment reduction, effective April 1, 2012. PDHC providers were refunded in July 2013 for the payment reduction for services provided after April 1, 2012. In October 2014, PDHC providers were exempted further for the period of June 1, 2011 to March 31, 2012 and refunded any payment reductions applied for this period.
 - The Department received CMS approval on August 28, 2013 to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department stopped the 10% payment reduction in November 2013 and refunded the payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.
 - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
 - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.
 - **Phase II:** Phase II includes all the previously enjoined providers.
 - DME/Medical Supplies payment reduction recoupment for dates of service from June 1, 2011 to October 24, 2013.
 - Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 are exempt from the 10% payment reduction effective August 31, 2013.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 131

- For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 are exempt from the 10% payment reduction effective December 1, 2013.
- Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions are exempt from the 10% payment reduction effective March 31, 2012.
- The 10% payment reduction for dental providers was implemented September 2013. Effective July 1, 2015, SB 75 (Chapter 18, Statutes of 2015) exempts dental providers from the 10% payment reductions.
- Per Welfare and Institutions (W&I) Code, Section 14105.45(i), FFS prospective pharmacy provider reductions for drug products with dates of services on and after April 1, 2017 were discontinued as a result of the Department moving to an actual acquisition cost (AAC) and dispensing fee reimbursement methodology.

Non-drug pharmacy products, not exempt from AB 97, will continue to be reduced by 10%.

Annual Prospective Pharmacy Savings	TF
Pharmacy drug products (restored effective April 2017)	(\$22,577,000)
Pharmacy non-drug products (prospective reductions shown in PC 137)	(\$8,551,000)
Total prospective Pharmacy reductions	(\$31,128,000)

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

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	9/1/2017	63
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	3/1/2016	58
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 131

4. The estimated savings (TF) from AB 97 payment reduction are:
(Dollars in Thousands)

Provider Type		FY 2018-19	FY 2019-20	Annual
Phase I	FFS	(\$46,823)	(\$46,823)	(\$46,823)
	FFS Retro	\$0	\$0	\$0
	Phase I Total	(\$46,823)	(\$46,823)	(\$46,823)
Phase II				
Physicians	FFS	(\$49,746)	(\$49,746)	(\$49,746)
	FFS Retro	\$0	\$0	\$0
Medical Transportation	FFS	(\$14,461)	(\$14,461)	(\$14,461)
	FFS Retro	\$0	\$0	\$0
DME/Medical Supplies	FFS	(\$17,394)	(\$17,394)	(\$17,394)
	FFS Retro	(\$7,510)	(\$7,510)	(\$7,510)
Dental	FFS	\$0	\$0	\$0
	FFS Retro	\$0	\$0	\$0
Clinics	FFS	(\$18,512)	(\$18,512)	(\$18,512)
	FFS Retro	\$0	\$0	\$0
Pharmacy	FFS	(\$31,128)	(\$31,128)	(\$31,128)
	FFS Retro	(\$6,430)	(\$6,430)	(\$6,430)
	FFS	(\$131,241)	(\$131,241)	(\$131,241)
	FFS Retro	(\$13,940)	(\$13,940)	(\$13,940)
	Phase II Total	(\$145,181)	(\$145,181)	(\$145,181)
Phase III (CHDP)	FFS	(\$2,414)	(\$2,414)	(\$2,414)
	FFS Retro	\$0	\$0	\$0
	Phase III Total	(\$2,414)	(\$2,414)	(\$2,414)
	FFS	(\$180,478)	(\$180,478)	(\$180,478)
	FFS Retro	(\$13,940)	(\$13,940)	(\$13,940)
	Managed Care	\$0	\$0	\$0
Grand Total	Grand Total	(\$194,418)	(\$194,418)	(\$194,418)

Funding:

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

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 132
 IMPLEMENTATION DATE: 2/2016
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1703

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$30,452,000	-\$12,295,000
- STATE FUNDS	-\$15,226,000	-\$6,147,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	38.89 %	54.29 %
APPLIED TO BASE		
TOTAL FUNDS	-\$18,609,200	-\$5,620,000
STATE FUNDS	-\$9,304,610	-\$2,810,020
FEDERAL FUNDS	-\$9,304,610	-\$2,810,020

DESCRIPTION

Purpose:

This policy change estimates savings from a 10% payment reduction to clinical laboratories or laboratory services, and the savings from a new reimbursement methodology for these services.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 AB 1494 (Chapter 28, Statutes of 2012)
 AB 1124 (Chapter 8, Statutes of 2014)
 AB 659 (Chapter 346, Statutes of 2017)

Interdependent Policy Changes:

Funding Adjust.—ACA Opt. Expansion
 Funding Adjust.—OTLICP

Background:

AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allowed for payments to be reduced by 10% for clinical laboratories or laboratory services for dates of service on and after July 1, 2012, through June 30, 2015. The Family Planning, Access, Care, and Treatment Program (FPACT) and outpatient hospital services were exempt from the 10% provider payment reductions per AB 1494. Effective July 1, 2015, the new reimbursement methodology is applicable to certain clinical laboratory or laboratory service codes, which may include FPACT and outpatient hospital services. AB 659 changed the frequency of data collection and rate development from once a year to once every three years, with the new rates being effective July 1, 2020.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase in savings due to delayed implementation of the 2015-16 rate year (RY) retroactive recoupment from May 2018 to June 2018, resulting in a one month shift in savings from FY 2017-18 to FY 2018-19.

LABORATORY RATE METHODOLOGY CHANGE**REGULAR POLICY CHANGE NUMBER: 132**

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease in savings due to the expected completion of the RY 2015-16 retroactive recoupments in FY 2018-19.

Methodology:

1. Assume savings will begin upon California Medicaid Management Information System (CA-MMIS) system implementation.
2. The AB 97 10% payment reduction will be assessed after the AB 1494 10% payment reduction and new laboratory rate methodology reduction.
3. The revised total for the retroactive AB 1494 10% savings from July 1, 2012 to June 30, 2015, is estimated to be \$28,098,000 TF and is expected to be recovered over 60 months beginning May 2018.
4. The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015.
5. The 2015-16 rate year change was implemented in February 2016 and has been captured in the FFS base trends. The recoupment of retroactive savings from July 2015 through January 2016 is expected to be completed over 12 months beginning June 2018.
6. Effective July 1, 2016, the laboratory rate change savings is projected to be \$6,641,000 TF for the 2016-17 rate year and was implemented in February 2017. The recoupment of retroactive savings from July 2016 through January 2017 is expected to be completed over 12 months beginning December 2017.
7. Effective July 1, 2017, the laboratory rate change savings is projected to be \$34,000 TF for the 2017-18 rate year and was implemented on September 25, 2017. The recoupment of retroactive savings from July 2017 to September 2017 was completed in FY 2017-18.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
New Rate Methodology Savings	(\$6,675)	(\$3,337)	(\$3,338)
AB 1494 Retro Savings	(\$5,620)	(\$2,810)	(\$2,810)
New Rate Methodology Retro Savings	(\$18,157)	(\$9,079)	(\$9,078)
Total	(\$30,452)	(\$15,226)	(\$15,226)

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
New Rate Methodology Savings	(\$6,675)	(\$3,337)	(\$3,338)
AB 1494 Retro Savings	(\$5,620)	(\$2,810)	(\$2,810)
Total	(\$12,295)	(\$6,147)	(\$6,148)

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 133
 IMPLEMENTATION DATE: 8/2015
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$56,863,000	-\$48,923,000
- STATE FUNDS	-\$28,431,500	-\$24,461,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	39.78 %	46.24 %
APPLIED TO BASE		
TOTAL FUNDS	-\$34,242,900	-\$26,301,000
STATE FUNDS	-\$17,121,450	-\$13,150,500
FEDERAL FUNDS	-\$17,121,450	-\$13,150,500

DESCRIPTION

Purpose:

This policy change estimates savings due to the implementation of a reduction to radiology reimbursement rates.

Authority:

SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:

Funding Adjust.—ACA Opt. Expansion

Funding Adjust.—OTLICP

Background:

SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. The Department submitted a State Plan Amendment (SPA) to reduce these rates below 80% of Medicare levels; however, due to a delay in federal approval, it was determined that a two-year retroactive application of this reduction could adversely impact beneficiary access to radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that federal approval of a reduction with a lengthy retroactive recoupment was extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010, to October 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) requires SPA approval for all rate reductions. On June 2, 2017, SPA 17-014 was submitted to the CMS and is expected to be approved in November 2018.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease in savings due to:

- Delayed implementation of the retroactive recoupment for the October 2015 rate adjustments, from August 2018 to December 2018,
- Delayed implementation of the prospective and retroactive recoupments for the April 2017 rate adjustments, and

REDUCTION TO RADIOLOGY RATES**REGULAR POLICY CHANGE NUMBER: 133**

- The removal of the January 2018 rate adjustments.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease in savings due to seven months of the October 2015 retroactive recoupment occurring in FY 2018-19 compared to five months in FY 2019-20.

Methodology:

1. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of Medicare rates.
2. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.
3. The rate adjustments effective October 1, 2015, reflect an annual FFS savings of \$22,620,000 TF. These rates were implemented on April 23, 2018.

The total recoupment of retroactive savings from October 1, 2015, through April 22, 2018, is estimated to be \$58,435,000 TF and is expected to be implemented in December 2018 over 12 months.

4. The rate adjustments effective April 1, 2017, reflect an annual FFS savings of \$623,000 TF. These rates are expected to be implemented in April 2019.

The total recoupment of retroactive savings from April 1, 2017, through March 31, 2019, is estimated to be \$1,453,000 TF and is expected to be implemented in August 2019 over 12 months.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Prospective Savings	(\$22,776)	(\$11,388)	(\$11,388)
Recoupment of Retro Savings	(\$34,087)	(\$17,044)	(\$17,043)
Total	(\$56,863)	(\$28,432)	(\$28,431)

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Prospective Savings	(\$23,243)	(\$11,622)	(\$11,621)
Recoupment of Retro Savings	(\$25,680)	(\$12,840)	(\$12,840)
Total	(\$48,923)	(\$24,462)	(\$24,461)

Funding:

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

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 134
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1475

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$6,261,304,000	\$4,444,161,000
- STATE FUNDS	\$3,722,541,000	\$2,041,168,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,261,304,000	\$4,444,161,000
STATE FUNDS	\$3,722,541,000	\$2,041,168,000
FEDERAL FUNDS	\$2,538,763,000	\$2,402,993,000

DESCRIPTION

Purpose:

This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (QAF) program.

Refer to the Hospital QAF – Managed Care Payments policy change for the managed care hospital QAF payments.

Authority:

AB 1383 (Chapter 627, Statutes of 2009)
 AB 188 (Chapter 645, Statutes of 2009)
 AB 1653 (Chapter 218, Statutes of 2010)
 SB 90 (Chapter 19, Statutes of 2011)
 SB 335 (Chapter 286, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)
 SB 920 (Chapter 452, Statutes of 2012)
 SB 239 (Chapter 657, Statutes of 2013)
 AB 1607 (Chapter 27, Statutes of 2016)
 Proposition 52 (2016)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1383 authorized the implementation of a QAF on applicable general acute care hospitals for the period of April 1, 2009, through December 31, 2010. This QAF program period is referred to as QAF I.

SB 90 extended the Hospital QAF program for the period January 1, 2011, through June 30, 2011, based on a modified amount of payments to hospitals and an increased amount for children's health care coverage. This QAF program period is referred to as QAF II.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 134

SB 335 extended the Hospital QAF program from July 1, 2011, through December 31, 2013. This QAF program period is referred to as QAF III.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This QAF program period is referred to as QAF IV. SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to:

- Shifting QAF IV Designated Public Hospital (DPH) grants to FY 2018-19,
- Adding a QAF IV additional grant payment for DPHs and non-designated public hospitals (NDPHs),
- Adding a QAF IV FFS reconciliation payment for Cycles 1 through 9,
- Shifting one quarter of FY 2015-16 UPL overage and two quarters of FY 2016-17 UPL overage from FY 2017-18 to FY 2018-19,
- Adding a FY 2013-14 through FY 2015-16 UPL overage payment,
- Updating ACA amounts for FY 2016-17 and FY 2017-18 based on more current data,
- Adding QAF V FFS reconciliation payment for Cycles 1 and 2, and
- Adding subacute payments approved under State Plan Amendment (SPA) 18-012.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to:

- A QAF IV reconciliation payment occurring in FY 2018-19,
- An additional ACA payment in FY 2018-19, and
- Additional cycle payments occurring in FY 2018-19.

Methodology:

QAF IV-QAF VI

1. SB 239 extended the QAF for 36-months from January 1, 2014, through December 31, 2016 (QAF IV). Subsequently, AB 1607 extended the program for a one-year period from January 1, 2017, to December 31, 2018. Furthermore, Proposition 52 permanently extends the Hospital QAF program. The Hospital QAF V program period covers the 30-month period from January 1, 2017, through June 30, 2019 (QAF V).
2. Assume the Hospital QAF VI program periods covers a 30-month period from July 1, 2019, through December 31, 2021.
3. The first QAF IV FFS payment was made in March 2015. This includes Designated Public Hospital and NDPH grant amounts.
4. Payments associated with QAF V were approved by CMS in December 2017.
5. Due to implementation delays, QAF V FFS payments began in February 2018.

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 134

6. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. The FFS ACA payments for FY 2013-14 and FY 2014-15 were claimed in December 2017 and deposited in Fund 3158. These funds will be used to pay back CMS for the QAF IV UPL overage for FY 2013-14 through FY 2016-17. In FY 2018-19, FFS ACA payments for the remaining two quarters of FY 2016-17 and FY 2017-18 will be claimed. In FY 2019-20, FFS ACA payments for FY 2018-19 will be claimed. The Hospital Quality Assurance Revenue Fund will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.
7. A final program reconciliation for QAF IV payments for Cycles 1 through 9 was paid in September 2018. These cycles are outside of the two-year claiming limit, which will result in an additional UPL overage for FY 2016-17. This UPL overage will be paid back to CMS using excess fees in Fund 3158.
8. Subacute payments for affected hospitals approved under SPA 18-012 are added in FY 2018-19 and FY 2019-20.
9. QAF V reconciliations for FY 2016-17 and FY 2017-18 are planned in FY 2018-19 and FY 2019-20.
10. Preliminary models for FY 2019-20 were developed for the QAF VI program period. To arrive at the projected amounts for FY 2019-20, a preliminary retrospective review was done on the FY 2018-19 inpatient UPL and trended to FY 2019-20. The same inpatient trend from FY 2018-19 to FY 2019-20 was applied on the FY 2018-19 outpatient UPL. The preliminary models take into consideration known supplemental payment changes and the QAF IV subacute adjustment, but does not account for potential rollover of fees from prior program periods or actual FY 2018-19 UPL overages.
11. On a cash basis, the estimated QAF IV-QAF VI payments are:

HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 134

(Dollars in Thousands)

FY 2018-19	TF	SF(HQARF)	FF	ACA FF	*Return to Fund 3158
QAF IV					
FY 2015-16	\$2,019	\$2,019	\$0	\$0	\$0
FY 2016-17	\$20,205	\$20,205	\$0	\$0	\$0
QAF IV Reconciliation	\$847,676	\$429,851	\$417,825	\$0	\$0
FY 2015-16 UPL Overage	\$0	\$174,699	(\$94,267)	(\$80,432)	\$0
FY 2016-17 UPL Overage	\$0	\$391,429	(\$228,811)	(\$162,618)	\$0
FY 2013-14 through FY 2015-16 UPL Overage	\$0	\$321,106	(\$249,740)	(\$71,366)	\$0
QAF V					
FY 2016-17 ACA	\$243,513	\$0	(\$270,571)	\$514,084	\$243,513
FY 2017-18 ACA	\$510,017	\$0	(\$573,251)	\$1,083,268	\$510,017
FY 2016-17 Reconciliation	\$268,408	\$137,224	\$131,184	\$0	\$0
FY 2017-18	\$989,470	\$512,585	\$476,885	\$0	\$0
FY 2018-19	\$3,379,996	\$1,733,423	\$1,646,573	\$0	\$0
Total FY 2018-19	\$6,261,304	\$3,722,541	\$1,255,827	\$1,282,936	\$753,530

(Dollars in Thousands)

FY 2019-20	TF	SF(HQARF)	FF	ACA FF	*Return to Fund 3158
QAF V					
FY 2018-19 ACA	\$520,000	\$0	(\$597,780)	\$1,117,780	\$520,000
FY 2017-18 Reconciliation	\$498,997	\$270,686	\$228,311	\$0	
FY 2018-19	\$1,126,666	\$577,808	\$548,858	\$0	\$0
QAF VI					
FY 2019-20	\$2,298,498	\$1,192,674	\$1,105,824	\$0	\$0
Total FY 2019-20	\$4,444,161	\$2,041,168	\$1,285,213	\$1,117,780	\$520,000

*The Return to Fund 3158 column is for display purposes only (see QAF IV-QAF VI Methodology #6).

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135
 IMPLEMENTATION DATE: 3/2015
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1761

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,746,122,000	\$1,897,400,000
- STATE FUNDS	\$1,167,438,000	\$589,407,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,746,122,000	\$1,897,400,000
STATE FUNDS	\$1,167,438,000	\$589,407,000
FEDERAL FUNDS	\$2,578,684,000	\$1,307,993,000

DESCRIPTION

Purpose:

This policy change estimates the Managed Care payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

Refer to the Hospital QAF – FFS Payments policy change for the fee-for-service (FFS) hospital QAF payments.

Authority:

SB 239 (Chapter 657, Statutes of 2013)
 AB 1607 (Chapter 27, Statutes of 2016)
 Proposition 52 (2016)

Interdependent Policy Changes:

Not Applicable

Background:

SB 335 extended the Hospital QAF program from July 1, 2011, through December 31, 2013. This QAF program period is referred to as QAF III.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This QAF program period is referred to as QAF IV. SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V. The QAF V model was approved by CMS in December 2017.

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a cost shift of the HQAF V FY 2018-19 rating period payments to FY 2019-20. In addition, the funding splits have been updated based on more recent payment data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to 18 months of HQAF V payments occurring in FY 2018-19 (January 2017 through July 2018), while only 12 months of HQAF V payments are anticipated to occur in FY 2019-20 (June 2018 through July 2019).

Methodology:

- HQAF V payments for January 1, 2017 through June 30, 2017, rating period and FY 2017-18 rating period are anticipated to occur in FY 2018-19.
- HQAF V payments for FY 2018-19 rating period are anticipated to occur in FY 2019-20.
- Increased capitation payments under Section 14165.58 are the actuarial equivalent to AB 113 (Chapter 20, Statutes of 2011) payments made to Non-Designated Public Hospitals (NDPHs). The Department will collect from NDPHs based on the IGTs in the below table.
- The following calculations are based on the approved fee model pending actuarially approved PMPMs and are subject to change, for the following rating periods:
 - January 1, 2017, to June 30, 2017
 - FY 2017-18
 - FY 2018-19
- On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2018-19	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
FY 2016-17	\$1,800,022	\$556,710	\$450,171	\$61,252	\$731,889
FY 2017-18	\$1,800,000	\$565,087	\$454,586	\$61,852	\$718,475
Total MC	\$3,600,022	\$1,121,797	\$904,757	\$123,104	\$1,450,364
NDPH IGT					
FY 2016-17	\$48,700	\$15,063	\$12,179	\$1,657	\$19,801
FY 2017-18	\$97,400	\$30,578	\$24,598	\$3,347	\$38,877
Total NDPH IGT	\$146,100	\$45,641	\$36,777	\$5,004	\$58,678
Total FY 2018-19	\$3,746,122	\$1,167,438	\$941,534	\$128,108	\$1,509,042

(Dollars in Thousands)

FY 2019-20	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF
Managed Care					
FY 2018-19	\$1,800,000	\$559,150	\$441,077	\$60,014	\$739,759
Total MC	\$1,800,000	\$559,150	\$441,077	\$60,014	\$739,759
NDPH IGT					
FY 2018-19	\$97,400	\$30,257	\$23,867	\$3,247	\$40,029
Total NDPH IGT	\$97,400	\$30,257	\$23,867	\$3,247	\$40,029
Total FY 2019-20	\$1,897,400	\$589,407	\$464,944	\$63,261	\$779,788

HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

Title XXI FFP (4260-611-0890)

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 12/2018
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 2024

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$894,195,000	\$377,133,000
- STATE FUNDS	\$337,051,000	\$144,976,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$894,195,000	\$377,133,000
STATE FUNDS	\$337,051,000	\$144,976,000
FEDERAL FUNDS	\$557,144,000	\$232,157,000

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:

Managed Care IGT Admin. & Processing Fee

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.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 136

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:

- 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. The 5% administrative fee will be assessed in addition to the IGT funding the nonfederal share of the cost. The IGT savings will be budgeted in the Managed Care IGT Admin. & Processing Fee policy change.

The Department submitted SPA 17-009 to CMS in March 2017 with a January 1, 2017 effective date. CMS approval of SPA 17-009 is anticipated in the second quarter of FY 2018-19.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- Updated payment methodology calculations which reduced the annual total computable estimate,
- Updated FY 2016-17 payments based on the revised annual estimate,
- Updated FY 2017-18 and FY 2018-19 payments which are determined by applying the Consumer Price Index (CPI) growth rate to the prior year's payments, and
- Inclusion of FY 2018-19 interim payments.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to retroactive payment years budgeted in FY 2018-19.

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 a distribution of approximately \$345.1 million total computable annually. Per SPA 17-009, beginning with FY 2017-18, the annual distribution amounts are adjusted based on the CPI.
 - FY 2016-17 payments are effective January 1, 2017 and will be the total of two quarters of the estimated annual or \$172.6 million TF.
 - Assume a 3% CPI annual increase for FY 2017-18, FY 2018-19, and FY 2019-20, which is estimated to provide \$355.5 million TF for FY 2017-18, \$366.1 million TF for FY 2018-19, and \$377.1 million TF for FY 2019-20 in annual total computable payments.

GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 136

4. Payments will be made on a lump-sum quarterly basis throughout the fiscal year and will not be paid as individual increases to current reimbursement rates for specific services.
5. The IGTs referenced in this policy change are not the basis for the 5% administrative fee for GME supplemental payments. The administrative fees are reflected in the Managed Care IGT Admin & Processing Fee policy change and will be 5% of the aggregate nonfederal share that is calculated at 50% FMAP of the Total Funds reflected in this policy change.
6. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar year 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP reduces to 95%, 94% beginning January 1, 2018, 93% beginning January 1, 2019, and 90% beginning January 1, 2020. The ACA reimbursement methodology is pending submission to CMS.
7. Assume ACA payments will begin in April 2019 for retroactive years and subsequent (current) quarters will coincide with the quarterly interim payments. The Medi-Cal Managed Care eligibility data from the most recent available cost reports will be used to determine the proportion of costs for newly eligible Medi-Cal beneficiaries.
8. Assume an effective date of January 1, 2017, pending CMS approval of SPA 17-009.
9. Assume the two quarters of FY 2016-17 will be paid in FY 2018-19.
10. Assume all four quarters of FY 2017-18 will be paid in FY 2018-19.
11. Assume all four quarters of FY 2018-19 will be paid in FY 2018-19.
12. Assume all four quarters of FY 2019-20 will be paid in FY 2019-20.

(Dollars in Thousands)

FY 2018-19	TF	IGT	FF	ACA FF
FY 2016-17	\$172,564	\$64,654	\$62,251	\$45,659
FY 2017-18	\$355,483	\$133,683	\$128,238	\$93,562
FY 2018-19	\$366,148	\$138,714	\$132,085	\$95,349
Total	\$894,195	\$337,051	\$322,574	\$234,570

(Dollars in Thousands)

FY 2019-20	TF	IGT	FF	ACA FF
FY 2019-20	\$377,133	\$144,976	\$136,048	\$96,109
Total	\$377,133	\$144,976	\$136,048	\$96,109

Funding:

Title XIX FFP (4260-101-0890)

DPH Graduate Medical Education Special Fund (4260-601-8113)

Title XIX ACA (4260-101-0890)

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137
 IMPLEMENTATION DATE: 1/2018
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 2048

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,311,240,000	\$1,399,061,000
- STATE FUNDS	\$412,872,040	\$459,453,880
PAYMENT LAG	0.9910	0.9915
% REFLECTED IN BASE	1.86 %	1.74 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,275,269,300	\$1,363,032,200
STATE FUNDS	\$401,545,890	\$447,621,970
FEDERAL FUNDS	\$873,723,390	\$915,410,270

DESCRIPTION

Purpose:

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

Authority:

AB 120 (Chapter 22, Statutes of 2017)
 Title 42, Code of Federal Regulations (CFR) 447(f)
 State Plan Amendment (SPA) 17-030
 SPA 18-0033
 SB 856 (Chapter 30, Statutes of 2018)

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 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 AB 120, the Department shall develop the structure of the supplemental payments. AB 120 includes up to \$325 million Proposition 56 funds for supplemental payments to new patient and established patient office/outpatient visits, psychiatric diagnostic evaluations, psychiatric diagnostic evaluations with medical services, and psychiatric pharmacological management services.

Pursuant to SB 856, the Department shall develop the structure and parameters for supplemental provider payments for physician services of up to \$500 million Proposition 56 funds in 2018-19.

**PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 137

The Department has proposed supplemental payments for physician services in both Medi-Cal Fee-for-Service (FFS) and Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for the following Current Procedural Terminology (CPT) codes will receive the associated supplemental payment identified, in addition to any other payment they receive from the State in FFS or from the health plan as a network provider in managed care.

The following are the CPT codes and supplemental payments, effective July 1, 2018:

CPT Code	Supplemental Payment	CPT Code	Supplemental Payment
99201	\$18.00	90863	\$5.00
99202	\$35.00	99381	\$77.00
99203	\$43.00	99382	\$80.00
99204	\$83.00	99383	\$77.00
99205	\$107.00	99384	\$83.00
99211	\$10.00	99385	\$30.00
99212	\$23.00	99391	\$75.00
99213	\$44.00	99392	\$79.00
99214	\$62.00	99393	\$72.00
99215	\$76.00	99394	\$72.00
90791	\$35.00	99395	\$27.00
90792	\$35.00		

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-030 for the FY 2017-18 FFS supplemental payments, and SPA 18-0033 for the FY 2018-19 FFS supplemental payments. For the managed care delivery system, the Department has obtained approval of an allowable directed plan for the managed care supplemental payments for FY 2017-18 and FY 2018-19. It is anticipated that the supplemental payments will continue in FY 2019-20 for FFS and managed care.

Managed Care Physician Directed Payments

CMS instituted the Medicaid Managed Care Final Rule in May 2016, which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems, 42 CFR section 438.6(c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments. The Department received federal approval to implement managed care capitation rate increases to fund MCPs to make supplemental payments for 13 CPT codes for FY 2017-18 and 23 CPT codes for FY 2018-19.

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for the above referenced CPT codes upon approval from CMS and receipt of funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data for rating period FY 2017-18 and FY 2018-19.

**PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 137

Reason for Change:

The change for FY 2018-19, from the prior estimate, is an increase due to updated utilization and the addition of 10 CPT codes that will receive the supplemental payment.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to increased FFS and managed care costs and the addition of the 2019-20 supplemental payments.

Methodology:

1. Payments will be made via supplemental payments.
2. This policy is effective July 1, 2017, and payments began in December 2017.

FFS Physician Supplemental Payments

3. Assume the FFS supplemental payments, on an accrual basis, are approximately \$24,198,000 TF for FY 2017-18, and approximately \$102,281,000 TF in FY 2018-19 and ongoing.
4. The FY 2017-18 FFS supplemental payments were implemented on December 5, 2017. These supplemental payments continued until September 23, 2018, when they were replaced by the new FY 2018-19 supplemental amounts.
5. The FY 2018-19 FFS supplemental payments were implemented on September 24, 2018. The EPC for the retroactive period of July 1, 2018, through September 23, 2018, was implemented on October 26, 2018.
6. Assume the FY 2019-20 FFS supplemental payments will be implemented in November 2019. The EPC for the retroactive period of July 2019 through October 2019 is expected to be implemented by March 2020.

Managed Care Physician Directed Payments

7. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on an accrual basis, is \$373,287,000 TF for FY 2017-18, and \$1,284,929,000 TF in FY 2018-19 and ongoing.
8. A risked-based capitation rate will be issued to MCPs based on anticipated utilization of the 23 CPT codes.
9. One month of the FY 2017-18 capitation rate increases and 11 months of the FY 2018-19 capitation rate increases are expected to occur in FY 2018-19.
10. One month of the FY 2018-19 capitation rate increases and 11 months of the FY 2019-20 capitation rate increases are expected to occur in FY 2019-20.

**PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 137

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

FY 2018-19	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts FY 2018-19	\$86,605,000	\$36,819,000	\$2,591,000	\$35,651,000	\$11,544,000
Managed Care Pmts FY 2017-18	\$31,108,000	\$9,449,000	\$1,155,000	\$8,527,000	\$11,977,000
Managed Care Pmts FY 2018-19	\$1,177,851,000	\$359,953,000	\$43,741,000	\$322,849,000	\$451,308,000
Retro FFS Pmts FY 2018-19	\$15,676,000	\$6,651,000	\$469,000	\$6,453,000	\$2,103,000
Total	\$1,311,240,000	\$412,872,000	\$47,956,000	\$373,480,000	\$476,932,000

FY 2019-20	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Pmts FY 2018-19	\$11,851,000	\$5,105,000	\$320,000	\$4,878,000	\$1,548,000
FFS Pmts FY 2019-20	\$81,379,000	\$35,143,000	\$2,155,000	\$33,500,000	\$10,581,000
Managed Care Pmts FY 2018-19	\$107,078,000	\$33,318,000	\$3,826,000	\$29,773,000	\$40,161,000
Managed Care Pmts FY 2019-20	\$1,177,851,000	\$376,969,000	\$38,082,000	\$327,502,000	\$435,298,000
Retro FFS Pmts FY 2019-20	\$20,902,000	\$8,919,000	\$605,000	\$8,604,000	\$2,774,000
Total	\$1,399,061,000	\$459,454,000	\$44,988,000	\$404,257,000	\$490,362,000

PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 137

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX FF / 50% SF (4260-101-3305 / 0890)	\$746,959,000	\$373,480,000	\$373,480,000
94% Title XIX FF / 6% SF (4260-101-3305 / 0890)	\$283,193,000	\$16,992,000	\$266,201,000
93% Title XIX FF / 7% SF (4260-101-3305 / 0890)	\$226,592,000	\$15,861,000	\$210,731,000
88% Title XXI FF / 12% SF (4260-113-0890)	\$54,496,000	\$6,539,000	\$47,956,000
Total	\$1,311,240,000	\$412,872,000	\$898,368,000

FY 2019-20	TF	SF	FF
50% Title XIX FF / 50% SF (4260-101-3305 / 0890)	\$808,514,000	\$404,257,000	\$404,257,000
93% Title XIX FF / 7% SF (4260-101-3305 / 0890)	\$310,434,000	\$21,730,000	\$288,703,000
90% Title XIX FF / 10% SF (4260-101-3305 / 0890)	\$224,065,000	\$22,406,000	\$201,659,000
88% Title XXI FF / 12% SF (4260-101-3305 / 4260-113-0890)	\$18,359,000	\$2,203,000	\$16,156,000
76.5% Title XXI FF / 23.5% SF (4260-101-3305 / 4260-113-0890)	\$37,689,000	\$8,857,000	\$28,832,000
Total	\$1,399,061,000	\$459,454,000	\$939,607,000

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 138
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1071

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$566,597,000	\$598,332,000
- STATE FUNDS	\$283,298,500	\$299,166,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$566,597,000	\$598,332,000
STATE FUNDS	\$283,298,500	\$299,166,000
FEDERAL FUNDS	\$283,298,500	\$299,166,000

DESCRIPTION

Purpose:

This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 SB 90 (Chapter 19, Statutes of 2011)
 SB 335 (Chapter 286, Statutes of 2011)
 HR 2 (2015)
 SPA 05-022
 SPA 16-010
 HR 1892 (2018)

Interdependent Policy Changes:

ACA DSH Reduction

Background:

Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payments under the DSH Replacement Program. These payments are determined using the same formulas and methodology that were previously in effect under the prior DSH methodology for the 2004-05 fiscal year. These payments are distributed to private hospitals along with \$160.00 of the annual DSH allotment. Combined, these payments satisfy the State's payment obligations to private hospitals under the Federal DSH statute.

The Centers for Medicare and Medicaid Services (CMS) approved SPA 16-010 in November 2017, which transfers the authority for DSH replacement payments from the BTR waiver to the California State Plan effective January 1, 2016.

PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 138

The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

The Affordable Care Act (ACA) requires a reduction to the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which postponed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. The private DSH replacement payments are affected by this reduction because, as required by SB 1100, the methodology to determine the DSH replacement payments is dependent on the DSH allotment and its associated payment methodologies. See the ACA DSH Reduction policy change for more information.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- FY 2014-15 payments shifted to FY 2018-19, and
- Updated payment data for FY 2014-15 and FY 2017-18.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to higher FY 2019-20 payments based on the estimated FY 2019-20 DSH allotment.

Methodology:

1. The remaining balance of FY 2016-17 and FY 2017-18 final payments are assumed to be paid in FY 2018-19. The FY 2016-17 remaining payments and recoupments occurring in FY 2018-19 result in a zero dollar impact.
2. The FY 2014-15 remaining payment is assumed to be paid in FY 2018-19. CMS approved the good cause waiver on May 29, 2018 which allowed for additional payments to be made beyond the two-year claiming limit, based on the increased FY 2014-15 final, published federal DSH allotment.
3. The FY 2018-19 estimated DSH allotment assumes a 2% increase over the FY 2017-18 preliminary DSH allotment. The FY 2019-20 estimated DSH allotment assumes a 2% increase over the FY 2018-19 estimated allotment.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2018-19	TF	GF	FF
FY 2014-15	\$614,000	\$307,000	\$307,000
FY 2017-18	\$28,655,000	\$14,327,000	\$14,328,000
FY 2018-19	\$537,328,000	\$268,664,000	\$268,664,000
Total FY 2018-19	\$566,597,000	\$283,298,000	\$283,299,000

FY 2019-20	TF	GF	FF
FY 2018-19	\$48,848,000	\$24,424,000	\$24,424,000
FY 2019-20	\$549,484,000	\$274,742,000	\$274,742,000
Total FY 2019-20	\$598,332,000	\$299,166,000	\$299,166,000

Funding:

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

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 78

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$503,241,000	\$244,740,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$503,241,000	\$244,740,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$503,241,000	\$244,740,000

DESCRIPTION

Purpose:

This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:

AB 915 (Chapter 747, Statutes of 2002)

Interdependent Policy Changes:

Not Applicable

Background:

AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to:

- The addition of FY 2013-14 adjusted ACA claims, FY 2014-15 adjusted payments, and FY 2017-18 Est. Calendar Year Claims;
- Shifting FY 2016-17 Est. Calendar Year claims from FY 2017-18 to FY 2018-19, and updating the amounts based on actuals;
- Revising FY 2016-17 Est. ACA Claims amount with updated claims data;
- Shifting FY 2016-17 Est. Payments from FY 2017-18 to FY 2018-19, and revising the amounts based on updated data; and
- Revising FY 2017-18 Est. Payments and ACA Claims amount with updated claims data, and trends.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 139

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the backlog of retroactive fiscal year payments occurring in FY 2018-19.

Methodology:

1. Payments of \$503,241,000 and \$244,740,000 are expected to be made in FY 2018-19 and FY 2019-20, respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.
2. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2018-19. Additional payments for Service Years 2005-06 and 2006-07 in the estimated amount of \$18,770,000 are expected to be made in FY 2018-19 as a result of the reconciliation.
3. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning calendar year 2017, the ACA allows for the following FMAPs: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and 90% beginning on January 1, 2020.
4. Traditional and ACA claims are processed separately. Payments are based on CPE claims and ACA claims which are adjusted based on the FMAP methodology described above. FY 2016-17 ACA claims are based on actual claims received. FY 2017-18 and 2018-19 ACA claims are estimated based on FY 2016-17 actuals further adjusted by the Consumer Price Index.
5. Estimated costs are as follows:

FY 2018-19	TF	FF	ACA
FY 2005-06 (Final Reconciliation)	\$9,385,000	\$9,385,000	\$0
FY 2006-07 (Final Reconciliation)	\$9,385,000	\$9,385,000	\$0
FY 2013-14 (Adjusted ACA Claims)	\$266,000	\$0	\$266,000
FY 2014-15 (Adjusted Payments)	(\$2,095,000)	(\$2,095,000)	\$0
FY 2016-17 (Est. ACA Claims)	\$111,763,000	\$0	\$111,763,000
FY 2016-17 (Calendar Year Claims)	\$1,117,000	\$1,117,000	\$0
FY 2016-17 (Est. Payments)	\$130,749,000	\$130,749,000	\$0
FY 2017-18 (Est. ACA Claims)	\$108,151,000	\$0	\$108,151,000
FY 2017-18 (Est. Payments)	\$133,887,000	\$133,887,000	\$0
FY 2017-18 (Est. Calendar Year Claims)	\$633,000	\$633,000	
Total FY 2018-19	\$503,241,000	\$283,061,000	\$220,180,000

FY 2019-20	TF	FF	ACA
FY 2017-18 (Est. Calendar Year Claims)	\$633,000	\$633,000	
FY 2018-19 (Est. ACA Claims)	\$107,006,000	\$0	\$107,006,000
FY 2018-19 (Est. Payments)	\$137,101,000	\$137,101,000	\$0
Total FY 2019-20	\$244,740,000	\$137,734,000	\$107,006,000

Funding:

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

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

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 140
 IMPLEMENTATION DATE: 1/2018
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2049

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$510,070,000	\$546,633,000
- STATE FUNDS	\$194,390,970	\$216,623,710
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$510,070,000	\$546,633,000
STATE FUNDS	\$194,390,970	\$216,623,710
FEDERAL FUNDS	\$315,679,030	\$330,009,290

DESCRIPTION

Purpose:

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

Authority:

AB 120 (Chapter 22, Section 3, Item 4260-101-3305, Budget Act of 2017)
 SB 840 (Chapter 29, Section 2, Item 4260-101-3305, Budget Act of 2018)

Interdependent Policy Changes:

Not Applicable

Background:

Effective April 2017, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, increased taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to increase funding for existing health care programs under the Medi-Cal program. AB 120 appropriated from Proposition 56 revenues \$140 million in Proposition 56 funds to provide supplemental payments for specific dental services. These supplemental payments for specific dental categories include restorative, endodontic, prosthodontic, oral and maxillofacial, adjunctive, visits and diagnostic services. For FY 2018-19 and FY 2019-20, the supplemental payment rates for the existing categories remain at a rate equal to 40 percent of the SMA. Effective July 1, 2018, SB 840 appropriated additional funds to allow for the increase in supplemental payments for specific procedures, and expanded supplemental payments for additional procedures.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to updates to the program and updated procedure and expenditure data used to project future years. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to an adjustment to the caseload growth factor.

PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 140

Methodology:

1. Payments are made via supplemental payments.
2. This policy was effective on July 1, 2017. Beginning July 1, 2018, the Department made changes to add additional procedures and is changing the supplemental amount for specific procedures.
3. Supplemental payments are either a percentage of the Dental SMA or a flat rate.
4. Funds allocated for the supplemental payments are as follows:

Funding:

FY 2018-19	TF	SF*	FF
50% Title XIX / 50% GF	\$363,344,000	\$181,672,000	\$181,672,000
ACA 93% FFP/7% GF (2019)	\$45,227,000	\$3,166,000	\$42,061,000
ACA 94% FFP/6% GF (2018)	\$43,780,000	\$2,627,000	\$41,153,000
Title 21 88% FFP/12% GF	\$57,719,000	\$6,926,000	\$50,793,000
Total	\$510,070,000	\$194,391,000	\$315,679,000

FY 2019-20	TF	SF*	FF
50% Title XIX / 50% GF	\$391,294,000	\$195,647,000	\$195,647,000
ACA 93% FFP/7% GF (2019)	\$45,617,000	\$3,193,000	\$42,424,000
ACA 90% FFP/10% GF (2020)	\$45,616,000	\$4,562,000	\$41,054,000
Title 21 88% FFP/12% GF	\$16,026,000	\$1,923,000	\$14,103,000
Title 21 76.5% FFP/ 23.5% GF	\$48,080,000	\$11,299,000	\$36,781,000
Total	\$546,633,000	\$216,624,000	\$330,009,000

*Healthcare Treatment Fund Prop 56

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 141
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1073

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$415,063,000	\$409,669,000
- STATE FUNDS	\$124,143,000	\$114,620,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$415,063,000	\$409,669,000
STATE FUNDS	\$124,143,000	\$114,620,000
FEDERAL FUNDS	\$290,920,000	\$295,049,000

DESCRIPTION

Purpose:

This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 AB 1066 (Chapter 86, Statutes of 2011)
 HR 2 (2015)
 SPA 05-022
 California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
 SB 815 (Chapter 111, Statutes of 2016)
 HR 1892 (2018)

Interdependent Policy Changes:

ACA DSH Reduction

Background:

Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022 and as part of the MH/UCD and BTR, the federal DSH allotment is available to provide funding for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Eligible hospitals are to receive funding through the DSH program in the following manner:

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and non-federal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

Effective July 1, 2015, DPHs, except State Government-operated University of California

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 141

Hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. See the Global Payment Program policy change for more information. State Government-operated University of California Hospitals will continue to receive their allocation of federal DSH payments through CPE and intergovernmental transfer-funded payments for expenditures up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs in this policy change.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund (GF) based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.
- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-022, are allocated a total of \$160.00 from the federal DSH allotment and GF each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the \$160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

AB 1066 amended Welfare & Institutions Code 14166.1 and provides the authority for the Department to implement new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) requires a reduction in the DSH allotments and was previously scheduled to go into effect on October 1, 2013. Instead, HR 2 (2015) was enacted on April 16, 2015, which postponed the reduction until October 1, 2017. HR 1892 (2018) was enacted on February 9, 2018, which further postpones the reduction until October 1, 2019. See the ACA DSH Reduction policy change for more information.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- Updated NDPH DSH allotment estimates for FY 2017-18 and FY 2018-19,
- FY 2011-12 payments and recoupments shifted to FY 2019-20,
- FY 2014-15 payments shifted to FY 2019-20,
- FY 2015-16 payments and recoupments shifted from FY 2017-18,
- FY 2016-17 remaining NDPH payments shifted from FY 2017-18, and
- Increased FY 2017-18 and FY 2018-19 payments based on updated payment data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to:

- FY 2011-12 payments and recoupments shifted from FY 2018-19,
- FY 2014-15 payments shifted from FY 2018-19,
- Increased DPH DSH allotment estimated for FY 2019-20, and
- Varying DSH payment years occurring in FY 2018-19 and FY 2019-20.

Methodology:

1. The FY 2018-19 estimated DSH allotment assumes a 2% increase over FY 2017-18. The FY 2019-20 estimated DSH allotment assumes a 2% increase over the estimated FY 2018-19 allotment. The FY 2018-19 and FY 2019-20 DSH allotments are estimated to be \$1,256,816,972, and \$1,281,953,311, respectively.

DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 141

2. It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2018-19	TF	GF**	FF	IGT*
DSH 2012-13	\$2,265,000	\$0	\$1,558,000	\$707,000
DSH 2015-16	\$5,109,000	\$0	\$309,000	\$4,800,000
DSH 2016-17	\$1,445,000	\$722,000	\$723,000	\$0
DSH 2017-18	\$34,627,000	\$1,154,000	\$24,615,000	\$8,858,000
DSH 2018-19	\$371,617,000	\$14,667,000	\$263,715,000	\$93,235,000
Total FY 2018-19	\$415,063,000	\$16,543,000	\$290,920,000	\$107,600,000

FY 2019-20	TF	GF**	FF	IGT*
DSH 2011-12	(\$5,399,000)	\$0	\$348,000	(\$5,747,000)
DSH 2014-15	\$2,734,000	\$0	\$1,967,000	\$767,000
DSH 2018-19	\$33,783,000	\$1,333,000	\$23,974,000	\$8,476,000
DSH 2019-20	\$378,551,000	\$14,667,000	\$268,760,000	\$95,124,000
Total FY 2019-20	\$409,669,000	\$16,000,000	\$295,049,000	\$98,620,000

Funding:

100% Demonstration DSH Fund (4260-601-7502)

50% Title XIX / 50% MIPA (4260-606-0834/4260-101-0890)*

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

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1085

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$317,899,000	\$297,033,000
- STATE FUNDS	\$137,900,000	\$137,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$317,899,000	\$297,033,000
STATE FUNDS	\$137,900,000	\$137,900,000
FEDERAL FUNDS	\$179,999,000	\$159,133,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
 AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14
 SPA 14-008
 SPA 15-003
 SPA 16-014
 SPA 16-022

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of \$118,400,000 annually from the General Fund (GF) (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100. Due to the inactivation of the Selective Provider

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 142

Contracting Program (SPCP) for private hospitals on July 1, 2013, State Plan Amendments (SPAs) were required to continue the Private Hospital Supplemental Program and secure distributions from the Private Hospital Supplemental Fund.

The Department received SPA approvals from the Centers of Medicare and Medicaid Services (CMS) to continue the Private Hospital Supplemental Program for FY 2013-14 through FY 2017-18. On July 13, 2016, CMS approved SPA 16-014 which allows payments to be made outside of the fourth quarter for each SFY. In addition, CMS approved SPA 16-022 on December 8, 2016, which reduces the IGT payments from Alameda County to St. Rose Hospital. SPA 18-010 will be submitted to CMS for approval in September 2018 to continue the Private Hospital Supplemental Program through June 30, 2019.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to FY 2016-17 Affordable Care Act (ACA) payments shifted from FY 2017-18 and updated ACA claims data for FY 2017-18.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to FY 2018-19 includes FY 2016-17 ACA payments which shifted from FY 2017-18, and a gradual reduction in the ACA Federal Medical Assistance Percentage (FMAP) schedule.

Methodology:

1. The SF includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs. Beginning in FY 2017-18, the SF item will also include ACA adjustments.
2. IGT payments are estimated to be \$39 million TF in FY 2018-19, pending SPA submission to CMS for FY 2018-19. The estimated FY 2019-20 IGTs are based on the Counties' FY 2018-19 commitments but are subject to change.
3. SPA 16-022 was approved on December 8, 2016, and reduced the IGT payments from Alameda County to St. Rose Hospital from \$16 million TF to \$10 million TF in FY 2017-18. In FY 2018-19, assume the IGT payment from Alameda County to St. Rose will increase to \$16 million TF, pending SPA submission.
4. Assume the IGT payments from Alameda County to Children's Hospital and Research Center Oakland will increase from \$3 million TF to \$20 million TF in FY 2018-19, pending SPA submission.
5. The ACA allows for 100% FMAP for calendar years 2014 through 2016. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%. CMS approved the ACA claiming methodology in August 2017.
6. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2016-17 and FY 2017-18 ACA supplemental payments will be claimed in FY 2018-19. FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20.
 - The counties will be reimbursed for the IGTs (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.
 - The Private Hospital Supplemental Fund will be reimbursed for the SF portion (non-federal share) and an adjustment will be made for the federal share processed at the regular 50% FMAP.

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 142

7. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
8. The estimated Private Hospital Supplemental payments and ending balance for FY 2018-19 are shown below:

FY 2018-19 Private Hospital Supplemental Fund Summary	SF
FY 2017-18 Ending Balance	\$27,340,000
Appropriation (GF)	\$118,400,000
2018-19 IGT	\$19,500,000
FY 2017-18 Interest Earned	\$901,000
FY 2016-17 ACA FFP Adjustment to SF	\$20,701,000
FY 2017-18 ACA FFP Adjustment to SF	\$19,417,000
Funds Available	\$206,259,000
Less: FY 2018-19 Cash Expenditures to Hospitals	(\$137,900,000)
Est. FY 2018-19 Remaining Balance	\$68,359,000

(Dollars in Thousands)

FY 2018-19	TF	SF	FF	ACA FF	Return to Fund 3097*	Return to Counties*
FY 2018-19 Cash Expenditures to Hospitals**	\$275,800	\$137,900	\$137,900	\$0	\$0	\$0
FY 2016-17 ACA FF Adjustment to SF***	\$20,701	\$0	(\$21,815)	\$42,516	\$20,701	\$0
FY 2017-18 ACA FF Adjustment to SF***	\$19,417	\$0	(\$21,817)	\$41,234	\$19,417	\$0
FY 2017-18 ACA FF Adjustment to Counties***	\$1,981	\$0	(\$2,225)	\$4,206	\$0	\$1,981
Total	\$317,899	\$137,900	\$92,043	\$87,956	\$40,118	\$1,981

PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 142

9. The estimated Private Hospital Supplemental payments and ending balance for FY 2019-20 are shown below:

FY 2019-20 Private Hospital Supplemental Fund Summary	SF
FY 2018-19 Ending Balance	\$68,359,000
Appropriation (GF)	\$118,400,000
2019-20 IGT	\$19,500,000
Est. FY 2018-19 Interest Earned	\$725,000
FY 2018-19 ACA FFP Adjustment to SF	\$18,981,000
Funds Available	\$225,965,000
Less: FY 2019-20 Cash Expenditures to Hospitals	(\$137,900,000)
Est. FY 2019-20 Remaining Balance	\$88,065,000

(Dollars in Thousands)

FY 2019-20	TF	SF	FF	ACA FF	Return to Fund 3097*	Return to Counties*
FY 2019-20 Cash Expenditures to Hospitals**	\$275,800	\$137,900	\$137,900	\$0	\$0	\$0
FY 2018-19 ACA FF Adjustment to SF***	\$18,981	\$0	(\$21,817)	\$40,798	\$18,981	\$0
FY 2018-19 ACA FF Adjustment to Counties***	\$2,252	\$0	(\$2,589)	\$4,841	\$0	\$2,252
Total	\$297,033	\$137,900	\$113,494	\$45,639	\$18,981	\$2,252

*The Return to Fund 3097 and Return to Counties columns are for display purposes only (see Methodology #6).

Funding:

Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)

50% Title XIX / 50% Private Hospital Supplemental Fund (4260-601-3097/4260-101-0890)**

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

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

100% GF (4260-105-0001)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 143
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1600

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$160,421,000	\$111,637,000
- STATE FUNDS	\$48,666,000	\$41,672,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$160,421,000	\$111,637,000
STATE FUNDS	\$48,666,000	\$41,672,000
FEDERAL FUNDS	\$111,755,000	\$69,965,000

DESCRIPTION

Purpose:

This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:

AB 113 (Chapter 20, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

SPA 16-015 was approved by the Centers for Medicare & Medicaid Services (CMS) on July 20, 2016, to allow for an interim IGT payment in the event that an Upper Payment Limit (UPL) has not been finalized by CMS by April 30th of each State fiscal year.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to:

- Increased UPL estimate for FY 2017-18 and FY 2018-19,
- Shifting FY 2015-16 payments to NDPHs (adjustment), and Children's Services from FY 2017-18 to FY 2018-19 due to pending CMS FY 2015-16 UPL approval,
- Updated FY 2016-17 payments to NDPHs and FY 2016-17 Children's (Est.) with current data,
- Updated FY 2017-18 and FY 2018-19 payments to NDPHs.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to fewer adjustments occurring in FY 2019-20.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 143

Methodology:

1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.
2. FY 2015-16 and FY 2016-17 are currently pending UPL methodology review with CMS. FY 2017-18 and FY 2018-19 UPLs will be subsequently submitted.
3. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, 94% beginning on January 1, 2018, 93% beginning on January 1, 2019, and then 90% beginning on January 1, 2020, for all subsequent years.
4. The FY 2015-16 tentative UPL amount is \$63,151,000 TF and the FY 2016-17 through FY 2019-20 tentative UPL amount is \$111,637,000 TF. The UPL room for FY 2017-18 and FY 2018-19, and FY 2019-20 are estimated using 80 percent of the last approved UPL in FY 2014-15.
5. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. For FY 2015-16, ACA supplemental payments were claimed in FY 2017-18. The FY 2016-17 and FY 2017-18 ACA supplemental payments will be claimed in FY 2018-19, and the FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20. For adjustments from traditional payments, the NDPHs will be reimbursed for the IGT (nonfederal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP.
6. The FY 2015-16 Payments to NDPHs (ACA Adjustment) contains adjustments due to changes in the FY 2015-16 UPL calculation in addition to ACA adjustments.
7. FY 2015-16, FY 2016-17, and FY 2017-18 Children's Services payments have been collected based on the interim payments made for both FYs. Upon receiving approved UPLs, these amounts will be recalculated.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 143

8. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

FY 2018-19	TF	GF*	IGT**	FF	ACA	***Return to NDPHs
FY 2015-16 Adjustment to NDPHs	\$4,621	\$0	\$0	(\$13,841)	\$18,462	\$4,621
FY 2015-16 Children's Services (Est.)	\$1,369	(\$2,209)	\$3,578	\$0	\$0	\$1,369
FY 2016-17 Additional Payment to NDPHs	\$37,336	\$0	\$3,221	\$2,408	\$31,707	\$0
FY 2016-17 Children's Services (Est.)	\$0	(\$3,897)	\$3,897	\$0	\$0	\$0
FY 2017-18 Additional Payment to NDPHs	\$37,337	\$0	\$4,197	\$2,408	\$30,732	\$0
FY 2017-18 Children's Services (Est.)	\$0	(\$3,993)	\$3,993	\$0	\$0	\$0
FY 2017-18 Payments to NDPHs	\$5,458	\$0	\$2,729	\$2,729	\$0	\$0
FY 2018-19 Payments to NDPHs	\$74,300	\$0	\$37,150	\$37,150	\$0	\$0
Total FY 2018-19	\$160,421	(\$10,099)	\$58,765	\$30,854	\$80,901	\$5,990

(Dollars in Thousands)

FY 2019-20	TF	GF*	IGT**	FF	ACA
FY 2018-19 Additional Payment to NDPHs	\$37,337	\$0	\$4,522	\$2,408	\$30,407
FY 2018-19 Children's Services (Est.)	\$0	(\$4,025)	\$4,025	\$0	\$0
FY 2019-20 Payment to NDPHs	\$74,300	\$0	\$37,150	\$37,150	\$0
Total FY 2019-20	\$111,637	(\$4,025)	\$45,697	\$39,558	\$30,407

***The Return to NDPHs column is for display purposes only (see methodology #5).

Funding:

50% Title XIX /50% MIPA (4260-606-0834/4260-101-0890)**

100% GF (4260-101-0001)*

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

100% MIPA (4260-606-0834)

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 144
 IMPLEMENTATION DATE: 5/2008
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1078

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$147,389,000	\$221,505,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$147,389,000	\$221,505,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$147,389,000	\$221,505,000

DESCRIPTION

Purpose:

This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.35
 State Plan Amendment (SPA) 05-023
 SPA 16-020

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2005, pursuant to SPA 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (CMS) in December 2007. CMS approved the "Physician and Non-Physician Practitioner Time Study Implementation Plan" on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 144

SPA 16-020 was approved by CMS on December 6, 2016, which updates the language to reflect the current names of the hospital participants and to account for any future hospital name changes.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- FY 2007-08, FY 2008-09, and FY 2009-10 final reconciliations are delayed and no longer included in the estimate,
- FY 2013-14 and FY 2014-15 final reconciliation and Affordable Care Act (ACA) payments shifted to FY 2019-20,
- FY 2015-16 final reconciliations and ACA payments were updated and shifted to FY 2019-20,
- FY 2016-17 interim reconciliations and interim ACA amounts increased based on updated data and
- FY 2018-19 interim payments have decreased based on updated data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to payments and reconciliations previously scheduled for FY 2018-19 shifted to FY 2019-20.

Methodology:

1. In FY 2018-19 and FY 2019-20, one annual interim payment will be made to DPHs for those respective years.
2. Interim reconciliations of program years are anticipated to be completed upon receipt of the Physician/Non-Physician Practitioner time studies and the filed cost report information which are required components of the reconciliation process.
3. The ACA optional population supplemental payment methodology is pending CMS approval which is expected to occur in FY 2018-19 and will be retroactive to January 1, 2014. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017 through December 31, 2017, the ACA optional population FMAP will be 95%, and 94% beginning January 1, 2018.
4. Reconciliation/final settlement of program years is anticipated to be completed upon conclusion of final audited settlements. Final reconciliations are subject to cost report audit schedules.

FY 2018-19	TF	FF
FY 2016-17 Interim Reconciliation	\$6,938,000	\$6,938,000
FY 2016-17 Interim Payment ACA	\$65,814,000	\$65,814,000
FY 2018-19 Interim Payment	\$74,637,000	\$74,637,000
Total	\$147,389,000	\$147,389,000

DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 144

FY 2019-20	TF	FF
FY 2013-14 Final Reconciliation	(\$17,387,000)	(\$17,387,000)
FY 2013-14 Payment ACA	\$14,802,000	\$14,802,000
FY 2014-15 Final Reconciliation	\$647,000	\$647,000
FY 2014-15 Payment ACA	\$47,997,000	\$47,997,000
FY 2015-16 Final Reconciliation	(\$15,881,000)	(\$15,881,000)
FY 2015-16 Payment ACA	\$54,200,000	\$54,200,000
FY 2017-18 Interim Reconciliation	(\$1,337,000)	(\$1,337,000)
FY 2017-18 Interim Payment ACA	\$63,827,000	\$63,827,000
FY 2019-20 Interim Payment	\$74,637,000	\$74,637,000
Total	\$221,505,000	\$221,505,000

Funding:

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

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

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 145
 IMPLEMENTATION DATE: 6/2002
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 86

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$145,438,000	\$65,669,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$145,438,000	\$65,669,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$145,438,000	\$65,669,000

DESCRIPTION

Purpose:

This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals.

Authority:

AB 430 (Chapter 171, Statutes of 2001)

Interdependent Policy Changes:

Not Applicable

Background:

This program is designed to allow DP-NFs to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal beneficiaries.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013, to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013, for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013, pursuant to the provisions of SB 239 (Chapter 657, Statutes of 2013).

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 145

ABX2 1 (Chapter 3, Statutes of 2016) prohibits the Department from seeking to retroactively implement certain Medi-Cal provider base payment reductions and limitations with regards to reimbursements for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals for dates of service on or after June 1, 2011, and on or before September 30, 2013, and from seeking to recoup overpayments of the base rate. This prohibition does not apply to supplemental payments for skilled nursing services nor the recoupment of such supplemental funds.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to:

- The addition of FY 2015-16 adjusted claims, and FY 2017-18 ACA,
- FY 2016-17 and FY 2017-18 claims were delayed and have shifted to be paid in FY 2018-19, and
- FY 2016-17, FY 2017-18, and FY 2018-19 amounts have been revised based on updated payment data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to fewer prior year payments estimated to occur in FY 2019-20.

Methodology:

1. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.
2. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Scheduled interim payments and reconciliation payments are represented below.
3. ACA allows for 100% FMAP for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning calendar year 2017, FMAP for ACA population allows for the following: 95% beginning on January 1, 2017, 94% beginning on January 1, 2018, and 93% beginning January 1, 2019. The ACA methodology has been approved by CMS. FY 2016-17 and FY 2017-18 ACA payments will be made in FY 2018-19. Half of the FY 2018-19 ACA payments will be made in FY 2019-20.
4. FY 2017-18 non-ACA payments are based on FY 2016-17 actuals with a 3% growth factor. Assume FY 2018-19 and FY 2019-20 non-ACA payments will also increase by 3% over the prior year.
5. Assume half of the payments occur in the same fiscal year, and the remaining payments occur in the subsequent fiscal year. FY 2018-19 payments, however, include delayed payments from prior years.

(Dollars in Thousands)

FY 2018-19	TF	FFP	ACA FFP
FY 2015-16 Adjusted Claims	\$1,788	\$0	\$1,788
FY 2016-17	\$36,611	\$36,611	\$0
FY 2016-17 ACA	\$11,076	\$0	\$11,076
FY 2017-18	\$57,499	\$57,499	\$0
FY 2017-18 ACA	\$8,852	\$0	\$8,852
FY 2018-19	\$29,612	\$29,612	\$0
FY 2018-19 Total	\$145,438	\$123,722	\$21,716

CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 145

(Dollars in Thousands)

FY 2019-20	TF	FFP	ACAFFP
FY 2018-19	\$29,612	\$29,612	\$0
FY 2018-19 ACA	\$5,557	\$0	\$5,557
FY 2019-20	\$30,500	\$30,500	\$0
FY 2019-20 Total	\$65,669	\$60,112	\$5,557

Funding:

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

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

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 146
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 82

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$126,344,000	\$128,455,000
- STATE FUNDS	\$34,913,500	\$36,139,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$126,344,000	\$128,455,000
STATE FUNDS	\$34,913,500	\$36,139,500
FEDERAL FUNDS	\$91,430,500	\$92,315,500

DESCRIPTION

Purpose:

This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:

SB 1732 (Chapter 1635, Statutes of 1988)
 SB 2665 (Chapter 1310, Statutes of 1990)
 SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:

Not Applicable

Background:

SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013, due to the implementation of the Diagnosis Related Group payment methodology. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code. The Department claims federal funds using certified public expenditures from eligible DP-NFs. CMS approved SPA 00-010 on July 17, 2001, which maintains the Federal authority for SB 1128.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 146

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to projected SB 1732 interim payments, ACA adjustments, and interim reconciliation amounts being revised based on the final FY 2014-15 Medi-Cal Utilization Rate (MUR).

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to lower ACA adjustments, lower interim reconciliations, and higher interim payments being made in FY 2019-20 for the SB 1732 hospitals.

Methodology:

1. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017 and 94% FMAP for calendar year 2018, for newly eligible Medi-Cal beneficiaries.
2. For SB 1732, ACA payments will be processed one year after the respective FY's supplemental payments have been issued in order to determine the proportion of the hospital's costs for newly eligible Medi-Cal beneficiaries. FY 2016-17 ACA and FY 2017-18 ACA supplemental payments will be claimed in FY 2018-19 and FY 2019-20, respectively. The General Fund (GF) will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the regular 50% FMAP.
3. The estimated payments on a cash basis are:

FY 2018-19	TF	GF	FF	ACA
Hospitals (SB 1732)				
Interim Payment				
FY 2016-17	\$1,953,000	\$977,000	\$976,000	\$0
FY 2017-18	\$54,184,000	\$27,092,000	\$27,092,000	\$0
FY 2018-19	\$34,587,000	\$17,293,000	\$17,294,000	\$0
ACA Adjustment to GF				
FY 2016-17	\$0	(\$15,458,000)	(\$16,545,000)	\$32,003,000
Interim Reconciliation				
FY 2014-15	\$15,120,000	\$5,009,000	\$5,010,000	\$5,101,000
DP-NFs (SB 1128)				
Interim Payment				
FY 2017-18	\$20,500,000	\$0	\$20,500,000	\$0
Total FY 2018-19	\$126,344,000	\$34,913,000	\$54,327,000	\$37,104,000

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 146

FY 2019-20	TF	GF	FF	ACA
Hospitals (SB 1732)				
Interim Payment				
FY 2017-18	\$653,000	\$327,000	\$326,000	\$0
FY 2018-19	\$58,104,000	\$29,052,000	\$29,052,000	\$0
FY 2019-20	\$35,167,000	\$17,583,000	\$17,584,000	\$0
ACA Adjustment to GF				
FY 2017-18	\$0	(\$13,931,000)	(\$15,709,000)	\$29,640,000
Interim Reconciliation				
FY 2015-16	\$14,031,000	\$3,108,000	\$3,109,000	\$7,814,000
DP-NFs (SB 1128)				
Interim Payment				
FY 2018-19	\$20,500,000	\$0	\$20,500,000	\$0
Total FY 2019-20	\$128,455,000	\$36,139,000	\$54,862,000	\$37,454,000

Funding:

100% Title XIX (4260-101-0890)

50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

100% GF Capital Debt (4260-102-0001)

100% Title XIX Capital Debt FFP (4260-102-0890)

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

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 11/2015
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1899

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$119,213,000	\$119,092,000
- STATE FUNDS	\$49,680,100	\$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$119,213,000	\$119,092,000
STATE FUNDS	\$49,680,100	\$50,000,000
FEDERAL FUNDS	\$69,532,900	\$69,092,000

DESCRIPTION

Purpose:

This policy change estimates the inpatient Medi-Cal Fee-for-Service (FFS) and supplemental payments to a new private nonprofit hospital, Martin Luther King, Jr. – Los Angeles (MLK-LA) Healthcare Corporation.

Authority:

SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions (W&I) Code 14165.50
 SPA 17-023
 SPA 18-0021

Interdependent Policy Changes:

Not Applicable

Background:

SB 857 requires specific funding requirements to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. Pursuant to W&I Code 14165.50, the cost-based reimbursement methodology for Medi-Cal FFS and managed care payments to the new MLK-LA hospital will provide compensation at a minimum of 100% of the projected costs for each fiscal year (FY), contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide, beginning the fiscal year MLK-LA opens through FY 2016-17, the non-federal share of a guaranteed level (minimum payment level) of 77% of the total Medi-Cal FFS inpatient projected cost. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of the Medi-Cal FFS inpatient projected costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs.

**MARTIN LUTHER KING JR. COMMUNITY HOSPITAL
PAYMENTS
REGULAR POLICY CHANGE NUMBER: 147**

Beginning FY 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72% of projected Medi-Cal FFS costs. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 72% of the Medi-Cal FFS inpatient projected costs, the GF will be required to fund the non-federal share of the additional payments up to 72% of the costs.

In order to enable reimbursement for the MLK-LA to reach 100% of the FFS inpatient projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the Department shall seek further federal approval to enable MLK-LA to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100% minimum funding requirement may be sought through additional supplemental programs upon federal approval.

State Plan Amendment (SPA) 17-023 capped payments at \$113.4 million in FY 2017-18. SPA 18-0021, which was approved by CMS on July 19, 2018, increased the payment cap from \$113.4 million to \$115.2 million, effective July 1, 2018. The \$115.2 million total payment represents \$100 million in supplemental payments and \$15.2 million in Diagnosis Related Group (DRG) add-on payments.

The reconciliation process may find an overpayment or underpayment to MLK-LA and will be handled as follows:

- For overpayments, MLK-LA will be subject to recovery of the payment for the amount exceeding the supplemental and DRG add-on payment cap and the amount of DRG add-on payments exceeding the minimum payment level based on actual costs.
- For underpayments, MLK-LA will receive an additional payment equal to the reconciled amount for DRG add-on payments needed to meet the minimum payment level, subject to the supplemental and DRG add-on payment cap.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to the inclusion of the estimated FY 2017-18 DRG add-on and supplemental interim reconciliation amounts and updated Affordable Care Act (ACA) optional population payment data for FY 2017-18.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the inclusion of the FY 2017-18 interim reconciliation in FY 2018-19.

Methodology:

1. Medi-Cal certification approval is retroactive to the effective date of June 30, 2015.
2. DRG inpatient payments to MLK-LA were implemented beginning November 2015 for dates of service on or after July 1, 2015.
3. MLK-LA received the DRG statewide, wage adjusted, base rate.
4. Assume DRG payments and DRG add-on payments, if necessary, will be sufficient to reach the 72% minimum payment level for FY 2018-19 and FY 2019-20.
5. Expenditures for FY 2018-19 and FY 2019-20 costs up to 72% of total Medi-Cal FFS inpatient projected costs will be paid through DRG FFS payments which are incorporated in the FFS base.

**MARTIN LUTHER KING JR. COMMUNITY HOSPITAL
PAYMENTS
REGULAR POLICY CHANGE NUMBER: 147**

6. Assume for FFS and supplemental payments, there are no Title XXI payments, based on updated MLK-LA payment data.
7. Supplemental payments are equal to the difference between MLK-LA's Medi-Cal FFS inpatient hospital charges and all amounts paid to MLK-LA by the Medi-Cal FFS inpatient hospital program per fiscal year. For FY 2018-19, the supplemental payments and DRG add-on payments are limited by the payment cap of \$115.2 million. FY 2018-19 and FY 2019-20 supplemental payments are estimated to be \$100 million TF annually.
8. FY 2017-18 interim reconciliations resulted in the following:
 - Additional DRG add-on payments of \$907,000 TF (\$453,000 GF, \$454,000 FF)
 - ACA adjustment of \$720,000 TF (\$40,000 GF, \$680,000 FF)
 - Supplemental payment recoupment of \$1,627,000 TF
9. The ACA supplemental payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. FY 2017-18 ACA supplemental payments will be claimed in FY 2018-19. For FY 2018-19, the ACA payment will be claimed in FY 2019-20. The County will be reimbursed for the IGT (non-federal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018, and further reduces to 93% beginning January 1, 2019. CMS approved the ACA supplemental payment methodology in August 2017.
10. Managed care costs for MLK-LA are reflected in the managed care policy changes. The chart below shows the FY 2018-19 and FY 2019-20 totals with managed care for informational purposes only.
 - Retroactive payments for FY 2017-18 and FY 2018-19 will be made in FY 2018-19 and FY 2019-20, respectively, in the Retro MC Rate Adjustments policy change.

(Dollars in Thousands)

FY 2018-19	TF
Supplemental 2018-19	\$100,000
Supplemental ACA 2017-18	\$19,213
DRG Add-on Interim Recon 2017-18	\$1,627
Supplemental Interim Recon 2017-18	(\$1,627)
Total	\$119,213
Managed Care 2017-18 Retro	\$17,978
Total Managed Care	\$17,978
Total FY 2018-19	\$137,191

**MARTIN LUTHER KING JR. COMMUNITY HOSPITAL
PAYMENTS
REGULAR POLICY CHANGE NUMBER: 147**

(Dollars in Thousands)

FY 2019-20	TF
Supplemental 2019-20	\$100,000
Supplemental ACA 2018-19	\$19,092
Total	\$119,092
Managed Care 2018-19 Retro	\$18,956
Total Managed Care	\$18,956
Total FY 2019-20	\$138,048

11. On a cash basis, costs in FY 2018-19 and FY 2019-20 are expected to be:

FY 2018-19	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2018-19	\$100,000,000	\$0	\$50,000,000	\$50,000,000	\$0	\$0
Supplemental ACA 2017-18	\$19,213,000	\$0	\$0	(\$21,588,000)	\$40,801,000	\$19,213,000
DRG Add-On Interim Reconciliation 2017-18	\$1,627,000	\$493,000	\$0	\$454,000	\$680,000	\$0
Supplemental Interim Reconciliation 2017-18	(\$1,627,000)	\$0	(\$813,000)	(\$814,000)	\$0	\$0
Total	\$119,213,000	\$493,000	\$49,187,000	\$28,052,000	\$41,481,000	\$19,213,000

FY 2019-20	TF	GF	IGT*	FF	ACA FF	Return to County**
Supplemental 2019-20	\$100,000,000	\$0	\$50,000,000	\$50,000,000	\$0	\$0
Supplemental ACA 2018-19	\$19,092,000	\$0	\$0	(\$21,945,000)	\$41,037,000	\$19,092,000
Total	\$119,092,000	\$0	\$50,000,000	\$28,055,000	\$41,037,000	\$19,092,000

**The Return to County column is for display purposes only (see methodology #9)

MARTIN LUTHER KING JR. COMMUNITY HOSPITAL
PAYMENTS
REGULAR POLICY CHANGE NUMBER: 147

Funding:

50% Title XIX / 50% Reimbursement GF (4260-601-0995/4260-101-0890)*

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

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

94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)

93% Title XIX ACA FF / 7% GF (4260-101-0001/0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 104

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$116,107,000	\$138,617,000
- STATE FUNDS	\$53,752,000	\$64,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$116,107,000	\$138,617,000
STATE FUNDS	\$53,752,000	\$64,000,000
FEDERAL FUNDS	\$62,355,000	\$74,617,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:

Welfare & Institutions Code, Sections 14164 and 14087.3

Interdependent Policy Changes:

Not Applicable

Background:

This program allows Los Angeles and Alameda counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net decrease due to:

- An increase in the estimated FY 2017-18 LA initial payment. In addition, there is a delay in the Los Angeles County initial FY 2017-18 payment, originally scheduled to occur in FY 2017-18 to FY 2018-19,
- A shift in the Los Angeles County initial FY 2018-19 payment originally scheduled to occur in FY 2018-19 to FY 2019-20, and
- An increase to FY 2017-18 Affordable Care Act (ACA) payments.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to higher ACA adjustments to counties and regular payments occurring in FY 2019-20.

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 148

Methodology:

1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).
2. ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, 95% FMAP for calendar year 2017, 94% FMAP for calendar year 2018 and 93% FMAP for calendar year 2019, for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.
3. ACA payments will be processed nine months after the respective FY's supplemental payments have been issued in order to determine the proportion of the hospital's trauma care costs for newly eligible Medi-Cal beneficiaries. For FY 2017-18, the ACA supplemental payments will be claimed in FY 2018-19. ACA payments for FY 2018-19 will be claimed in FY 2019-20. The County will be reimbursed for the nonfederal share, and an adjustment will be made for the federal share processed at the regular 50% FMAP.

(Dollars in Thousands)

FY 2018-19	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2017-18 ACA Adjustment to Counties	\$8,603	\$0	(\$9,666)	\$18,269	\$8,603
FY 2017-18	\$107,504	\$53,752	\$53,752	\$0	\$0
Total FY 2018-19	\$116,107	\$53,752	\$44,086	\$18,269	\$8,603

(Dollars in Thousands)

FY 2019-20	TF	Special Deposit Fund	FF	ACA FF	*Return to Counties
FY 2018-19 ACA Adjustment to Counties	\$10,617	\$0	(\$12,204)	\$22,821	\$10,617
FY 2018-19	\$128,000	\$64,000	\$64,000	\$0	\$0
Total FY 2019-20	\$138,617	\$64,000	\$51,796	\$22,821	\$10,617

*The Return to Counties column is for display purposes only (see Methodology #3).

Funding:

50% Local Trauma Centers Fund / 50% Title XIX FF (4260-601-0942142) / (4260-101-0890)

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

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 149
 IMPLEMENTATION DATE: 4/2014
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1563

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$89,326,000	\$88,000,000
- STATE FUNDS	\$44,663,000	\$44,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$89,326,000	\$88,000,000
STATE FUNDS	\$44,663,000	\$44,000,000
FEDERAL FUNDS	\$44,663,000	\$44,000,000

DESCRIPTION

Purpose:

This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to Freestanding Skilled Nursing Facility Level-Bs (FS/NF-Bs) and Freestanding Subacute Nursing Facility Level-B (FSSA/NF-B) facilities through the Special Fund.

Authority:

SB 853 (Chapter 717, Statutes of 2010)
 AB 1489 (Chapter 631, Statutes of 2012)
 AB 119 (Chapter 17, Statutes of 2015)
 SB 97 (Chapter 52, Statutes of 2017)
 State Plan Amendment (SPA) 17-024
 SPA 18-0034

Interdependent Policy Changes:

Not Applicable

Background:

SB 853 implemented a quality and accountability supplemental payments (QASP) program for FS/NF-Bs and FSSA/NF-B facilities. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 149

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP Program through July 31, 2020. Further, beginning in rate year 2015-16, the annual weighted average rate increase was set at 3.62%, and the General Fund appropriation for the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning fiscal year 2015-16, the legislation required the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

SB 97 increases the minimum staffing requirement from 3.2 to 3.5, which will be applied to the QASP program for eligibility purposes, beginning in the 2019-20 rate year. This requirement increases the number of facilities eligible for the QASP.

The California Department of Aging (CDA) has direct appropriation authority of \$1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to higher than anticipated PLI savings in FY 2017-18 and FY 2018-19, resulting in adjusted supplemental payments.

The change from FY 2017-18 to FY 2018-19, in the current estimate is a decrease due to lower supplemental payments being made to facilities in FY 2019-20.

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.
2. The estimated incoming funds for the Special Fund are:

Incoming Funds	FY 2018-19	FY 2019-20
Penalties on Nursing Facilities	\$100,000	\$100,000
QASP GF Appropriation	\$43,236,000	\$43,236,000
PLI savings	\$6,846,000	\$6,846,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments may be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.
4. Estimated CDPH annual administrative costs are \$6,790,000 TF (\$3,395,000 Special Fund) for FY 2018-19, and \$6,500,000 (\$3,250,000 Special Fund) for FY 2019-20.
5. The GF appropriated QASP funding will continue at FY 2014-15 levels, instead of setting aside a portion of the annual increase.

**QUALITY AND ACCOUNTABILITY SUPPLEMENTAL
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 149

6. Supplemental payments are estimated to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	SF	FF
Supplemental Payments***	\$89,326	\$0	\$44,663	\$44,663
Transfer from GF* to Special Fund**	\$0	\$50,252	(\$50,252)	\$0
Total	\$89,326	\$50,252	(\$5,589)	\$44,663

(Dollars in Thousands)

FY 2019-20	TF	GF	SF	FF
Supplemental Payments***	\$88,000	\$0	\$44,000	\$44,000
Transfer from GF* to Special Fund**	\$0	\$50,083	(\$50,083)	\$0
Total	\$88,000	\$50,083	(\$6,083)	\$44,000

Funding:

100% GF (4260-605-0001)*

SNF Quality & Accountability (less funded by GF) (4260-698-3167)**

SNF Quality & Accountability (4260-605-3167)***

Title XIX FFP (4260-101-0890)***

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 150
 IMPLEMENTATION DATE: 12/2017
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 2044

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$203,057,000	\$159,614,000
- STATE FUNDS	\$54,198,000	\$41,943,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	69.90 %	88.96 %
APPLIED TO BASE		
TOTAL FUNDS	\$61,120,200	\$17,621,400
STATE FUNDS	\$16,313,600	\$4,630,510
FEDERAL FUNDS	\$44,806,560	\$12,990,880

DESCRIPTION

Purpose:

This policy estimates the expenditures related to time-limited supplemental reimbursements under the Family Planning, Access, Care, Treatment (Family PACT) program for the Evaluation and Management (E&M) portion of office visits and medical pregnancy termination services.

Authority:

AB 120 (Chapter 22, Statutes of 2017)
 Proposition 56 (2016)
 Senate Bill (SB) 856

Interdependent Policy Changes:

Not Applicable

Background:

On November 8, 2016, California voters approved the California Healthcare, Research, and Prevention Tobacco Tax Act, Proposition 56, to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a specified portion of the tobacco tax revenue is allocated to the Department for use as the nonfederal share of health care expenditures in accordance with the annual state budget process. AB 120 amended the Budget Act of 2017 to appropriate proposition 56 funds for specified Department health care expenditures during the 2017-18 state fiscal year. SB 856 extends the appropriation of Proposition 56 funds for FY 2018-19.

CMS approved State Plan Amendment (SPA) 17-029 on November 30, 2017. The SPA allocated \$40 million for time-limited supplemental reimbursements, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for E&M office visits rendered for comprehensive family planning services. The effective date for this SPA is July 1, 2017, with an end date of June 30, 2018. Additionally, SPA 18-0031, approved by CMS on September 5, 2018, has an effective date of July 1, 2018 with an end date of June 30, 2019.

A total of \$50 million is appropriated; \$40 million for comprehensive family planning services, and \$10 million for time-limited supplemental payments for medical pregnancy termination.

PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 150

Reason for Change:

The overall increase from the previous estimate, for FY 2018-19, resulted from the Department processing Erroneous Payment Corrections for physician payment in the amount of \$44.6M, and Medical Pregnancy Termination payments in the amount of \$3.2M. The decrease in cost not related to the EPCs is due to a decline in actual expenditures. The change in the current estimate, from FY 2018-19 to FY 2019-20 resulted from the EPC payments in FY 2018-19.

Methodology:

1. Payments will be made via supplemental payments.
2. This policy is effective July 1, 2017; however payments began for pregnancy termination supplemental payments in December 2017, and for E&M office visit supplemental payments in January 2018.
3. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2018-19	TF	SF	FF
E&M Office Visits	\$ 192,213	\$ 43,354	\$ 148,859
Medical Pregnancy Termination	\$ 10,844	\$ 10,844	\$ -
Total	\$ 203,057	\$ 54,198	\$ 148,859

FY 2019-20	TF	SF	FF
E&M Office Visits	\$ 151,941	\$ 34,270	\$ 117,671
Medical Pregnancy Termination	\$ 7,673	\$ 7,673	\$ -
Total	\$ 159,614	\$ 41,943	\$ 117,671

Funding:

Healthcare Treatment Fund (4260-101-3305)

100% Title XIX (4260-101-0890)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 151
 IMPLEMENTATION DATE: 4/2014
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1661

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$37,505,000	\$6,826,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$37,505,000	\$6,826,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$37,505,000	\$6,826,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:

AB 678 (Chapter 397, Statutes of 2011)
 SB 523 (Chapter 773, Statutes of 2017)

Interdependent Policy Changes:

Not Applicable

Background:

A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) #09-024 on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 151

SPA 18-007, which will be submitted to CMS in FY 2018-19, proposes to update the definition of allowable costs to include shared direct costs and to revise the timeline for final settlements.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a slight decrease due to:

- Updating FY 2014-15 and FY 2015-16 amounts based on more recently available data, and
- Updating FY 2017-18 estimated payments based on updated data.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to processing fewer retroactive year payments in FY 2019-20, and a reduction of CPE reimbursements starting FY 2018-19 due to the GEMT QAF payments.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
2. The ACA allows for 100% FMAP for calendar years 2014 through 2016, 95% FMAP for calendar year 2017, 94% FMAP for calendar year 2018, and 93% for calendar year 2019 for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.
3. Payments estimated for FY 2017-18 and FY 2018-19 are CPE based.
4. Effective July 1, 2018, SB 523 established the GEMT Provider Quality Assurance Fee (QAF) Program. GEMT QAF payments will reduce GEMT CPE reimbursements beginning in FY 2018-19.
5. Interim reconciliations are performed within two years of receipt of the as-filed cost report. Final reconciliations are based on audited cost reports, and the audit and settlement process is completed within three years of the postmark date of the approved cost report. Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2018-19 and FY 2019-20.
6. SPA 18-007, when approved, will be retroactive to dates of service beginning July 1, 2018.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 151

The estimated payments on a cash basis are:

FY 2018-19	Total FFP	Regular FFP	ARRA	ACA
FY 2009-10 Final Recon.	\$12,769,000	\$10,366,000	\$2,403,000	\$0
FY 2010-11 Final Recon.	\$6,594,000	\$5,151,000	\$1,443,000	\$0
FY 2011-12 Final Recon.	(\$396,000)	(\$396,000)	\$0	\$0
FY 2012-13 Final Recon.	(\$310,000)	(\$310,000)	\$0	\$0
FY 2013-14 Final Recon.	(\$70,000)	(\$47,000)	\$0	(\$23,000)
FY 2014-15 Final Recon.	(\$2,643,000)	(\$1,332,000)	\$0	(\$1,311,000)
FY 2015-16 Interim Recon.	\$193,000	\$84,000	\$0	\$109,000
FY 2017-18 Interim Payment	\$21,368,000	\$7,801,000	\$0	\$13,567,000
Total FY 2018-19	\$37,505,000	\$21,317,000	\$3,846,000	\$12,342,000

FY 2019-20	Total FFP	Regular FFP	ACA
FY 2015-16 Final Recon.	(\$8,910,000)	(\$3,716,000)	(\$5,194,000)
FY 2016-17 Interim Recon.	\$151,000	\$56,000	\$95,000
FY 2018-19 Interim Payment	\$15,585,000	\$5,743,000	\$9,842,000
Total FY 2019-20	\$6,826,000	\$2,083,000	\$4,743,000

Funding:

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

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

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152
 IMPLEMENTATION DATE: 4/2018
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 2045

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$29,421,000	\$27,819,000
- STATE FUNDS	\$13,764,760	\$13,041,300
PAYMENT LAG	0.9985	1.0000
% REFLECTED IN BASE	71.48 %	75.48 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,378,300	\$6,821,200
STATE FUNDS	\$3,919,820	\$3,197,730
FEDERAL FUNDS	\$4,458,460	\$3,623,490

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)
 SB 856 (Chapter 30, Statutes of 2018)
 SPA 17-028
 SPA 18-0029

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 \$2.87 per pack of 20 cigarettes on distributors selling cigarettes in California with an equivalent excise tax rate increase on other tobacco products.

AB 120 allocated up to \$27,000,000 Proposition 56 funds for supplemental payments to ICF/DDs. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-028 for these supplemental payments.

SB 856 appropriates a specified portion of the Proposition 56 revenue for use as the nonfederal share of health care expenditures for the 2018-19 state fiscal year. This includes funding for supplemental payments to continue for an additional year for ICF/DD, ICF/DD-H, and ICF/DD-N facilities, and ICF/DD Continuous Nursing Care (CNC) facilities.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS**REGULAR POLICY CHANGE NUMBER: 152**

The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0029, which provides the one-year extension to the supplemental payment for ICF-DDs, effective August 1, 2018.

ICF/DDs will receive a supplemental payment based on the difference between the frozen rate at the 2008-09 65th percentile, increased by 3.7%; and the 2017-18 unfrozen rate. The resulting supplemental payment per diem amounts for 2018-19 are as reflected by facility peer group below:

Facility Peer Group	Amount
ICF/DD (1-59 beds)	\$15.47
ICF/DD (60+ beds)	\$0.00
ICF/DD-H (4-6 beds)	\$10.75
ICF/DD-H (7-15 beds)	\$0.00
ICF/DD-N (4-6 beds)	\$12.47
ICF/DD-N (7-15 beds)	\$22.30

Reason for Change:

The change for FY 2018-19, from the prior estimate, is a net increase due to:

- Revised FY 2018-19 FFS and managed care annual costs;
- The addition of Coordinated Care Initiative (CCI) payments; and
- The FFS payments for the ICF/DD, ICF/DD-H, and ICF/DD-N facilities are 100% in the FFS base trends.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net decrease due to less CCI payments in FY 2019-20 and a decrease in managed care payments in 2019-20.

Methodology:

1. Payments will be made via FFS supplemental payments and increased managed care capitation payments.
2. This policy is effective August 1, 2017, through July 31, 2019.

Fee-for-Service Supplemental Payments

3. The FFS supplemental payments were implemented June 25, 2018. Assume the supplemental payments will continue in FY 2019-20.
4. The annual FFS supplemental payments for ICF/DD, ICF/DD-H, and ICF-DD/N facilities are expected to be \$20.997 million TF for FY 2018-19 and FY 2019-20. The FFS supplemental payments for ICF/DD CNC facilities are expected to be \$458,000 annually.

Managed Care Supplemental Payments

5. One month of the FY 2017-18 managed care payments will be paid in FY 2018-19.
6. The annual managed care supplemental payments, including CCI, are estimated to be \$6.364 million TF in FY 2018-19 and FY 2019-20.

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS**REGULAR POLICY CHANGE NUMBER: 152**

7. For non-CCI managed care payments:
- Assume 11 months of the FY 2018-19 capitation rate increases are expected to occur in FY 2018-19.
 - Assume one month of the FY 2018-19 capitation rate increases and 11 months of the FY 2019-20 capitation rate increases are expected to occur in FY 2019-20.
8. For CCI managed care payments:
- Assume payments for Calendar Year (CY) 2017 and 2018 will be paid in FY 2018-19. Five months of CY 2019 payments will be made in FY 2018-19.
 - Assume seven months of CY 2019 and five months of CY 2020 payments will be paid in FY 2019-20.
9. Funds allocated for the supplemental payments are as follows:

FY 2018-19	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Payments - ongoing (ICF/DD, ICF/DD-H, ICF/DD-N)	\$20,998,000	\$10,426,000	\$0	\$10,415,000	\$157,000
18-19 FFS Payments (ICF/DD-CNC)	\$229,000	\$114,000	\$0	\$113,000	\$2,000
18-19 FFS Retro (ICF/DD-CNC)	\$191,000	\$95,000	\$0	\$95,000	\$1,000
2017 CCI Payments	\$800,000	\$400,000	\$0	\$400,000	\$0
2018 CCI Payments	\$1,920,000	\$960,000	\$0	\$960,000	\$0
2019 CCI Payments	\$800,000	\$400,000	\$0	\$400,000	\$0
17-18 Managed Care Pmts	\$409,000	\$124,000	\$15,000	\$112,000	\$158,000
18-19 Managed Care Pmts	\$4,074,000	\$1,246,000	\$151,000	\$1,117,000	\$1,560,000
Total	\$29,421,000	\$13,765,000	\$166,000	\$13,612,000	\$1,878,000

FY 2019-20	TF	SF	Title XXI FF	Title XIX FF	ACA FF
FFS Payments - ongoing (ICF/DD, ICF/DD-H, ICF/DD-N)	\$20,998,000	\$10,429,000	\$0	\$10,415,000	\$154,000
18-19 FFS Payments (ICF/DD-CNC)	\$38,000	\$19,000	\$0	\$19,000	\$0
19-20 FFS Payments (ICF/DD-CNC)	\$419,000	\$208,000	\$0	\$208,000	\$3,000
2019 CCI Payments	\$1,120,000	\$560,000	\$0	\$560,000	\$0
2020 CCI Payments	\$800,000	\$400,000	\$0	\$400,000	\$0
18-19 Managed Care Pmts	\$370,000	\$115,000	\$13,000	\$103,000	\$139,000
19-20 Managed Care Pmts	\$4,074,000	\$1,310,000	\$130,000	\$1,133,000	\$1,501,000
Total	\$27,819,000	\$13,041,000	\$143,000	\$12,838,000	\$1,797,000

PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 152

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX FF / 50% SF (4260-101-3305 / 0890)	\$27,223,000	\$13,611,000	\$13,612,000
94% Title XIX FF / 6% SF (4260-101-3305 / 0890)	\$1,005,000	\$61,000	\$944,000
93% Title XIX FF / 7% SF (4260-101-3305 / 0890)	\$1,004,000	\$70,000	\$934,000
88% Title XXI FF / 12% SF (4260-113-0890)	\$189,000	\$23,000	\$166,000
Total	\$29,421,000	\$13,765,000	\$15,656,000

FY 2019-20	TF	SF	FF
50% Title XIX FF / 50% SF (4260-101-3305 / 0890)	\$25,674,000	\$12,837,000	\$12,837,000
93% Title XIX FF / 7% SF (4260-101-3305 / 0890)	\$982,000	\$69,000	\$913,000
90% Title XIX FF / 10% SF (4260-101-3305 / 0890)	\$982,000	\$98,000	\$884,000
88% Title XXI FF / 12% SF (4260-101-3305 / 4260-113-0890)	\$45,000	\$5,000	\$40,000
76.5% Title XXI FF / 23.5% SF (4260-101-3305 / 4260-113-0890)	\$136,000	\$32,000	\$104,000
Total	\$27,819,000	\$13,041,000	\$14,778,000

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 153
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1038

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$10,001,000	\$10,000,000
- STATE FUNDS	\$5,000,500	\$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,001,000	\$10,000,000
STATE FUNDS	\$5,000,500	\$5,000,000
FEDERAL FUNDS	\$5,000,500	\$5,000,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:

SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:

Not Applicable

Background:

SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:

The change from the prior estimate for FY 2018-19 and from FY 2018-19 to FY 2019-20 within the current estimate, is due to a portion of CY 2018 quarter one funds being withheld in FY 2017-18 and redistributed to be paid in FY 2018-19.

Methodology:

1. Due to the closure of Tulare Regional Medical Center, CY 2018 funding to this hospital will be withheld and redistributed to the remaining eligible providers for payment in FY 2018-19.
2. CY 2018 quarter one distributions of approximately \$1,000 were withheld in FY 2017-18 and are expected to be paid in FY 2018-19.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH**REGULAR POLICY CHANGE NUMBER: 153**

3. Assume annual reimbursements for disproportionate share of outpatient services are \$10,000,000 TF (\$5,000,000 GF).

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CY 2018	\$7,501	\$3,750	\$3,751
CY 2019	\$2,500	\$1,250	\$1,250
Total	\$10,001	\$5,000	\$5,001

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CY 2019	\$7,500	\$3,750	\$3,750
CY 2020	\$2,500	\$1,250	\$1,250
Total	\$10,000	\$5,000	\$5,000

Funding:

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

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154
 IMPLEMENTATION DATE: 12/2010
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1616

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$9,389,000	\$8,039,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,389,000	\$8,039,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$9,389,000	\$8,039,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental payments to state veterans' homes.

Authority:

AB 959 (Chapter 162, Statutes of 2006)

Interdependent Policy Changes:

Not Applicable

Background:

Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to:

- An increase in FY 2017-18 ACA payments based on updated data, and
- The addition of newly eligible providers causing an increase in the FY 2018-19 interim payments, an increase in the FY 2017-18 initial reconciliation payments and the addition of FY 2016-17 initial reconciliation payments.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to an additional initial reconciliation payment for newly eligible providers occurring in FY 2018-19.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

Methodology:

Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

The estimate is based on:

1. Interim payments,
2. Initial reconciliation payments, and
3. A final reconciliation payment, if necessary.

Program payment amounts are estimated to be:

FY 2018-19	FF
ACA Payments	
FY 2017-18	\$239,000
Interim Payments	
FY 2018-19	\$4,050,000
Initial Reconciliation Payment	
FY 2016-17	\$1,200,000
FY 2017-18	\$3,900,000
FY 2018-19 Total	\$9,389,000

FY 2019-20	FF
ACA Payments	
FY 2018-19	\$239,000
Interim Payments	
FY 2019-20	\$4,050,000
Initial Reconciliation Payment	
FY 2018-19	\$3,750,000
FY 2019-20 Total	\$8,039,000

Funding:

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

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 155
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1039

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$8,000,000	\$8,000,000
- STATE FUNDS	\$4,000,000	\$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,000,000	\$8,000,000
STATE FUNDS	\$4,000,000	\$4,000,000
FEDERAL FUNDS	\$4,000,000	\$4,000,000

DESCRIPTION

Purpose:

This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:

AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:

Not Applicable

Background:

This program provides SRHs with increased reimbursement rates. The Department calculates payments on a calendar year (CY) basis and reimburses eligible providers on a quarterly basis through a payment action notice (PAN). Each payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each calendar year will be paid the following calendar year.

Reason for Change:

There is no change for FY 2018-19 from the prior estimate, and from FY 2018-19 to FY 2019-20 within the current estimate.

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 155

Methodology:

1. Assume annual reimbursements to SRHs providing outpatient services are \$8,000,000 TF (\$4,000,000 GF).

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
CY 2018	\$6,000	\$3,000	\$3,000
CY 2019	\$2,000	\$1,000	\$1,000
Total	\$8,000	\$4,000	\$4,000

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
CY 2019	\$6,000	\$3,000	\$3,000
CY 2020	\$2,000	\$1,000	\$1,000
Total	\$8,000	\$4,000	\$4,000

Funding:

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

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 156
 IMPLEMENTATION DATE: 11/2017
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 2050

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$6,800,000	\$6,800,000
- STATE FUNDS	\$3,400,000	\$3,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	3.90 %	3.51 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,534,800	\$6,561,300
STATE FUNDS	\$3,267,400	\$3,280,660
FEDERAL FUNDS	\$3,267,400	\$3,280,660

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)
 Proposition 56 (2016)

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 developed the structure of the supplemental payments and posted those parameters on its Internet Web site on 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

PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS**REGULAR POLICY CHANGE NUMBER: 156**

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.

The Department received approval of a waiver amendment to incorporate the allocation from AB 120 and increase specific AIDS waiver rates on September 22, 2017, retroactive to July 1, 2017.

In FY 2017-18, the Department appropriated \$4,000,000 in Proposition 56 funding to provide supplemental payments for specific AIDS Waiver services.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. Payments will be made via supplemental payments.
2. This policy is effective July 1, 2017; however payments began on November 27, 2017.
3. Supplemental payments were based on CY 2015 actual expenditure data.
4. Assume rates will increase by 90%, excluding administration and care management services.
5. Assume administration rates will increase by 45% and 59% for care management services.
6. Funds allocated for the supplemental payments are as follows:

(Dollars in Thousands)

FY 2018-19	TF	SF	FF
Healthcare Treatment Fund Prop. 56	\$3,400	\$3,400	\$0
100% Title XIX	\$3,400	\$0	\$3,400
Total	\$6,800	\$3,400	\$3,400
FY 2019-20	TF	SF	FF
Healthcare Treatment Fund Prop. 56	\$3,400	\$3,400	\$0
100% Title XIX	\$3,400	\$0	\$3,400
Total	\$6,800	\$3,400	\$3,400

Funding:

Healthcare Treatment Fund (4260-101-3305)

100% Title XIX (4260-101-0890)

PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157
 IMPLEMENTATION DATE: 11/2018
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 2103

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$7,333,000	\$1,811,000
- STATE FUNDS	\$3,546,600	\$876,010
PAYMENT LAG	0.8440	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,189,100	\$1,811,000
STATE FUNDS	\$2,993,330	\$876,010
FEDERAL FUNDS	\$3,195,720	\$934,990

DESCRIPTION

Purpose:

This policy change estimates the expenditures related to providing supplemental payments to Freestanding Pediatric Subacute (FS/PSA) Facilities.

Authority:

SB 856 (Chapter 30, Statutes of 2018)
 SPA 18-0042

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 FS/PSA facilities.

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.

Pursuant to SB 856, the Department shall develop the structure and parameters for supplemental payments for FS/PSA facilities in FY 2018-19.

On September 18, 2018, the Centers for Medicaid and Medicare Services approved State Plan Amendment (SPA) 18-0042 for the supplemental payments.

PROP 56 FS-PSA SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

Reason for Change:

These payments were previously budgeted in the LTC Rate Adjustment policy change in the May 2018 Estimate. The change for FY 2018-19, in the current estimate, is a decrease based on 11 months of payments estimated in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease based on only one month of supplemental payments occurring in FY 2019-20.

Methodology:

1. The Fee-for-Service (FFS) supplemental payments will be provided for RY 2018-19, beginning August 1, 2018, through July 31, 2019. No managed care impact is assumed.
2. The RY 2018-19 supplemental payments are expected to implement in November 2018. An Erroneous Payment Correction (EPC) for the retroactive period of August 2018 through October 2018 is expected to be implemented in January 2019. The July 2019 payments will occur in FY 2019-20.
3. The following payments are estimated in FY 2018-19 and FY 2019-20:

FY 2018-19	TF	SF	Title XIX FF	Title XXI FF	ACA FF
Supplemental Pmts	\$5,333,000	\$2,579,000	\$2,559,000	\$98,000	\$97,000
Retro Supplemental Pmts	\$2,000,000	\$967,000	\$960,000	\$36,000	\$37,000
Total	\$7,333,000	\$3,546,000	\$3,519,000	\$134,000	\$134,000

FY 2019-20	TF	SF	Title XIX FF	Title XXI FF	ACA FF
Supplemental Pmts	\$1,811,000	\$876,000	\$869,000	\$33,000	\$33,000

Funding:

FY 2018-19	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$7,038,000	\$3,519,000	\$3,519,000
94% Title XIX / 6% SF (4260-101-3305 / 0890)	\$65,000	\$4,000	\$61,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$78,000	\$5,000	\$73,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$152,000	\$18,000	\$134,000
Total	\$7,333,000	\$3,546,000	\$3,787,000

FY 2019-20	TF	SF	FF
50% Title XIX / 50% SF (4260-101-3305 / 0890)	\$1,738,000	\$869,000	\$869,000
93% Title XIX / 7% SF (4260-101-3305 / 0890)	\$35,000	\$2,000	\$33,000
88% Title XXI / 12% SF (4260-101-3305 / 4260-113-0890)	\$38,000	\$5,000	\$33,000
Total	\$1,811,000	\$876,000	\$935,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 158
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 1076

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$5,830,000	\$4,263,000
- STATE FUNDS	\$2,425,000	\$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,830,000	\$4,263,000
STATE FUNDS	\$2,425,000	\$1,900,000
FEDERAL FUNDS	\$3,405,000	\$2,363,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.17
 State Plan Amendment (SPA) 14-009
 SPA 15-004
 SPA 16-031

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on January 1, 2014, State Plan Amendments (SPAs) were required to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund. In September 2016, the Department received SPA approval for a two-year transitional SPA 16-031 from the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program for FY 2016-17 and FY 2017-18. SPA 18-017 will be submitted to CMS for approval by September 2018 to continue the NDPH Supplemental program through June 30, 2019.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 158

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to:

- FY 2016-17 Affordable Care Act (ACA) adjustment shifted from FY 2017-18,
- Updated FY 2017-18 ACA claims data, and
- Remaining FY 2017-18 payment shifted from FY 2017-18.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to a delayed adjustment and payment shifted from FY 2017-18 to FY 2018-19, and a gradually reduced ACA Federal Medical Assistance Percentage (FMAP).

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated. Beginning in FY 2017-18, The SF item will also include ACA adjustments.
2. SB 1100 requires that \$1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.
3. The ACA allows for 100% FMAP for calendar years 2014 through 2016 for newly eligible Medi-Cal beneficiaries. Beginning January 1, 2017, the ACA optional population FMAP is 95%, and reduces to 94% beginning January 1, 2018. Beginning January 1, 2019, the ACA optional population FMAP reduces to 93%. CMS approved the ACA claiming methodology in August 2017.
4. ACA adjustments will be processed nine months after the respective fiscal year's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. The FY 2016-17 and FY 2017-18 ACA adjustments will be claimed in FY 2018-19. The FY 2018-19 ACA adjustment will be claimed in FY 2019-20. The ACA adjustments for the non-federal share will be transferred into the NDPH Supplemental Fund.
5. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 158

6. The estimated NDPH Supplemental payments and ending balance for FY 2018-19 are shown below:

FY 2018-19 NDPH Supplemental Fund Summary	SF
FY 2017-18 Ending Balance	\$2,451,000
Appropriation (GF)	\$1,900,000
Est. FY 2017-18 Interest Earned	\$35,000
FY 2016-17 ACA FFP Adjustment to SF	\$506,000
FY 2017-18 ACA FFP Adjustment to SF	\$474,000
Funds Available	\$5,366,000
Less: FY 2017-18 Cash Expenditures to Hospitals	(\$525,000)
Less: FY 2018-19 Cash Expenditures to Hospitals	(\$1,900,000)
Est. FY 2018-19 Remaining Balance	\$2,941,000

FY 2018-19	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2017-18 Cash Expenditures to Hospitals**	\$1,050,000	\$525,000	\$525,000	0	0
FY 2018-19 Cash Expenditures to Hospitals**	\$3,800,000	\$1,900,000	\$1,900,000	\$0	\$0
FY 2016-17 ACA FF Adjustment to SF***	\$506,000	\$0	(\$532,000)	\$1,038,000	\$506,000
FY 2017-18 ACA FF Adjustment to SF***	\$474,000	\$0	(\$532,000)	\$1,006,000	\$474,000
Total	\$5,830,000	\$2,425,000	\$1,361,000	\$2,044,000	\$980,000

7. The estimated NDPH Supplemental payments and ending balance for FY 2019-20 are shown below:

FY 2019-20 NDPH Supplemental Fund Summary	SF
FY 2018-19 Ending Balance	\$2,941,000
Appropriation (GF)	\$1,900,000
Est. FY 2018-19 Interest Earned	\$55,000
FY 2018-19 ACA FFP Adjustment to SF	\$463,000
Funds Available	\$5,359,000
Less: FY 2019-20 Cash Expenditures to Hospitals	(\$1,900,000)
Est. FY 2019-20 Remaining Balance	\$3,459,000

NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 158

FY 2019-20	TF	SF	FF	ACA FF	Return to Fund 3096*
FY 2019-20 Cash Expenditures to Hospitals**	\$3,800,000	\$1,900,000	\$1,900,000	\$0	\$0
FY 2018-19 ACA FF Adjustment to SF***	\$463,000	\$0	(\$532,000)	\$995,000	\$463,000
Total	\$4,263,000	\$1,900,000	\$1,368,000	\$995,000	\$463,000

*The Return to Fund 3096 column is for display purposes only (see Methodology #4).

Funding:

100% GF (4260-104-0001)

NDPH Supplemental Fund (less funded by GF) (4260-698-3096)

50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)**

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

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 159
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1158

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$112,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$112,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$112,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to select private hospitals.

Authority:

Welfare & Institutions Code 14164

Interdependent Policy Changes

Not Applicable

Background:

The Welfare & Institutions Code provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

The Selective Provider Contracting Program ended in June 2013. As part of the Private Hospital Supplemental Fund, the Centers for Medicare and Medicaid (CMS) approved State Plan Amendment (SPA) 14-008 on October 24, 2014 to authorize IGT distributions to eligible private hospitals. The Department obtained CMS approval of SPA 15-003 to continue IGT distributions to eligible private hospitals through FY 2017-18. Subsequent SPAs include 16-014 which made a technical change to the timing of payments and was approved by CMS on July 19, 2016, and 16-022 which reduced the total supplemental payment to St. Rose Hospital and was approved by CMS on December 8, 2016.

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 159

This program will sunset on June 30, 2018, because Los Angeles County has elected to discontinue the IGTs used to fund the non-federal share of the supplemental payments. The final supplemental payment from this program was made in the 4th quarter of FY 2017-18 but, per the ACA methodology, the final ACA payment to Los Angeles County will not be made until FY 2018-19.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to updated actuals for the FY 2017-18 ACA payments.

Methodology:

1. FY 2017-18 is the last year in which IGT payments were made. This program and its payments were terminated effective June 30, 2018, as Los Angeles County declined to contribute any IGTs in future fiscal years.
2. Federal approval of the ACA payment methodology was received in FY 2017-18 and payments began in December 2017. Payments are based on a ratio of the ACA optional expansion aid codes to total Medi-Cal aid codes, deriving an ACA percentage for each hospital. The ratio is then applied to each hospital's total supplemental payment in order to determine the actual amount of ACA reimbursement.
3. The ACA allows for 100% Federal Medical Assistance Percentage (FMAP) for calendar years 2014 through 2016, for newly eligible Medi-Cal beneficiaries. Beginning on January 1, 2017, FMAP for the ACA population decreases to 95%, then to 94% on January 1, 2018, and to 93% on January 1, 2019.
4. ACA payments will be processed 9 months after the respective FY's supplemental payments have been issued in order to determine the proportion of the costs for newly eligible Medi-Cal beneficiaries. For FY 2017-18, the ACA payment will be made in FY 2018-19. The County will be reimbursed for the IGT (nonfederal share), and an adjustment will be made for the federal share processed at the regular 50% FMAP.
5. Cash basis payments are estimated to be:

FY 2018-19	TF	IGT	FF	ACA FF	*Return to Counties
FY 2017-18 ACA Adjustment to Counties	\$112,000	\$0	(\$124,000)	\$236,000	\$112,000
Total FY 2018-19	\$112,000	\$0	(\$124,000)	\$236,000	\$112,000

*The Return to Counties column is for display purposes only (see Methodology #4).

Funding:

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

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

MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 160
 IMPLEMENTATION DATE: 9/2019
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2055

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$2,100,000,000
- STATE FUNDS	\$0	\$652,099,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$2,100,000,000
STATE FUNDS	\$0	\$652,099,000
FEDERAL FUNDS	\$0	\$1,447,901,000

DESCRIPTION

Purpose:

This policy change estimates the managed care Private Hospital Directed Payments (PHDP) to private hospitals through enhanced capitation payments to managed care plans (MCPs).

Authority:

AB 1607 (Chapter 27, Statutes of 2016)
 Proposition 52 (2016)
 Title 42, Code of Federal Regulations (CFR) 438.6(c)

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. The result is changes in the usage of managed care delivery systems. 42 CFR 438.6(c) provides State's flexibility to implement delivery system and provider payment initiatives under Medicaid MCPs contracts based on allowable directed payments that focus on delivery system reform.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department will direct MCPs to reimburse private hospitals as defined in WIC 14169.51 for PHDP based on actual utilization of contracted services. The payments will be enhanced by a uniform dollar increment (uniform unit cost add on) and is contingent upon hospitals providing adequate access to service, including primary, specialty, and inpatient (both tertiary and quaternary) care.

The total funding available for the enhanced contracted payments will be limited to a predetermined amount (pool). Upon determination of actual utilization, the Department will direct the MCPs to make enhanced payments to private hospitals for contracted services. Following the issuance of all enhanced payments, the Department will adjust per-member-per-month increments for actual utilization.

**MANAGED CARE PRIVATE HOSPITAL DIRECTED
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 160

Reason for Change:

This is a new policy change.

Methodology:

1. The total value of the funding for the private hospital directed payment pool is \$2.1 billion total fund for rating period 2017-18.
2. The non-federal share will be supported by the Hospital Quality Assurance Revenue Fund (HQARF).
3. Enhanced payments will be issued to MCPs based on actual private hospital utilization for contracted services.
4. The payments will be issued in two separate periods for each rating year, based on service date.
5. The FY 2017-18 rating period payments are anticipated to occur in September 2019 and March 2020.
6. On a cash basis, the estimated payments are:

(Dollars in Thousands)

FY 2019-20	TF	SF (HQARF)	FF (Title 19)	FF (Title 21)	ACA FF
FY 2017-18	\$2,100,000	\$652,099	\$523,357	\$71,209	\$853,335
Total FY 2019-20	\$2,100,000	\$652,099	\$523,357	\$71,209	\$853,335

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

Title XXI FFP (4260-611-0890)

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER: 161
 IMPLEMENTATION DATE: 12/2018
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1936

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$57,224,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$57,224,000	\$0
FEDERAL FUNDS	-\$57,224,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation repayment to the Centers for Medicare and Medicaid Services (CMS) for ineligible claims made through the distinct part skilled nursing facility (DP-NF) Capital Project Debt Reimbursement supplemental payment program.

Authority:

SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:

Not Applicable

Background:

SB 1128 authorized a DP-NF of a public acute care hospital providing specified services and other specific conditions as specified in Section 14105.26 of the Welfare and Institutions Code, to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The Department claims federal funds using certified public expenditures. To be eligible for payments, the capital projects must be completed and have been issued a certificate of occupancy.

On June 16, 2015, CMS notified the Department that it denied the "good cause" waiver request, thus disapproving total payments of \$57,224,000 for payments that were made to Edgemoor Geriatric Hospital and Laguna Honda Hospital and Rehabilitation Center for costs prior to the certificate of occupancy and/or were not made within the two-year claiming limit. The repayment to CMS will occur in FY 2018-19. The Department is in discussions with Laguna Honda Hospital and Rehabilitation Center regarding a repayment schedule.

Reason for Change:

There is no change in FY 2018-19 from the prior estimate, however, the month of payment has shifted from August 2018 to December 2018.

DP-NF CAPITAL PROJECT DEBT REPAYMENT

REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. The Department is anticipated to reimburse the federal funds, totaling \$57,224,000, in FY 2018-19.

(Dollars in Thousands)

Facility Name	TF	GF	FF
Edgemoor Geriatric Hospital	\$0	\$1,317	(\$1,317)
Laguna Honda Hospital and Rehabilitation Center	\$0	\$55,907	(\$55,907)
FY 2018-19	\$0	\$57,224	(\$57,224)

Funding:

100% GF (4260-101-0001)

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

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 167
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2092

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$581,878,000	\$139,858,000
- STATE FUNDS	\$290,939,000	\$69,929,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$581,878,000	\$139,858,000
STATE FUNDS	\$290,939,000	\$69,929,000
FEDERAL FUNDS	\$290,939,000	\$69,929,000

DESCRIPTION

Purpose:

This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF) and the AB 1629 Quality Assurance Fee (QAF) assessed on Skilled Nursing Facilities and the QAF assessed on Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs).

Authority:

Welfare & Institutions Code section 14169.52

Interdependent Policy Changes:

Long Term Care Quality Assurance Fund Expenditures

Background:

To recover past due hospital quality assurance fees from delinquent providers, the Department currently withholds portions of the delinquent provider's FFS payments and transfers the withheld portion to the HQAF revenue fund on behalf of the delinquent provider. As Medi-Cal is on a cash basis, these expenditures were originally budgeted in the fiscal year the claim was processed.

This withhold process was also applied to collections for the AB 1629 QAF assessed on Skilled Nursing Facilities and the QAF assessed on Intermediate Care Facilities for the Developmentally Disabled. The withheld portion is transferred to the Long Term Care Quality Assurance Fund (LTCQAF), and subsequently to the General Fund (GF), providing savings once the transfer occurs. The fund adjustment from the LTCQAF to the GF is budgeted in the Long Term Care Quality Assurance Fund Expenditures policy change.

QAF WITHHOLD TRANSFER

REGULAR POLICY CHANGE NUMBER: 167

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to:

- Updating HQAF withhold amounts based on actual withhold transfers,
- Adding SNF and ICF/DD QAF prior year withhold transfers in FY 2018-19, and
- Adding offsets for the new FY 2018-19 HQAF and LTC QAF withholds that are not transferred in the same year.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to having fewer prior year withhold transfers in FY 2019-20.

Methodology:HQAF

1. Prior year HQAF withheld payments totaling \$414.96 million TF were paid in FY 2018-19.
2. An estimated \$76.13 million TF in HQAF withholds will occur in FY 2018-19 and offsets a portion of the \$414.96 million HQAF withhold transfer.
3. An estimated \$76.13 million of FY 2018-19 HQAF withheld payments will be paid in FY 2019-20.

LTCQAF

4. Prior year LTCQAF withheld payments totaling \$306.74 million TF will be paid in FY 2018-19.
5. An estimated \$63.73 million in LTCQAF withholds will occur in FY 2018-19 and offsets a portion of the \$306.74 million LTCQAF withhold transfer.
6. An estimated \$63.73 million of FY 2018-19 LTCQAF withheld payments will be paid in FY 2019-20.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
HQAF			
HQAF Prior Year Withhold Transfers	\$414,996	\$207,498	\$207,498
HQAF FY 2018-19 New Withholds	(\$76,128)	(\$38,064)	(\$38,064)
Subtotal HQAF	\$338,868	\$169,434	\$169,434
LTCQAF			
LTCQAF Prior Year Withhold Transfers	\$306,740	\$153,370	\$153,370
LTCQAF FY 2018-19 New Withholds	(\$63,730)	(\$31,865)	(\$31,865)
Subtotal LTCQAF	\$243,010	\$121,505	\$121,505
Total FY 2018-19	\$581,878	\$290,939	\$290,939

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
HQAF FY 2018-19 Withhold Transfer	\$76,128	\$38,064	\$38,064
LTCQAF FY 2018-19 Withhold Transfer	\$63,730	\$31,865	\$31,865
Total FY 2019-20	\$139,858	\$69,929	\$69,929

Funding:

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

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 170
 IMPLEMENTATION DATE: 2/2019
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1942

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$142,263,000	\$200,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$142,263,000	\$200,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$142,263,000	\$200,000,000

DESCRIPTION

Purpose:

This policy change estimates the reimbursement of In-Home Supportive Services (IHSS) overpayments and underpayments to the California Department of Social Services (CDSS) and the managed care plans.

Authority:

Welfare & Institutions Code (W&I) 14132.275

Interdependent Policy Changes:

Not Applicable

Background:

In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aimed to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their home or community. LTSS includes both home and community-based services, such as IHSS and institutional long-term care services. Services were provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. CDSS and the county social service offices were responsible for the administration and payment of IHSS expenditures. The cost of IHSS was built into the CCI capitated rates and paid to CDSS to reimburse IHSS providers for personal care services. The Department is responsible for the reconciliation of the IHSS category of service, which was a component of the capitated rate, to actual IHSS expenditures paid out to providers by CDSS for a specified period of time. The Department will determine the overpayments or underpayments to CDSS or the managed care plans during the reconciliation process.

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

CCI IHSS RECONCILIATION

REGULAR POLICY CHANGE NUMBER: 170

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to updated reconciliation payment data for CY 2015 and CY 2016 that will be paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to updated reconciliation payment data for CY 2017 that will be paid in FY 2019-20.

Methodology:

1. Assume the 2015 and 2016 reconciliation for calendar year (CY) 2015 and CY 2016 service months and reimbursement for overpayments and underpayments will be completed in FY 2018-19.
2. Assume the 2017 reconciliation for calendar year CY 2017 service months and reimbursement for overpayments and underpayments will be completed in FY 2019-20.
3. Based on CY 2015 and CY 2016 data, it is estimated the Department will reimburse CDSS \$142,263,000 TF for IHSS managed care in the seven CCI counties.
4. Based on CY 2017 data, it is estimated the Department will reimburse CDSS \$200,000,000 TF for IHSS managed care in the seven CCI counties.

Funding:

100% Title XIX (4260-101-0890)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1488

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$91,440,000	\$49,016,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$91,440,000	\$49,016,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$91,440,000	\$49,016,000

DESCRIPTION

Purpose:

This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt meaningful use (MU) Electronic Health Records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:

ARRA of 2009
 SB 945 (Chapter 433, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The HITECH act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. The Medi-Cal EHR Incentive Program is scheduled to sunset in 2021, with program closeout and audit closeouts potentially extending beyond 2021, based on the May 2018 Notice of Proposed Rulemaking. To qualify for incentive payments, health care providers must meet MU requirements with certified EHR technology in accordance with the HITECH act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department has implemented a State Level Registry (SLR) for incentive payment applicants, allowing for more seamless and efficient participation and payment for eligible providers and hospitals. The payments are intended to accelerate the meaningful use of EHR technology by providers serving the Medi-Cal population. Over 25,000 providers, and 330 hospitals currently participate in the program. Provider payments are funded with 100% federal financial participation (FFP).

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171

The SLR is necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive program. The Medi-Cal Fiscal Intermediary (FI) continues to develop the SLR to meet updated requirements published by CMS. System costs are budgeted in the Medical FI Optional Contractual Services policy change. Administrative costs for the State's Health Information Technology program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change:

The changes from the prior estimate, for FY 2018-19, is due to anticipated lower professional participation due to changes in program requirements per CMS guidance. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to lower remaining payments in FY 2019-20 as providers and hospitals move through the program.

Methodology:

1. Payments to the providers began in December 2011.
2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.
3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is \$21,250. Incentive payments for years two through six are \$8,500 per eligible year. The maximum incentive payment for a professional over the six year period is \$63,750. Professionals are no longer able to initiate participation in the program as of May 23, 2017. CMS allowed an extension to July 25, 2017 for providers attesting to 2016 as their first program year who completed all requirements by May 23, 2017, but had documented technical difficulties preventing submission. There are no outstanding year-one payments for professionals as of FY 2018-19.
4. Assume the aggregate hospital incentive payment amount is computed on a \$2,000,000 base amount adjusted depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth eligibility years. Hospitals are no longer able to initiate participation in the program as of May 23, 2017. Commencing with program year 2016, hospitals must also attest in consecutive years. There are no outstanding year-one payments for hospitals as of FY 2018-19.

For FY 2018-19 and FY 2019-20, incentive payments are adjusted based on hospitals' pending payments. For FY 2018-19, the year-two incentive payments will average \$720,000, the year-three payments will average \$170,000, and the year-four payments will average \$270,000. For FY 2019-20, the year-two payments will average \$500,000, the year-three payments will average \$200,000, and the year-four payments will average \$225,000.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 171

5. The estimated payments for FY 2018-19 and FY 2019-20 are on a cash-basis.

FY 2018-19 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
2	1,905	\$8,500	\$16,193,000
3	1,283	\$8,500	\$10,906,000
4	1,159	\$8,500	\$9,852,000
5	1,337	\$8,500	\$11,365,000
6	451	\$8,500	\$3,834,000
Total FY 2018-19 Professional Payments			\$52,150,000

Eligibility Year	Hospitals	Incentive Payments	FF
2	7	\$720,000	\$5,040,000
3	49	\$170,000	\$8,330,000
4	96	\$270,000	\$25,920,000
Total FY 2018-19 Hospital Payments			\$39,290,000

FY 2019-20 Incentive Payments:

Eligibility Year	Professionals	Incentive Payments	FF
2	819	\$8,500	\$6,962,000
3	782	\$8,500	\$6,647,000
4	672	\$8,500	\$5,712,000
5	722	\$8,500	\$6,137,000
6	298	\$8,500	\$2,533,000
Total FY 2019-20 Professional Payments			\$27,991,000

Eligibility Year	Hospitals	Incentive Payments	FF
2	3	\$500,000	\$1,500,000
3	20	\$200,000	\$4,000,000
4	69	\$225,000	\$15,525,000
Total FY 2019-20 Hospital Payments			\$21,025,000

Fiscal Year	Professional Payments	Hospital Payments	FF
FY 2018-19	\$52,150,000	\$39,290,000	\$91,440,000
FY 2019-20	\$27,991,000	\$21,025,000	\$49,016,000

Funding:

100% Title XIX (4260-101-0890)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 172
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$130,514,000	\$64,181,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$130,514,000	\$64,181,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$130,514,000	\$64,181,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:

Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:

Not Applicable

Background:

Beneficiaries that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. This policy change includes the additional FFP in FY 2018-19. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 172

Reason for Change:

The change for FY 2018-19 from the prior estimate, and from FY 2018-19 to FY 2019-20 within the current estimate, is due to shifting the prior year payments that included ARRA funding from FY 2017-18 to FY 2018-19.

Methodology:

1. FY 2018-19 includes a portion of payments for FY 2009-10, FY 2016-17, FY 2017-18, and FY 2018-19 expenditures. FY 2019-20 includes a portion of payments for FY 2017-18, FY 2018-19, and FY 2019-20 expenditures.
2. The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP
FY 2018-19	\$251,028	\$120,514	\$120,514	\$10,000	\$130,514
FY 2019-20	\$128,362	\$64,181	\$64,181	\$0	\$64,181

Funding:

100% Title XIX (4260-101-0890)

MINIMUM WAGE INCREASE FOR HCBS WAIVERS

REGULAR POLICY CHANGE NUMBER: 174
 IMPLEMENTATION DATE: 1/2017
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1975

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$43,323,000	\$47,398,000
- STATE FUNDS	\$21,661,500	\$23,699,000
PAYMENT LAG	0.9880	0.9880
% REFLECTED IN BASE	32.02 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$29,097,600	\$46,829,200
STATE FUNDS	\$14,548,780	\$23,414,610
FEDERAL FUNDS	\$14,548,780	\$23,414,610

DESCRIPTION

Purpose:

This policy change estimates the costs of increasing the minimum wage for the Assisted Living Waiver (ALW) and the Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver Program (MCWP).

Authority:

SB 3 (Chapter 4, Statutes of 2016)

Interdependent Policy Changes:

Overtime for WPCS Providers

Background:

The passage of AB 10 in 2013 set the minimum wage in California to \$10 an hour after January 1, 2016. SB 3 requires a schedule for a phased increase in the minimum wage from \$10.50 per hour to \$15 per hour by January 1, 2022, or January 1, 2023, depending on the size of the employer and general economic conditions, and link the minimum wage to the U.S. Consumer Price Index (CPI) once the minimum wage reaches \$15 per hour.

The minimum wage increase will result in increased costs for multiple long term care programs. Home and Community-Based Services (HCBS) are predominantly provided by individuals working for minimum wage, and this increase will raise the overall cost of HCBS for the following programs: the ALW and the AIDS MCWP.

The AIDS MCWP is a 1915(c) HCBS Waiver for Medi-Cal beneficiaries. MCWP provides comprehensive case management and direct care services at no cost to persons with Human Immunodeficiency Virus (HIV) disease or AIDS as an alternative to nursing facility care or hospitalization.

The ALW offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.

MINIMUM WAGE INCREASE FOR HCBS WAIVERS**REGULAR POLICY CHANGE NUMBER: 174****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is a decrease due to a lower estimated rate increase for care coordination. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to projected additional users for the ALW, a 2% increase in projected enrollment in the AIDS attendant care users, and the increase in the minimum wage.

Methodology:

- Beginning January 1, 2018, the minimum wage will increase \$.50 from \$10.50 to \$11.00 per hour. Beginning January 1, 2019, the minimum wage will increase \$.50 from \$11.00 to \$11.50 per hour. Beginning January 1, 2020, the minimum wage will increase \$.50 from \$11.50 to \$12.00 per hour.
- Assume a 10% cost increase for employers due to required payroll taxes and other costs.

ALW

- Assume the total amount of users is 3,744 in CY 2017, 4,744 in CY 2018, and 5,744 in CY 2019.
- For FY 2018-19, assume the total care coordination and assisted living cost minimum wage increase is \$43,073,000 TF. For FY 2019-20, assume the total care coordination and assisted living cost minimum wage increase is \$46,980,000 TF.

AIDS MCWP

- For CY 2018, assume there are 216 attendant care users. For CY 2019, assume there are 221 attendant care users. For CY 2020, assume there are 225 attendant care users.
- A unit is counted as 15 minutes of time.
- For CY 2018, assume a participant uses 1,180 units of attendant care services annually. For CY 2019, assume a participant uses 1,204 units of attendant care services annually. For CY 2020, assume a participant uses 1,228 units of attendant care services annually.
- For CY 2018, assume the estimated attendant care service rate is \$5.30 per unit. For CY 2019, assume the estimated attendant care service rate is \$5.88 per unit. For CY 2020, assume the estimated attendant care service rate is \$6.47 per unit.
- Assume the FY 2018-19 cost for AIDS MCWP Waiver minimum wage is \$250,000 TF. Assume the FY 2019-20 cost for the AIDS MCWP Waiver minimum wage increase is \$418,000 TF.

FY 2018-19	TF	GF	FF
ALW	\$43,073,000	\$21,537,000	\$21,536,000
HIV/AIDS	\$250,000	\$125,000	\$125,000
Total	\$43,323,000	\$21,662,000	\$21,661,000

FY 2019-20	TF	GF	FF
ALW	\$46,980,000	\$23,490,000	\$23,490,000
HIV/AIDS	\$418,000	\$209,000	\$209,000
Total	\$47,398,000	\$23,699,000	\$23,699,000

Funding:

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

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 177
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 2009

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$46,546,000	\$32,763,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,546,000	\$32,763,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$46,546,000	\$32,763,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Infant Development Program (IDP) services for infants and toddlers ages 0 to 3 with or at risk of developmental disabilities.

Authority:

Interagency Agreement 11-88601

Interdependent Policy Changes:

Not Applicable

Background:

On October 9, 2015, State Plan Amendment (SPA) 11-040 was approved by the Centers for Medicare and Medicaid Services to extend Medi-Cal coverage for IDP services provided to Medi-Cal eligible infants and toddlers ages 0 to 3 with or at risk of developmental delay under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, retroactive to October 1, 2011. This SPA authorizes CDDS to claim federal financial participation (FFP) for the provision of IDP services by the state's Regional Center network of nonprofit providers to persons with developmental disabilities.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updating expenditures with actuals and increased prior year expenditures.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to an expected decrease in previous year expenditures.

INFANT DEVELOPMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 177

Methodology:

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

(Dollars in Thousands)

	TF	CDDS GF	FF
FY 2018-19	\$93,091	\$46,545	\$46,546
FY 2019-20	\$65,526	\$32,763	\$32,763

Funding:

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 178
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1526

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$19,468,000	\$13,595,000
- STATE FUNDS	\$8,407,000	\$6,189,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$19,468,000	\$13,595,000
STATE FUNDS	\$8,407,000	\$6,189,000
FEDERAL FUNDS	\$11,061,000	\$7,406,000

DESCRIPTION

Purpose:

This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:

Interagency Agreement (IA) 07-65896

Interdependent Policy Changes:

Not Applicable

Background:

The California Department of Developmental Services (CDDS) makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008, through December 31, 2010. The Education, Jobs, and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011, through March 31, 2011, and 56.88% for April 1, 2011, through June 30, 2011. This policy change includes the additional FFP in FY 2018-19. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 178

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

Reason for Change:

The change for FY 2018-19, from the prior estimate, is a net increase due to updated expenditures data and ARRA expenditures originally expected to occur FY 2017-18 shifted to FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net decrease due to more prior year expenditures paid in FY 2018-19, and ARRA funds expected to be received in FY 2018-19.

Methodology:

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

(Dollars in Thousands)

Fiscal Year	RC Admin Fee	QAF & ICF Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP	ARRA
FY 2018-19	\$1,825	\$8,407	\$21,293	\$1,825	\$8,407	\$10,233	\$828
FY 2019-20	\$1,216	\$6,189	\$14,811	\$1,216	\$6,189	\$7,406	\$0

Funding:

100% GF (4260-101-0001)

100% FFP (4260-101-0890)

MEDI-CAL ESTATE RECOVERIES

REGULAR POLICY CHANGE NUMBER: 179
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1991

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$38,906,000	\$50,660,000
- STATE FUNDS	\$19,453,000	\$25,330,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	65.60 %	44.20 %
APPLIED TO BASE		
TOTAL FUNDS	\$13,383,700	\$28,268,300
STATE FUNDS	\$6,691,830	\$14,134,140
FEDERAL FUNDS	\$6,691,830	\$14,134,140

DESCRIPTION

Purpose:

This policy change estimates the cost for the changes in the Medi-Cal Estate Recovery (ER) program.

Authority:

SB 833 (Chapter 30, Statutes of 2016)
 Welfare and Institutions Code Section 14009.5
 Title 42, United States Code, Section 1396p
 Title 22, California Code of Regulations Sections 50960-50966

Interdependent Policy Changes:

Not Applicable

Background:

The Medi-Cal ER program is one of several controls to mitigate Medi-Cal costs for care. Upon death of a Medi-Cal beneficiary, the decedent's estate or any recipient of the decedent's estate may have to pay back the costs of services through the ER program. However, as of January 1, 2017, pursuant to SB 833, the program changes limited the ER program to the probated estates of deceased Medi-Cal members 55 years of age and older, for only federally mandated services (skilled nursing care, home and community-based services, and related services), and also eliminated recovery if a Medi-Cal beneficiary is survived by a spouse/registered domestic partner. In addition, the ER program is limited to proportionate share recovery when a substantial hardship waiver criterion is identified.

Reason for Change:

There is no change in FY 2018-19 from the prior estimate.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to continuing the trend of declining cases resulting in recoveries decreasing.

MEDI-CAL ESTATE RECOVERIES**REGULAR POLICY CHANGE NUMBER: 179****Methodology:**

1. The ER program changes, pursuant to SB 833, were effective January 1, 2017.
2. In FY 2016-17, ER recoveries were \$69.5 million or \$5.79 million monthly. During FY 2016-17, there were no recoveries from estates, in which the beneficiary died on or after January 1, 2017.
3. The total open ER cases which have accounts receivable balances decreased approximately 2.5 percent per month from January 1, 2017, to June 30, 2017. They further decreased approximately 4.96 percent per month from July 1, 2017, to January 31, 2018.

Due to the lag between when a case is established and when a settlement is received, ER recoveries were stable during FY 2016-17 because of cases before January 1, 2017, but began showing a decreasing trend beginning July 2017. The trend is expected to continue monthly, ongoing. The actual recoveries declined to approximately \$51.0 million in FY 2017-18, compared to FY 2016-17 recoveries. As a result, the savings loss estimated in FY 2017-18 was approximately \$18.5 million.

FY 2017-18:

\$69.5 million TF - \$51.0 million TF = \$18.5 million TF Savings Loss

4. It is further assumed that recoveries will continue to decline at 3.96 percent per month for FY 2018-19 and FY 2019-20. In FY 2018-19, ER cases are expected to decrease further by approximately 3.96 percent and recoveries are expected to continue to decline to approximately \$30.594 million. As a result, the savings loss estimated in FY 2018-19 is approximately \$38.906 million TF.

FY 2018-19:

\$69.5 million TF - \$30.594 million TF = \$38.906 million TF Savings Loss

5. In FY 2019-20, ER recoveries are expected to continue to decline further to approximately \$18.84 million. As a result, the savings loss estimated in FY 2019-20 is approximately \$50.66 million TF.

FY 2019-20:

\$69.5 million TF - \$18.84 million TF = \$50.66 million TF Savings Loss

(Dollars in Thousands)

Uncollectible Estate Recoveries	TF	GF	FF
FY 2018-19	\$38,906	\$19,453	\$19,453
FY 2019-20	\$50,660	\$25,330	\$25,330

Funding:

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

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 180
 IMPLEMENTATION DATE: 2/2016
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1852

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$8,088,000	\$8,356,000
- STATE FUNDS	\$4,044,000	\$4,178,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,088,000	\$8,356,000
STATE FUNDS	\$4,044,000	\$4,178,000
FEDERAL FUNDS	\$4,044,000	\$4,178,000

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
 SB 89 (Chapter 24, Statutes of 2017)

Interdependent Policy Changes:

Not Applicable

Background:

Federal regulations require In-Home Supportive Services (IHSS) and WPCS providers to be paid overtime. The W&I Code, Section 12300.4 requires 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. On January 3, 2016, the California Department of Social Services issued an All-County Letter 16-02 which allowed an IHSS/WPCS provider who works for one participant to work up to but no more than 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. Paid travel time cannot exceed seven hours per week. Beginning February 1, 2016, the Department began paying for overtime.

SB 89 amends Section 12300.4 of the W&I Code to add the In-Home Operations (IHO) Waiver to the provider exemptions language set forth in subdivision (e) of Section 14132.99. This Section extends these provisions to the Home and Community-Based Alternatives Waiver (formerly known as the Nursing Facility/Acute Hospital (NF/AH) Waiver), the IHO Waiver, and their successors.

SB 89 also adds provisions to Section 14132.99 of the W&I Code to extend two types of exemptions from the 66-hour workweek limit. A waiver provider who is granted an exemption would be allowed to

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 180

work overtime between IHSS and WPCS up to 12-hours a day, or 360 hours per month, on a case-by-case basis. Factors to consider when examining exemption eligibility include the following:

- The provider lives in the same home as the waiver participant, even if the provider is not a family member;
- The provider provides care to the waiver participant and has done so for two or more years continuously; and
- The waiver participant is unable to find a local caregiver who speaks the same language.

Currently, the Department only approves an exemption for a participant enrolled in the waiver on or before January 31, 2016, who meets the allowable circumstances for granting an exemption. SB 89 extends overtime exemption to new providers and providers of newly enrolled participants who meet one of the exemption eligibility criteria.

On January 1, 2018, the minimum wage increased from \$10.50 to \$11.00 per hour. Beginning January 1, 2019, the minimum wage will increase from \$11.00 to \$12.00 per hour. Beginning January 1, 2020, the minimum wage will increase from \$12.00 to \$13.00 per hour.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a revision in the methodology which factors in that WPCS providers, who also provide IHSS, may receive overtime through the IHSS program. The changes reflect the number of overtime hours a WPCS provider may receive while working for the WPCS program only. The change from FY 2018-19 to FY 2019-20, 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 848 WPCS beneficiaries will have providers receiving overtime in FY 2018-19 and 883 in FY 2019-20.
- 2) Assume the annual cost for overtime without exemptions or travel time in FY 2018-19 is \$333,000 and \$364,000 in FY 2019-20.
- 3) Assume 800 WPCS providers receive overtime exemptions in FY 2018-19 and 835 in FY 2019-20.
- 4) Assume the annual cost for overtime for providers who received an exemption in FY 2018-19 is \$7,543,000 and \$7,768,000 in FY 2019-20.
- 5) Assume the annual travel time cost for WPCS providers in FY 2018-19 is \$212,000 and \$223,000 in FY 2019-20.
- 6) Assume \$36,000 GF will be allocated from local assistance to state support costs to support activities related to the expansion of the WPCS overtime exemptions.
- 7) The estimated cost for overtime, including exemptions, and travel time for WPCS providers is **\$8,088,000 TF (\$4,044,000 GF)** in FY 2018-19 and **\$8,356,000 TF (\$4,178,000 GF)** in FY 2019-20.

Funding:

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

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL

REGULAR POLICY CHANGE NUMBER: 181
 IMPLEMENTATION DATE: 10/2017
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 2010

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$6,731,000	-\$1,580,000
- STATE FUNDS	\$3,365,500	-\$790,000
PAYMENT LAG	0.7690	0.9980
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,176,100	-\$1,576,800
STATE FUNDS	\$2,588,070	-\$788,420
FEDERAL FUNDS	\$2,588,070	-\$788,420

DESCRIPTION

Purpose:

This policy change estimates the cost of renewing the Home and Community Based Alternatives (HCBA) Waiver (formerly known as the Nursing Facility / Acute Hospital (NF/AH) Waiver).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The HCBA waiver offers services in the home or community to Medi-Cal beneficiaries who would otherwise receive care in a skilled nursing facility. Eligibility into the waiver is based on skilled nursing levels of care. The level of care is determined by the Medi-Cal beneficiary's medical need. The waiver is held to the principle of federal cost neutrality; thus, services are arranged so that the overall total costs for the waiver and Medi-Cal State Plan services cannot exceed the costs of facilities offering equivalent levels of care. The Department received approval for an amendment to the NF/AH waiver in November 2016, retroactive to February 1, 2016. The primary change enacted through this amendment was to allow a shift to the calculation of cost neutrality in the aggregate, based upon medical necessity. The Department received approval of the waiver renewal application on May 16, 2017, retroactive to January 1, 2017. As part of the approved renewal application, the waiver was renamed to the HCBA Waiver.

Under the NF/AH Waiver renewal, the Department received approval to:

- Increase the number of waiver slots with long-term savings by expanding capacity of the HCBA waiver, which would eliminate the waitlist and allow Medi-Cal beneficiaries to remain in their home or community and mitigate the risk of institutionalization while incentivizing increased long-term skilled nursing facility transition;

HOME & COMMUNITY-BASED ALTERNATIVES WAIVER RENEWAL REGULAR POLICY CHANGE NUMBER: 181

- Localize care management to comply with person-centered care planning and provide local care coordination that will increase access to medically necessary services for beneficiaries while reducing inpatient, emergency room, and skilled nursing facility admissions and readmissions. The reimbursement structure for Comprehensive Care Management will be a tiered per member per month based on acuity. The combination of transitions to Comprehensive Care Management and changing the role of state staff to oversight and monitoring will result in a reduction in health care costs over time through a significantly strengthened care management model;
- Shift to aggregate cost neutrality, based upon medical necessary waiver services, which was approved in the waiver amendment; and
- Gradual integration of the In-Home Operations (IHO) Waiver by transitioning IHO waiver beneficiaries into the HCBA waiver at the point of annual reassessment.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase in cost due to a slightly slower enrollment of new beneficiaries and capturing their savings. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase in savings due to the projected increase enrollment in the HCBA Waiver.

Methodology:

1. Beginning February 1, 2016, for FY 2018-19 and FY 2019-20, assume 1,732 and 2,034 respectively, current participants are over their waiver cap and their monthly cost for unmet need is \$367.
2. The renewed waiver was approved on May 16, 2017 with an effective date of January 1, 2017.
3. There are currently 3,417 waiver participants. Assume 1,590 new participants will be enrolled in FY 2018-19 and 1,000 in FY 2019-20.
4. From the newly enrolled participants, assume 60% will be from long-term skilled nursing facilities and the Early Periodic Screening and Diagnostic Treatment (EPSDT) Program and 40% participants will be from the community.
5. Assume the average monthly cost for comprehensive care management is \$275 and that care management costs will begin in August 2018 to allow time to implement the Waiver Agency model.
6. Assume 90% of all current and new waiver participants will enroll with a Waiver Agency and receive comprehensive care management.
7. Assume the monthly cost for administration is \$186.56.
8. Assume the monthly cost for waiver services from the community is \$3,040.
9. Assume the monthly cost for wavier services transitioning from institutions and EPSDT is \$4,698.
10. Assume the average monthly cost in a skilled nursing facility is \$10,736.

**HOME & COMMUNITY-BASED ALTERNATIVES WAIVER
RENEWAL
REGULAR POLICY CHANGE NUMBER: 181**

FY 2018-19	TF	GF	FF
Administrative Cost	\$9,949,000	\$4,975,000	\$4,974,000
Care Management	\$13,505,000	\$6,752,000	\$6,753,000
Waiver Svcs. - Community	\$22,196,000	\$11,098,000	\$11,098,000
Waiver Svcs. - EPSDT	\$8,575,000	\$4,288,000	\$4,287,000
Waiver Svcs. – Institutional Tran.	\$42,874,000	\$21,437,000	\$21,437,000
Unmet Need	\$7,607,000	\$3,803,000	\$3,804,000
Institutional Transitions Savings	(\$97,975,000)	(\$48,988,000)	(\$48,988,000)
Total	\$6,731,000	\$3,365,000	\$3,366,000
FY 2019-20	TF	GF	FF
Administrative Cost	\$11,964,000	\$5,982,000	\$5,982,000
Care Management	\$17,636,000	\$8,818,000	\$8,818,000
Waiver Svcs. - Community	\$36,788,000	\$18,394,000	\$18,394,000
Waiver Svcs. - EPSDT	\$14,212,000	\$7,106,000	\$7,106,000
Waiver Svcs. – Institutional Tran.	\$71,062,000	\$35,531,000	\$35,531,000
Unmet Need	\$9,147,000	\$4,574,000	\$4,573,000
Institutional Transitions Savings	(\$162,389,000)	(\$81,195,000)	(\$81,194,000)
Total	(\$1,580,000)	(\$790,000)	(\$790,000)

Funding:

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

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 182
 IMPLEMENTATION DATE: 11/2016
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1866

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$3,322,000	\$3,649,000
- STATE FUNDS	\$1,661,000	\$1,824,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,322,000	\$3,649,000
STATE FUNDS	\$1,661,000	\$1,824,500
FEDERAL FUNDS	\$1,661,000	\$1,824,500

DESCRIPTION

Purpose:

This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:

In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]

Interagency Agreement (IA) 16-93498

Interdependent Policy Changes:

Not Applicable

Background:

The WPCS benefit is designed to assist the waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled in and receiving personal care services through the federally funded State Plan Personal Care Services program in order to be eligible for WPCS benefits. There are approximately 2,600 WPCS providers that receive payment via the Case Management Information Payrolling System (CMIPS II). The California Department of Social Services (CDSS) pays for the insurance claims for the WPCS providers and the Department reimburses CDSS for the costs. The current Workers' Compensation IA was implemented as of March 1, 2017 and will remain in effect until June 30, 2019 at which point will be renewed for a new contract term.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the rise in healthcare costs which increased the benefits by approximately 10%.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 182

Methodology:

1. The current workers' compensation contract, IA 16-93498, went into effect July 1, 2017 and will be in effect until June 30, 2019. The estimated costs are based on the assumption that a new or amended contract will be implemented effective July 1, 2019.
2. The Department will reimburse CDSS monthly for the costs of any WPCS program worker's compensation claims filed by eligible WPCS providers.
3. The reimbursement of CDSS will cover costs associated with monthly administrative fees for Third Party Administrator / Sub-contractor services, monthly fees required by the State Controller's Office to perform Checkwrite functions and standard activities associated with issuing worker's compensation payments, and monthly administrative costs accrued by CDSS and the Office of Risk and Insurance Management.
4. WPCS recipients represent approximately 1% of the population receiving IHSS so the Department will only be responsible for reimbursing CDSS for 1% of the sub-contractor administrative fees.
5. Based on data provided by the CDSS, the total cost to be paid for workers' compensation in FY 2018-19 is \$3,322,000 TF and \$3,649,000 TF in FY 2019-20.

	TF	GF	FF
FY 2018-19	\$3,322,000	\$1,661,000	\$1,661,000
FY 2019-20	\$3,649,000	\$1,825,000	\$1,824,000

Funding:

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 184
 IMPLEMENTATION DATE: 4/1998
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 111

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$1,265,000	\$1,884,000
- STATE FUNDS	-\$10,000,000	-\$10,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,265,000	\$1,884,000
STATE FUNDS	-\$10,000,000	-\$10,000,000
FEDERAL FUNDS	\$11,265,000	\$11,884,000

DESCRIPTION

Purpose:

This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to American Indians (AIs) eligible for Fee-For-Service (FFS) Medi-Cal.

Authority:

Public Law 93-638

Interdependent Policy Changes:

Not Applicable

Background:

The Department implemented the Indian Health Services/Memorandum of Agreement 638 Clinics (IHS/MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to AIs through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a change in claim submission and reimbursement. Beginning January 1, 2018, claims for Medi-Cal Managed Care Plan (MMCP) members shifted from the Department's fiscal intermediary (FI) to the MMCPs. The policy change now only budgets FFS Medi-Cal beneficiary claims. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to the rate increase from current year to budget year.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 184

Methodology:

1. Currently, there are 79 Indian health clinics participating in Medi-Cal.
2. In FY 2017-18, the Department spent \$20,000,000 TF (\$10,000,000 GF) for services provided to AIs.
3. Due to the implementation of the new billing policy, the base expenditures is estimated at \$20,000,000 TF annually prior to the annual rate adjustment.
4. Effective CY 2018, the Federal Register, Volume 83, Number 4, January 5, 2018, updated the per visit rate payable to the Indian health clinics by \$36, from \$391 to \$427. The FY 2018-19 estimate includes an additional \$422,000 TF due to the increased rate of the period of January through June 2018. The annual rate increase for the additional \$36, is \$843,000 TF.
5. The FY 2019-20 estimate includes an additional \$347,000 TF due to the rate increase from \$427 to \$453 for the period of January 2019 through June 2019. The annual rate increase for the additional \$26 is estimated at \$694,000 TF.

	FY 2018-19	FY 2019-20
CY 2018 rate increase	\$843,000	\$843,000
CY 2019 rate increase	\$0	\$694,000
Retro Jan – June 2018 rate increase	\$422,000	\$0
Retro Jan – June 2019 rate increase	\$0	\$347,000
Total Rate increase	\$1,265,000	\$1,884,000
FY 2017-18 Base expenditures	\$20,000,000	\$20,000,000
Total expenditures	\$21,265,000	\$21,884,000

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
IHS FY 2017-18 Base exp. (50% GF / 50% FF)	(\$20,000)	(\$10,000)	(\$10,000)
IHS total expenditures (100% FF)	\$21,265	\$0	\$21,265
FY 2018-19 Total	\$1,265	(\$10,000)	\$11,265

FY 2019-20			
IHS FY 2017-18 Base exp. (50% GF / 50% FF)	(\$20,000)	(\$10,000)	(\$10,000)
IHS total expenditures (100% FF)	\$21,884	\$0	\$21,884
FY 2019-20 Total	\$1,884	(\$10,000)	\$11,884

*Totals may differ due to rounding.

Funding:

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 110

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$191,648,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$191,648,000	\$0
FEDERAL FUNDS	-\$191,648,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:

Public Law 95-452

Interdependent Policy Changes:

Not Applicable

Background:

Federal Audit A-09-13-02015: The Department identified on its adjustment reports as non-emergency services provided to qualified aliens for which it did not claim Federal Medicaid reimbursement. The Department did not correctly identify all non-reimbursable claims for non-emergency services provided to qualified aliens. The Department incorrectly claimed Federal Medicaid reimbursement. The audit period covers payments made during the period for quarters ended June 2010, September 2010, June 2011, June 2012, June 2013, and June 2014.

Federal Audit A-09-11-02016: The Department either made unallowable, or the data was insufficient to determine if allowable, Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers. The audit period covers payments made for dates of service between July 1, 2009 through June 30, 2010.

Federal Audit A-09-16-30056: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 5 out of 140 reviewed eligibility redeterminations were missing at least one type of required eligibility information. The audit period covers payments made between July 1, 2014 through June 30, 2015.

Federal Audit A-09-17-31846: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 7 out of 69 reviewed eligibility redeterminations were not performed at the required interval of once every twelve months.

AUDIT SETTLEMENTS**REGULAR POLICY CHANGE NUMBER: 187**

The audit period covers payments made between July 1, 2015 through June 30, 2016.

Federal Audit 2017-002: The Department has delegated the performance of eligibility redeterminations to county welfare agencies in subawards. This audit found that 26 out of 140 reviewed eligibility redeterminations did not meet full compliance for the federal award. The audit period covers payments made between July 1, 2016 through June 30, 2017.

PERM Recovery FY 2016-17 was evaluated through the Improper Payments Information Act of 2002 which requires Federal agencies to review and estimate improper payments.

Federal Audit A-09-15-02040: The OIG audit determined the Department claimed Federal Medicaid reimbursement for Specialty Mental Health Services (SMHS), unallowable under the Federal and State requirements for SMHS. The audit covers payments made during the period of federal fiscal year 2014. The Department repaid CMS in December 2018. The responsibility for SMHS was realigned to counties as a part of 2011 Realignment. As such, these disallowances will ultimately be repaid by the counties on a quarterly basis, over a period of four years, beginning in the last quarter of FY 2018-19

Reason for Change:

The change from prior estimate for FY 2018-19 is an increase due to three additional audit findings that are expected to be paid in FY 2018-19.

Methodology:

FY 2018-19	Audit	Finding	GF
PERM Recovery FY 2016-17	California Medicaid Error Rates for FY 2016-17	Identified and estimated amount of improper payments for Medicaid	\$187,000
PERM Recovery FY 2016-17	California CHIP Error Rates for FY 2016-17	Identified and estimated amount of improper payments for Medicaid	\$6,000
Eligibility	Review of State's Quarterly Alien Claiming Audit	The Department incorrectly claimed Federal Medicaid reimbursement	\$9,873,000
Mental Health Services	California Claimed Hundreds of Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services	Identified and estimated amount of improper payments for Medicaid	\$180,700,000
Financial Management Branch	CA Unallowable Medicaid Payments for Services Claimed by Excluded Providers	The Department incorrectly made Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers	\$839,000
Eligibility	Annual Single Audit, FY 2014-15, FY 2015-16, and FY 2016-17	The Department failed to make, or failed to retain records to show, that eligibility redetermination were done as required	\$43,000
		FY 2018-19 Total	\$191,648,000

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$0	\$191,648	(\$191,648)

Funding:

100% GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 188
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 35

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$34,524,000	\$19,223,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$34,524,000	\$19,223,000
FEDERAL FUNDS	-\$34,524,000	-\$19,223,000

DESCRIPTION

Purpose:

This policy change estimates the cost of federal fund (FF) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs), both through Fee-For-Service (FFS) and Managed Care (MC) delivery systems.

Authority:

Title 42, Code of Federal Regulations 435.1009
 Welfare & Institutions Code 14053.3

Interdependent Policy Changes:

Not Applicable

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 21 through 64 residing in IMDs are not eligible for federal reimbursement. Identifiers are currently not available in the Medi-Cal Eligibility Data System (MEDS) to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement. The Department uses data from the mental health Client and Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FF, as required by CMS. This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Due to the Court of Appeals' decision for the County of Colusa case on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs. The State is now financially responsible for ancillary outpatient services provided to eligible individuals who are residing in an IMD.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 188

For managed care, a base claims file of Client Identification Numbers (CIN) was utilized to identify capitation that was paid when a Medi-Cal beneficiary was admitted and stayed in an IMD.

CMS has estimated IMD deferrals of \$3 million federal funds per quarter. According to 42 CFR 430.40, when CMS issues a deferral of claims for federal financial participation (FFP), the state must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to:

- Updating the IMD FFS repayments for FY 2016-17,
- Adding IMD FFS repayments through the December 2018 quarter, and
- Updating the IMD managed care repayments.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to estimating fewer quarters of repayments in FY 2019-20.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.
2. In FY 2018-19, the Department estimates to repay FFS IMD deferrals from July 2016 through December 2018, and managed care repayments from FY 2011-12 through FY 2016-17.
3. For FY 2019-20, the Department estimates to repay FFS deferrals from January 2019 through December 2019 and managed care deferrals from FY 2017-18 to December 2019.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 188

4. The estimated IMD repayments are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Fee-For-Service (FFS)			
FY 2016-17 Q1 (Jul to Sep 2016)	\$0	\$1,363	(\$1,363)
FY 2016-17 Q2 (Oct to Dec 2016)	\$0	\$1,580	(\$1,580)
FY 2016-17 Q3 (Jan to Mar 2017)	\$0	\$2,201	(\$2,201)
FY 2016-17 Q4 (Apr to Jun 2017)	\$0	\$2,369	(\$2,369)
Subtotal FY 2016-17	\$0	\$7,513	(\$7,513)
FY 2017-18 Q1 (Jul to Sep 2017)	\$0	\$1,594	(\$1,594)
FY 2017-18 Q2 (Oct to Dec 2017)	\$0	\$1,907	(\$1,907)
FY 2017-18 Q3 (Jan to Mar 2018)	\$0	\$2,063	(\$2,063)
FY 2017-18 Q4 (Apr to Jun 2018)	\$0	\$2,322	(\$2,322)
Subtotal FY 2017-18	\$0	\$7,886	(\$7,886)
FY 2018-19 Q1 (Jul to Sep 2018)	\$0	\$3,000	(\$3,000)
FY 2018-19 Q2 (Oct to Dec 2018)	\$0	\$3,000	(\$3,000)
Subtotal FY 2018-19	\$0	\$6,000	(\$6,000)
Subtotal FFS	\$0	\$21,399	(\$21,399)
Managed Care			
FY 2011-12	\$0	\$224	(\$224)
FY 2012-13	\$0	\$533	(\$533)
FY 2013-14	\$0	\$1,370	(\$1,370)
FY 2014-15	\$0	\$5,219	(\$5,219)
FY 2015-16	\$0	\$3,038	(\$3,038)
FY 2016-17	\$0	\$2,741	(\$2,741)
Subtotal Managed Care	\$0	\$13,125	(\$13,125)
Total FY 2018-19	\$0	\$34,524	(\$34,524)

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 188

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Fee-For-Service (FFS)			
FY 2018-19 Q3 (Jan-Mar 2019)	\$0	\$3,000	(\$3,000)
FY 2018-19 Q4 (Apr-Jun 2019)	\$0	\$3,000	(\$3,000)
Subtotal FY 2018-19	\$0	\$6,000	(\$6,000)
FY 2019-20 Q1 (Jul-Sep 2019)	\$0	\$3,000	(\$3,000)
FY 2019-20 Q2 (Oct-Dec 2019)	\$0	\$3,000	(\$3,000)
Subtotal FY 2019-20	\$0	\$6,000	(\$6,000)
Subtotal FFS	\$0	\$12,000	(\$12,000)
Managed Care			
FY 2017-18	\$0	\$2,889	(\$2,889)
FY 2018-19	\$0	\$2,889	(\$2,889)
FY 2019-20 Q1 and Q2 (Jul- Dec 2019)	\$0	\$1,445	(\$1,445)
Subtotal Managed Care	\$0	\$7,223	(\$7,223)
Total FY 2019-20	\$0	\$19,223	(\$19,223)

Funding:

100% General Fund (4260-101-0001)

Title XIX FFP (4260-101-0890)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 189
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1087

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:

California Tobacco Health Protection Act of 1988 (Proposition 99)
 AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:

Not Applicable

Background:

The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change supports healthcare coverage for beneficiaries in the Medi-Cal program.

Reason for Change:

Dollars were revised from prior estimate to reflect updated revenues and expenditures related to Proposition 99.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 189

Methodology:

FY 2018-19	
Hospital Services Account	\$73,335,000
Physicians' Services Account	\$22,496,000
Unallocated Account	\$31,609,000
Total CTPS/Prop. 99	\$127,440,000
GF	(\$127,440,000)
Net Impact	\$0

FY 2019-20	
Hospital Services Account	\$125,979,000
Physicians' Services Account	\$39,526,000
Unallocated Account	\$59,266,000
Total CTPS/Prop. 99	\$224,771,000
GF	(\$224,771,000)
Net Impact	\$0

Funding:

Proposition 99 Hospital Services Account (4260-101-0232)
 Proposition 99 Physician Services Account (4260-101-0233)
 Proposition 99 Unallocated Account (4260-101-0236)
 Title XIX GF (4260-101-0001)

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 190
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1906

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement of county funds for the Optional Targeted Low Income Children's Program (OTLICP).

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1494 authorized the transition of all Healthy Family Program (HFP) subscribers into the Medi-Cal OTLICP. Effective January 1, 2013, HFP subscribers transitioned into OTLICP through a phase-in methodology.

Of the subscribers, an estimated 23,381 California Children Services (CCS) – HFP eligibles shifted to CCS-OTLICP in FY 2013-14. CCS-HFP was funded with 65% FFP, 17.5% GF, and 17.5% county funds through September 30, 2015. Effective October 1, 2015, CCS-HFP funding adjusted to 88% FFP, 6% GF, and 6% county funds. It is assumed that the county share will continue under OTLICP.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to updated monthly expenditures from July 1, 2018, through September 1, 2018, and updated numbers from the phase-in of high cost treatments.

The increase from FY 2018-19 to FY 2019-20, in the current estimate, is due to the phase-in of CCS OTLICP beneficiaries receiving Orkambi, DEFLAZACORT, Exondys 51, Brineura, Symdeko, and Endari.

COUNTY SHARE OF OTLICP-CCS COSTS

REGULAR POLICY CHANGE NUMBER: 190

Methodology:

1. The county share reimbursement for CCS-OTLICP in FY 2018-19 at 6% is estimated to be \$8,910,000.
2. The county share reimbursement for CCS-OTLICP in FY 2019-20, at 6% for quarter 1 and 11.75% for quarters 2 through 4, is estimated to be \$9,613,000.

Fiscal Year	TF	GF	GF Reimbursement
FY 2018-19	\$0	(\$8,910,000)	\$8,910,000
FY 2019-20	\$0	(\$9,613,000)	\$9,613,000

Funding:

100% Title XXI State GF (4260-113-0001)
Reimbursement (4260-610-0995)

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 191
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Sasha Jetton
 FISCAL REFERENCE NUMBER: 1633

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the technical adjustment in funding offsetting 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:

Health & Safety Code, Sections 105285, 105305 and 105310
 Interagency Agreement (IA) #16-93210

Interdependent Policy Changes:

Not Applicable

Background:

Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate. The state share of cost for the lead testing component is partly funded by the CLPP Fund.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization.

Pursuant to AB 1316, (Chapter 507, statutes of 2017), the use of the CLPP Fund for blood lead testing is prohibited. The fund is now to be utilized for monitoring and oversight of blood lead testing, to include enhanced lead prevention activities.

CLPP FUND**REGULAR POLICY CHANGE NUMBER: 191****Reason for Change:**

There is no change from the prior estimate or between fiscal years 2018-19 and 2019-20.

Methodology:

1. Funding for Medi-Cal is at 50% State Funds.
2. The current IA with the Department of Public Health began July 1, 2016, and continues through June 30, 2019. The CLPP funding allocated for FY 2018-19 is \$725,000.
3. The CLPP Funding for FY 2019-20 is assumed to be \$725,000.

Funding:**FY 2018-19**

100% CLPP Fund (4260-111-0080)	\$ 725,000
100% GF (4260-101-0001)	\$ (725,000)
Net Impact	\$ -

FY 2019-20

100% CLPP Fund (4260-111-0080)	\$ 725,000
100% GF (4260-101-0001)	\$ (725,000)
Net Impact	\$ -

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 192
 IMPLEMENTATION DATE: 4/2015
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1760

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to the extension of a quality assurance fee (QAF) for hospitals from January 1, 2014, and after.

Authority:

SB 239 (Chapter 657, Statutes of 2013)
 AB 1607 (Chapter 27, Statutes of 2016)
 Proposition 52 (2016)

Interdependent Policy Changes:

Not Applicable

Background:

SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011, through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014, through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014. The Department received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

AB 1607 extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

HOSPITAL QAF - CHILDREN'S HEALTH CARE**REGULAR POLICY CHANGE NUMBER: 192****Reason for Change:**

The change in FY 2018-19, from the prior estimate, is a net increase due to:

- Updating and shifting the HQAF IV (FY 2014-15 through FY 2016-17) reconciliation payment to FY 2019-20. The changes to the children's net benefit calculation for the reconciliation payment resulted in an additional \$107.8 million for children's health care savings, and
- The HQAF IV funding adjustment having occurred July 2018.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to a larger adjustment payment in FY 2018-19 and anticipating lower payments for HQAF VI in FY 2019-20.

Methodology:

1. Payments for children's health care are estimated through the period ending March 30, 2020 in this policy change.
2. The HQAF IV program period is from January 1, 2014, to December 31, 2016. The HQAF V program period is from January 1, 2017, to June 30, 2019.
3. Assume the HQAF VI program period covers a 30-month period from July 1, 2019, through December 31, 2021.
4. SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program.
5. Payments associated with AB 1607 and Proposition 52 are based on the approved HQAF V Fee & Payment Model.
6. Preliminary models for FY 2019-20 were developed for the HQAF VI program period, from which 24% of the net benefit to hospitals was calculated as the amount for children's health care coverage. To arrive at the projected amounts for FY 2019-20, a preliminary retrospective review was done on the FY 2018-19 inpatient UPL and trended to FY 2019-20. The same inpatient trend from FY 2018-19 to FY 2019-20 was applied on the FY 2018-19 outpatient UPL. The preliminary models take into consideration known supplemental payment changes and the HQAF IV subacute adjustment, but does not account for potential rollover of fees from prior program periods or actual FY 2018-19 UPL overages.
7. On an accrual basis, annual funds for children's health care coverage are estimated to be:

(Dollars in Thousands)

Fiscal Year	Authority	HQAF IV Period (36 months)	Amount
FY 2013-14	SB 239	1/1/14 to 6/30/14	\$310,000
FY 2014-15	SB 239	7/1/14 to 6/30/15	\$726,400
FY 2015-16	SB 239	7/1/15 to 6/30/16	\$739,500
FY 2016-17	SB 239	7/1/16 to 12/31/16	\$400,500

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 192

(Dollars in Thousands)

Fiscal Year	Authority	HQAF V Period (30 months)	Amount
FY 2016-17	AB 1607	1/1/17 to 6/30/17	\$513,154
FY 2017-18	AB 1607 (through 12/31/17); Proposition 52 (1/1/18 and forward)	7/1/17 to 6/30/18	\$1,087,722
FY 2018-19	Proposition 52	7/1/18 to 6/30/19	\$1,134,384

(Dollars in Thousands)

Fiscal Year	Authority	HQAF VI Period (12 of 30 months)	Amount
FY 2019-20	Proposition 52	7/1/19 to 6/30/20	\$913,500

8. The HQAF payments are usually first funded by the General Fund (GF) and then within a few days, funds from the Hospital Quality Assurance Revenue Fund (HQARF) are transferred to offset the GF payment. The HQARF to GF offset transfer did not happen in June 2018 and instead, the \$263.7 million for HQAF IV Cycles 10 through 12 transfer was completed in July 2018.
9. One quarter of FY 2017-18 and three quarters of FY 2018-19 HQAF V payments will be paid in FY 2018-19.
10. HQAF IV children's health care coverage savings for the FY 2014-15 through FY 2016-17 reconciliation of \$107.845 million will be paid in FY 2019-20.
11. One quarter of FY 2018-19 HQAF V and three quarters of FY 2019-20 HQAF VI payments will be paid in FY 2019-20.
12. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2018-19	TF	GF	Hosp. QA Rev Fund
HQAF IV Funding Adjustment	\$0	(\$263,729)	\$263,729
FY 2017-18	\$0	(\$271,931)	\$271,931
FY 2018-19	\$0	(\$850,788)	\$850,788
Total FY 2018-19	\$0	(\$1,386,448)	\$1,386,448

(Dollars in Thousands)

FY 2019-20	TF	GF	Hosp. QA Rev Fund
HQAF IV (FY 2014-15 through FY 2016-17)	\$0	(\$107,845)	\$107,845
FY 2018-19	\$0	(\$283,596)	\$283,596
FY 2019-20	\$0	(\$685,125)	\$685,125
Total FY 2019-20	\$0	(\$1,076,566)	\$1,076,566

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 192

Funding:

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 193
 IMPLEMENTATION DATE: 4/2017
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 2034

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$243,175,000	\$200,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$243,175,000	\$200,000,000
FEDERAL FUNDS	-\$243,175,000	-\$200,000,000

DESCRIPTION

Purpose:

This policy change estimates the repayment of deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
 Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:

Not Applicable

Background:

CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

The County Administration Enhanced Funding deferral repayments and resolutions are budgeted in a separate policy change. See the County Administration CMS Deferred Claims policy change for more information. The Fiscal Intermediary and administrative deferral repayments are budgeted in a separate policy change. See the CMS Deferred Claims – Other Admin policy change for more information.

CMS DEFERRED CLAIMS

REGULAR POLICY CHANGE NUMBER: 193

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to Federal Fiscal Year (FFY) 2016 Quarter 4 and FFY 2018 Quarter 1 repayments shifted to FY 2018-19, and updated data based on actual deferral and resolution amounts from CMS.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to differing Federal Fiscal Quarter repayments which include varying deferral items and amounts.

Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2018 Quarter 1.
2. The Department repaid the FFY 2015 Quarters 1 and 2 deferrals in FY 2016-17, and the FFY 2015 Quarters 3 and 4 and FFY 2016 Quarters 1 through 3 deferrals in FY 2017-18. The Department will repay the federal funds (FF) according to the required timelines but will continue to work on resolving the deferrals.
3. In FY 2018-19, the Department estimates to repay a net total of \$353.650 million which includes \$125.924 million FF for the CMS deferrals issued for FFY 2016 Q4 through FFY 2018 Q1, \$27.726 million FF for FFY 2016 Quarter 4 and FFY 2018 Quarter 1 for CHIP, and \$200 million FF for projected repayments.
4. In FY 2018-19, the Department reclaimed \$110.475 million FF for resolved deferrals for 1115 Waiver SNCP claims and Enhanced Funding for Community First Choice capitation payments.
5. In FY 2019-20, the Department estimates to repay \$200 million FF for projected repayments.
6. The Department will repay/resolve the following estimated deferred claims:

(Dollars in Thousands)

FY 2018-19	Total Estimated Repayment
FFY 2016 Quarter 4 (Jul-Sep 2016)	\$2,197
FFY 2017 Quarter 1 (Oct-Dec 2016)	\$28,346
FFY 2017 Quarter 2 (Jan-Mar 2017)	\$1,114
FFY 2017 Quarter 3 (Apr-Jun 2017)	\$78,845
FFY 2017 Quarter 4 (Jul-Sep 2017)	\$1,952
FFY 2018 Quarter 1 (Oct-Dec 2017)	\$41,196
FFY 2018 Quarter 2 (Jan-Mar 2018)	\$50,000
FFY 2018 Quarter 3 (Apr-Jun 2018)	\$50,000
FFY 2018 Quarter 4 (Jul-Sep 2018)	\$50,000
FFY 2019 Quarter 1 (Oct-Dec 2018)	\$50,000
Subtotal Estimated Repayments	\$353,650
Resolved Deferrals:	
FFY 2017 Quarter 1 (Oct-Dec 2016)	(\$110,475)
Total FY 2018-19	\$243,175

CMS DEFERRED CLAIMS
REGULAR POLICY CHANGE NUMBER: 193

(Dollars in Thousands)

FY 2019-20	Total Estimated Repayment
FFY 2019 Quarter 2 (Jan-Mar 2019)	\$50,000
FFY 2019 Quarter 3 (Apr-Jun 2019)	\$50,000
FFY 2019 Quarter 4 (Jul-Sep 2019)	\$50,000
FFY 2020 Quarter 1 (Oct-Dec 2019)	\$50,000
Total FY 2019-20	\$200,000

Funding:

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

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

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

100% Title XXI GF (4260-113-0001)

REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES

REGULAR POLICY CHANGE NUMBER: 194
 IMPLEMENTATION DATE: 9/2018
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2082

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$25,856,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$25,856,000	\$0
FEDERAL FUNDS	-\$25,856,000	\$0

DESCRIPTION

Purpose:

This policy changes estimates the federal funds repayment to the Centers for Medicare and Medicaid Services (CMS) to resolve incorrectly reported Federal Medical Assistance Percentages (FMAPs) for Medi-Cal recoveries from January 2014 to December 2016.

Authority:

42 Code of Federal Regulations 433.154(b)

Interdependent Policy Changes:

Not Applicable

Background:

During the period from January 2014 to December 2016, the Department reported all recoveries at the 50% FMAP. Effective January 1, 2014, the Affordable Care Act (ACA) authorized increased FMAPs for state expenditures for low-income individuals in the newly eligible and the enhanced expansion groups. The Department did not account for the special Title XIX ACA funding or the Title XXI Children's Health Insurance Program (CHIP) funding during this period. As a result, the Department will make a payment to CMS to resolve the incorrectly reported FMAPs for Medi-Cal recoveries from January 2014 to December 2016.

Reason for Change:

There is no fiscal change from the prior estimate for FY 2018-19, however, the month of the payment has shifted from July 2018 to September 2018. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the completion of the payments in FY 2018-19.

REPAYMENT TO CMS FOR MEDI-CAL RECOVERIES

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. Assume that all recoveries were reported at 50% FMAP and will be corrected to their appropriate FMAP for the January 2014 to December 2016 period.
2. Assume the repayment will occur in September 2018.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX Repayment	\$0	\$24,715	(\$24,715)
Title XXI Repayment	\$0	\$1,141	(\$1,141)
Total FY 2018-19	\$0	\$25,856	(\$25,856)

Funding:

- 100% GF (4260-101-0001)
- 100% Title XIX ACA FF (4260-101-0890)
- 100% Title XXI FF (4260-113-0890)

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 195
 IMPLEMENTATION DATE: 6/2018
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 2054

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	-\$16,418,000	-\$42,687,000
- STATE FUNDS	-\$8,209,000	-\$21,343,500
PAYMENT LAG	0.9030	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$14,825,500	-\$42,687,000
STATE FUNDS	-\$7,412,730	-\$21,343,500
FEDERAL FUNDS	-\$7,412,730	-\$21,343,500

DESCRIPTION

Purpose:

This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The ALW offers services in an assisted living or public subsidized housing setting to Medi-Cal members who would likely otherwise receive care in a skilled nursing facility. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by the Care Coordination Agencies to assess potential participants.

The Department seeks to expand 2,000 waiver slots from 3,744 slots to 5,744 slots for FY 2017-18, FY 2018-19, and FY 2019-20 to accommodate current and anticipated need. A reserve capacity will be set for new enrollments which will require that 60% of all new enrollments be reserved for individuals transitioning from institutional settings after residing in them for a minimum of 90 consecutive days. The Department plans to receive CMS approval for the waiver amendment to expand the additional slots in FY 2018-19.

Reason for Change:

The change in FY 2018-19, in the current estimate, is an increase in savings due to an increase in the average annual cost for skilled nursing facilities. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to additional participants transitioning into the ALW.

Methodology:

1. Assume 2,000 new participants will be phased in by FY 2019-20.

ASSISTED LIVING WAIVER EXPANSION

REGULAR POLICY CHANGE NUMBER: 195

2. Of the new 2,000 participants, assume 1,200 will be from an institution and 800 will be from the community.
3. Assume the average annual cost for waiver services is \$16,477.
4. Assume the average annual cost in a skilled nursing facility is \$74,580.

FY 2018-19	TF	GF	FF
Total Cost from Waiver Services	\$11,326,000	\$5,663,000	\$5,663,000
Total Savings from SNF Transitions	(\$27,744,000)	(\$13,872,000)	(\$13,872,000)
Net Impact Savings	(\$16,418,000)	(\$8,209,000)	(\$8,209,000)
FY 2019-20	TF	GF	FF
Total Cost from Waiver Services	\$29,447,000	\$14,724,000	\$14,723,000
Total Savings from SNF Transitions	(\$72,134,000)	(\$36,067,000)	(\$36,067,000)
Net Impact Savings	(\$42,687,000)	(\$21,343,000)	(\$21,344,000)

Funding:

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

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 198
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1915

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$1,912,603,770	-\$1,881,957,460
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,912,603,770	-\$1,881,957,460
FEDERAL FUNDS	\$1,912,603,770	\$1,881,957,460

DESCRIPTION

Purpose:

This policy change estimates the adjustment to accurately reflect the enhanced percentage of federal funding match for the Affordable Care Act (ACA) optional expansion population.

Authority:

Affordable Care Act (ACA)

Interdependent Policy Changes:

Fee-for-Service Base Expenditures
 AB 1629 Annual Rate Adjustment
 LTC Rate Adjustment
 DPH Interim Rate Growth
 Hospice Rate Increases
 Laboratory Rate Methodology Change
 Reduction to Radiology Rates

Background:

Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of the ACA optional expansions. The ACA provides an enhanced federal match for optional expansion adults of 100% through calendar year (CY) 2016, and then decreases the match in yearly phases to 90% by 2020.

Reason for Change:

The Department removed and added policy changes based on applicable funding sources.

FUNDING ADJUST.—ACA OPT. EXPANSION**REGULAR POLICY CHANGE NUMBER: 198****Methodology:**

- 1) The Department identified funds allocated to beneficiaries in the Newly aid category that were Title XIX funding with 50% federal match in the policy change in which they originated.
- 2) The federal match for FY 2018-19 is matched at 94% through CY 2018, and then decreases to 93% in CY 2019. The federal match for FY 2019-20 is matched at 93% through CY 2019, and then decreases to 90% in CY 2020.
- 3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2018-19 is estimated as \$4,393,374,855 and \$4,522,711,498 in FY 2019-20. These amounts are credited to the Title XIX fund.
- 4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

FY 2018-19	GF	FF
Fee-For-Service Base Expenditures	\$ (1,904,311)	\$ 1,904,311
AB 1629 Annual Rate Adjustments	\$ (3,006)	\$ 3,006
DPH Interim Rate Growth	\$ (12,981)	\$ 12,981
LTC Rate Adjustment	\$ (348)	\$ 348
Hospice Rate Increases	\$ (241)	\$ 241
Laboratory Rate Methodology Change	\$ 2,227	\$ (2,227)
Reduction to Radiology Rates	\$ 6,057	\$ (6,057)
Total	\$ (1,912,604)	\$ 1,912,604

FY 2019-20	GF	FF
Fee-For-Service Base Expenditures	\$ (1,851,874)	\$ 1,851,874
AB 1629 Annual Rate Adjustments	\$ (4,347)	\$ 4,347
DPH Interim Rate Growth	\$ (28,699)	\$ 28,699
LTC Rate Adjustment	\$ (616)	\$ 616
Hospice Rate Increases	\$ (287)	\$ 287
Laboratory Rate Methodology Change	\$ 636	\$ (636)
Reduction to Radiology Rates	\$ 3,230	\$ (3,230)
Total	\$ (1,881,958)	\$ 1,881,958

FUNDING ADJUST.—ACA OPT. EXPANSION

REGULAR POLICY CHANGE NUMBER: 198

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX 50/50	\$ (4,393,374)	\$ (2,196,687)	\$ (2,196,687)
ACA Title XIX 94% FF	\$ 2,345,295	\$ 140,717	\$ 2,204,578
ACA Title XIX 93% FF	\$ 2,048,079	\$ 143,366	\$ 1,904,713
Total	\$ -	\$ (1,912,604)	\$ 1,912,604

FY 2019-20	TF	GF	FF
Title XIX 50/50	\$ (4,522,711)	\$ (2,261,356)	\$ (2,261,355)
ACA Title XIX 93% FF	\$ 2,429,102	\$ 170,037	\$ 2,259,065
ACA Title XIX 90% FF	\$ 2,093,609	\$ 209,361	\$ 1,884,248
Total	\$ -	\$ (1,881,958)	\$ 1,881,958

FUNDING ADJUST.—OTLICP

REGULAR POLICY CHANGE NUMBER: 199
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1926

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$366,000	\$337,000
- STATE FUNDS	-\$206,024,360	-\$164,431,360
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$366,000	\$337,000
STATE FUNDS	-\$206,024,360	-\$164,431,360
FEDERAL FUNDS	\$206,390,360	\$164,768,360

DESCRIPTION**Purpose:**

This policy change estimates the adjustment to reflect the costs that should be charged to the Children's Health Insurance Program (CHIP).

Authority:

Affordable Care Act (ACA)

Interdependent Policy Changes:

Fee-For-Service Base Expenditures
 Pharmacist-Delivered Medi-Cal Services
 Pathways to Well-Being
 Rate Increase for FQHCs/RHCs/CBRCs
 FQHC/RHC/CBRC Reconciliation Process
 AB 1629 Annual Rate Adjustments
 LTC Rate Adjustment
 Hospice Rate Increases
 10% Provider Payment Reduction
 Laboratory Rate Methodology Change
 Reduction to Radiology Rates

Background:

The Balanced Budget Act of 1997 added Title XXI to the Social Security Act creating CHIP to provide new coverage opportunities for children in families with incomes too high to qualify for Medicaid. States administer the CHIP program and they are jointly funded by federal and state governments.

The ACA provides enhanced federal funding to Title XXI. The California federal funding match was 65 percent through September 30, 2015. Effective October 1, 2015, the ACA extended and increased the enhanced federal matching rate for the CHIP program by 23 percent to 88 percent. Congress reauthorized the CHIP program in January, 2018, reducing the federal matching rate to 76.5 percent effective October 1, 2019, and further reducing the match rate to 65 percent effective October 1, 2020.

FUNDING ADJUST.—OTLIPC

REGULAR POLICY CHANGE NUMBER: 199

Reason for Change:

The Department removed and added policy changes based on applicable funding sources.

Methodology:

- 1) The Department identified funds allocated to CHIP beneficiaries in the OTLIPC aid category that were not adjusted for additional Title XXI funding in the policy change in which they originated.
- 2) The total amount of unadjusted CHIP funding for all policy changes in FY 2018-19 is estimated as \$542,172,215 and \$552,751,246 in FY 2019-20. These amounts are credited to the Title XIX fund.
- 3) The funds are then broken out according to reimbursement rates based on when the Department estimates the expenditure.
 - a. In FY 2018-19, the Department estimates the additional CHIP funding will offset general fund spending by \$206M.
 - b. In FY 2019-20, the Department estimates the additional CHIP funding will offset general fund spending by \$164.4M.
- 4) The Department estimates the Total Fund after the adjustment of CHIP funding to be \$366,000 in FY 2018-19 and \$337,000 in FY 2019-20.
- 5) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Fee-For-Service Base Expenditures	\$ -	\$ (202,411)	\$ 202,411
Pharmacist-Delivered Medi-Cal Services	\$ -	\$ (3)	\$ 3
Pathways to Well-Being	\$ 366	\$ -	\$ 366
Rate Increase for FQHCs/RHCs/CBRCs	\$ -	\$ (2,511)	\$ 2,511
FQHC/RHC/CBRC Reconciliation Process	\$ -	\$ (2,426)	\$ 2,426
AB 1629 Annual Rate Adjustments	\$ -	\$ (46)	\$ 46
LTC Rate Adjustment	\$ -	\$ (5)	\$ 5
Hospice Rate Increases	\$ -	\$ (199)	\$ 199
10% Provider Payment Reduction	\$ -	\$ 241	\$ (241)
Laboratory Rate Methodology Change	\$ -	\$ 370	\$ (370)
Reduction to Radiology Rates	\$ -	\$ 966	\$ (966)
Total	\$ 366	\$ (206,024)	\$ 206,390

FUNDING ADJUST.—OTLCP
REGULAR POLICY CHANGE NUMBER: 199

FY 2019-20	TF	GF	FF
Fee-For-Service Base Expenditures	\$ -	\$ (160,960)	\$ 160,960
Pharmacist-Delivered Medi-Cal Services	\$ -	\$ (7)	\$ 7
Pathways to Well-Being	\$ 337	\$ -	\$ 337
Rate Increase for FQHCs/RHCs/CBRCs	\$ -	\$ (2,673)	\$ 2,673
FQHC/RHC/CBRC Reconciliation Process	\$ -	\$ (1,232)	\$ 1,232
AB 1629 Annual Rate Adjustments	\$ -	\$ (54)	\$ 54
LTC Rate Adjustment	\$ -	\$ (7)	\$ 7
Hospice Rate Increases	\$ -	\$ (206)	\$ 206
10% Provider Payment Reduction	\$ -	\$ 190	\$ (190)
Laboratory Rate Methodology Change	\$ -	\$ 87	\$ (87)
Reduction to Radiology Rates	\$ -	\$ 430	\$ (430)
Total	\$ 337	\$ (164,431)	\$ 164,768

Funding:

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

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

76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)

CCHIP DELIVERY SYSTEM

REGULAR POLICY CHANGE NUMBER: 200
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2122

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,869,000
- STATE FUNDS	\$0	-\$400,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,869,000
STATE FUNDS	\$0	-\$400,120
FEDERAL FUNDS	\$0	-\$1,468,880

DESCRIPTION

Purpose:

This policy change estimates the savings achieved resulting from integrating CCHIP beneficiaries into the Medi-Cal Managed Care (MMC) delivery system.

Authority:

Welfare & Institution Code, 15803, 15826, and 15858

Interdependent Policy Changes:

Not Applicable

Background:

CCHIP provides affordable and comprehensive health, dental, and vision insurance for children who meet certain eligibility criteria. DHCS anticipates integrating CCHIP beneficiaries into the Medi-Cal Managed Care delivery system effective July 1, 2019. The CCHIP program would continue to be provided through the three county plans, in compliance with Maintenance of Efforts (MOE) requirements, in San Francisco, Santa Clara, and San Mateo.

DHCS is currently evaluating costs attributed to administrative functions such as premium collection and case management for both State and contracted vendor options.

Reason for Change:

This is a new policy change.

Methodology:

1. Assume the transition will occur in July 2019.
2. In FY 2019-20, \$1,869,000 is expected to be saved as a result of the transition.

CCHIP DELIVERY SYSTEM
REGULAR POLICY CHANGE NUMBER: 200

Funding:

Title XXI 88% FF / 12% GF

Title XXI 76.5% FF/ 23.5% GF

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 201
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1724

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$4,175,000	\$5,363,000
- STATE FUNDS	\$165,750	\$431,010
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,175,000	\$5,363,000
STATE FUNDS	\$165,750	\$431,010
FEDERAL FUNDS	\$4,009,250	\$4,931,990

DESCRIPTION

Purpose:

This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:

Welfare & Institutions Code 14021.51; 14021.6(b)(1); 14021.9(c); and 14105(a)
 Title 22, California Code of Regulations, Section 51516.1(a)(g)

Interdependent Policy Changes:

Not Applicable

Background:

The DMC program currently covers the following Substance Use Disorder (SUD) services under the State Plan: 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).

Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates using annual cost report settlement data, or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- NTP Dosing – Regular and Perinatal
- NTP Individual Counseling – Regular and Perinatal
- NTP Group Counseling – Regular and Perinatal
- IOT – Regular and Perinatal
- Naltrexone Treatment Service – Regular only
- RTS – Perinatal only
- ODF Individual Counseling – Regular and Perinatal
- ODF Group Counseling – Regular and Perinatal

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 201

Reason for Change:

This is a new policy change.

Methodology:

1. The FY 2017-18 and FY 2018-19 developed rates, and FY 2019-20 estimated rates for regular and perinatal services are:

Regular Services	FY 2017-18 Developed Rates	FY 2018-19 Developed Rates	FY 2019-20 Estimated Rates
NTP Methadone	\$13.11	\$13.54	\$13.88
NTP Individual Counseling	\$15.37	\$15.88	\$16.28
NTP Group Counseling	\$3.43	\$3.43	\$3.75
Intensive Outpatient Treatment	\$58.53	\$58.53	\$65.71
Naltrexone	\$19.06	\$19.06	\$19.06
RTS – EPSDT	N/A	\$90.14	\$98.74
ODF Individual Counseling	\$76.91	\$79.44	\$81.43
ODF Group Counseling	\$30.89	\$30.89	\$34.59

Perinatal Services	FY 2017-18 Developed Rates	FY 2018-19 Developed Rates	FY 2019-20 Estimated Rates
NTP Methadone	\$14.11	\$14.58	\$14.94
NTP Individual Counseling	\$16.39	\$16.39	\$19.56
NTP Group Counseling	\$4.28	\$4.28	\$5.94
Intensive Outpatient Treatment	\$84.43	\$87.21	\$89.39
Residential Treatment Services	\$90.14	\$90.14	\$98.74
ODF Individual Counseling	\$81.93	\$81.93	\$83.98
ODF Group Counseling	\$38.56	\$38.56	\$39.52

2. The incremental rate changes for FY 2018-19 and FY 2019-20 are shown below:

Incremental Difference	FY 2018-19 Regular	FY 2018-19 Perinatal	FY 2019-20 Regular	FY 2019-20 Perinatal
NTP Methadone	\$0.43	\$0.47	\$0.34	\$0.36
NTP Individual Counseling	\$0.51	\$0.00	\$0.40	\$3.17
NTP Group Counseling	\$0.00	\$0.00	\$0.32	\$1.66
Intensive Outpatient Treatment	\$0.00	\$2.78	\$7.18	\$2.18
Naltrexone	\$0.00	N/A	\$0.00	N/A
Residential Treatment Services	N/A	\$0.00	\$8.60	\$8.60
ODF Individual Counseling	\$2.53	\$0.00	\$1.99	\$2.05
ODF Group Counseling	\$0.00	\$0.00	\$3.70	\$0.96

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 201

3. The cost estimate based on the incremental rate changes for FY 2018-19 are:

FY 2018-19 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	8,579,291	\$0.43	\$3,689,000
NTP Individual Counseling	3,651,049	\$0.51	\$1,862,000
ODF Individual Counseling	78,925	\$2.53	\$200,000
Total for Regular			\$5,751,000

FY 2018-19 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	21,795	\$0.47	\$10,000
Intensive Outpatient Treatment	7,269	\$2.78	\$20,000
Total for Perinatal			\$30,000

4. The cost estimate based on the incremental rate changes for FY 2019-20 are:

FY 2019-20 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	8,579,291	\$0.34	\$2,917,000
NTP Individual Counseling	3,651,049	\$0.40	\$1,460,000
NTP Group Counseling	26,582	\$0.32	\$9,000
Intensive Outpatient Treatment	81,722	\$7.18	\$587,000
RTS EPSDT	0	\$8.60	\$0
ODF Individual Counseling	78,925	\$1.99	\$157,000
ODF Group Counseling	514,714	\$3.70	\$1,904,000
Total for regular			\$7,034,000

FY 2019-20 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	21,795	\$0.36	\$8,000
NTP Individual Counseling	9,018	\$3.17	\$29,000
NTP Group Counseling	184	\$1.66	\$1,000
Intensive Outpatient Treatment	7,269	\$2.18	\$16,000
Residential Treatment Services	16,087	\$8.60	\$138,000
ODF Individual Counseling	668	\$2.05	\$1,000
ODF Group Counseling	2,481	\$0.96	\$2,000
Total			\$195,000

DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 201

5. Total estimated costs for the annual rate adjustments are:

Annual Rate Adj. Cost	FY 2018-19	FY 2019-20
NTP	\$5,561,000	\$4,424,000
ODF	\$200,000	\$2,064,000
IOT	\$20,000	\$603,000
RTS	\$0	\$138,000
Total	\$5,781,000	\$7,229,000

FY 2018-19	TF	GF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	\$3,208,000	\$0	\$1,591,000	\$23,000	\$1,594,000
ACA Optional	\$2,543,000	\$165,000	\$2,378,000	\$0	\$0
Perinatal					
Current	\$24,000	\$0	\$12,000	\$0	\$12,000
ACA Optional	\$6,000	\$1,000	\$5,000	\$0	\$0
Total	\$5,781,000	\$166,000	\$3,986,000	\$23,000	\$1,606,000

FY 2019-20	TF	GF	FFP Title XIX	FFP Title XXI	CF
Regular					
Current	\$3,923,000	\$163,000	\$1,945,000	\$26,000	\$1,789,000
ACA Optional	\$3,112,000	\$265,000	\$2,847,000	\$0	\$0
Perinatal					
Current	\$154,000	\$0	\$77,000	\$0	\$77,000
ACA Optional	\$40,000	\$3,000	\$37,000	\$0	\$0
Total	\$7,229,000	\$431,000	\$4,906,000	\$26,000	\$1,866,000

Funding:

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

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

94% ACA Title XIX FF / 6% GF (4260-101-0001/0890)

93% ACA Title XIX FF / 7% GF (4260-101-0001/0890)

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

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

76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)

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

MEDI-CAL DRUG REBATES FUND

REGULAR POLICY CHANGE NUMBER: 202
 IMPLEMENTATION DATE: 9/2019
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2124

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of drug rebate collections from the Medi-Cal Drug Rebates Fund to the General Fund (GF).

Authority:

Proposed Trailer Bill Language

Interdependent Policy Changes:

Not Applicable

Background:

The Department proposes to establish the Medi-Cal Drug Rebates Fund, effective July 1, 2019. The non-federal share of federal and state supplemental Medi-Cal rebate collections will be deposited into the Medi-Cal Drug Rebates Fund. Transfers will occur from the Medi-Cal Drug Rebates Fund to offset the GF.

For information on the federal share of the rebate collections, see the Federal Drug Rebates, State Supplemental Drug Rebates, Managed Care Drug Rebates, Family PACT Drug Rebates, and BCCTP Drug Rebates policy changes.

Reason for Change:

This is a new policy change.

Methodology:

- In FY 2019-20, it is estimated that \$1.44 billion will be transferred from the Medi-Cal Drug Rebates Fund to the GF.

(Dollars in Thousands)

FY 2019-20	TF	GF	SF
Drug Rebates Transfer	\$0	(\$1,440,526)	\$1,440,526

MEDI-CAL DRUG REBATES FUND

REGULAR POLICY CHANGE NUMBER: 202

Funding:

(Dollars in Thousands)

FY 2019-20	TF	GF	SF
Medi-Cal Drug Rebates Fund (4260-601-3331)	\$1,440,526	\$0	\$1,440,526
100% GF (4260-101-0001)	(\$1,440,526)	(\$1,440,526)	\$0
Total	\$0	(\$1,440,526)	\$1,440,526

UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 204
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 2127

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$257,102,000
- STATE FUNDS	\$0	\$194,013,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$257,102,000
STATE FUNDS	\$0	\$194,013,000
FEDERAL FUNDS	\$0	\$63,089,000

DESCRIPTION

Purpose:

This policy change estimates the benefit costs to expand full-scope Medi-Cal benefits to adults 19-25 years of age, regardless of immigration status.

Authority:

FY 2019-20 Budget Bill

Interdependent Policy Changes:

Not Applicable

Background:

California provides restricted-scope Medi-Cal coverage (emergency and pregnancy related services only) to low income undocumented adults. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy related services. Individuals that are between 19-25 years of age and who do not have satisfactory immigration status or are unable to verify satisfactory immigration status or citizenship will be 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.

Reason for Change:

This is a new policy change.

Methodology:

1. Implementation date is assumed to be no sooner than July 1, 2019.
2. The Department assumes approximately 138,000 adults from three populations will transition to full-scope benefits within the first year. Undocumented full-scope children turning 19, current restricted-scope adults, and adults that are currently eligible, but have not enrolled into Medi-Cal.

**UNDOCUMENTED YOUNG ADULTS FULL SCOPE
EXPANSION
REGULAR POLICY CHANGE NUMBER: 204**

3. Undocumented full-scope children turning 19 and current restricted-scope undocumented adults aged 19-25 will be passively enrolled into full-scope Medi-Cal.
4. Assume 75% of the undocumented adults that are eligible, but not enrolled population will take up phased-in coverage over 24 months.
5. Assume offsetting cost savings for those currently enrolled in restricted-scope Medi-Cal that will transition into full-scope Medi-Cal.
6. Net expenditures are expected to be:

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Total FY 2019-20 Full-Scope Costs	\$257,102	\$194,013	\$63,089

Funding:

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

100% GF (4260-101-0001)

PROP 56 - VALUE-BASED PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 205
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 2128

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$360,000,000
- STATE FUNDS	\$0	\$180,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$360,000,000
STATE FUNDS	\$0	\$180,000,000
FEDERAL FUNDS	\$0	\$180,000,000

DESCRIPTION

Purpose:

This policy change estimates payments to providers made through increased capitation to managed care plans who meet DHCS requirements in value-based payment (VBP) arrangements.

Authority:

Trailer Bill Language

Interdependent Policy Changes:

None

Background:

VBP strategies incentivize health care providers to improve their performance on predetermined measures or meet targets that focus on quality and efficiency of care. DHCS proposes to create a set of VBP programs that managed care plans will be required to participate in through directed payment programs approved by CMS. These incentive programs will be targeted at physicians that meet specific achievements on certain metrics. Proposition 56 funding, along with federal funds, will be used to make the directed payments. DHCS will develop specific measures and targets that will determine the amount of the incentive payments.

Reason for Change:

This is a new policy change

Methodology:

Total directed payments are estimated to be \$360 million in FY 2019-20.

Funding:

FY 2019-20	TF	SF	FF
50% Title XIX FF / 50% SF (4260-101-3305 / 0890)	\$360,000,000	\$180,000,000	\$180,000,000

PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 206
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Jerrold Anub
 FISCAL REFERENCE NUMBER: 2129

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$105,000,000
- STATE FUNDS	\$0	\$52,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$105,000,000
STATE FUNDS	\$0	\$52,500,000
FEDERAL FUNDS	\$0	\$52,500,000

DESCRIPTION

Purpose:

This policy change estimates the cost for providing both trauma and developmental screenings.

Authority:

FY 2019-20 Budget Bill

Interdependent Policy Changes:

Not Applicable

Background:

Trauma-informed care is an organizational transformation process to provide a model of care intended to promote healing and reduce risk for re-traumatization. Early identification of trauma and providing the appropriate treatment is a critical tool at reducing long-term health care costs for both children and adults.

Developmental screening is the use of a standardized set of questions to see if a child's motor, language, cognitive, social, and emotional development are on track for their age. National guidelines recommend a developmental screening for all children at 9 months, 18 months, and 30 months of age.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

Trauma Screenings

1. Cost estimates for creating a new screening and/or assessment tool are anticipated to be minimal.

PROP 56 - TRAUMA AND DEVELOPMENTAL SCREENINGS

REGULAR POLICY CHANGE NUMBER: 206

2. Assume all children and adults under age 65 will be initially screened within 3 years. One-third of both the child and adult population will receive an initial screening in each year for 3 years.
3. Providers will be able to bill for children to receive periodic rescreening as determined appropriate and applicable, not more often than once a year and no less often than every 3 years.
4. Assume that 20% of those initially screened would require a complex assessment.
5. Assume that trauma screening costs are \$45,000,000 in FY 2019-20.

Developmental Screenings

6. Developmental screenings are recommended at three specific times in early childhood (9 months, 18 months, and 30 months).
7. Assume, in any given year, there are approximately 25,000 children age 9 months each month, 29,000 children age 18 months each month, and 29,000 children age 30 months each month.
8. Assume that developmental screening costs are \$60,000,000 in FY 2019-20.

Costs for this policy change are expected to be:

(Dollars in Thousands)

FY 2019-20	TF	Prop 56	FF
Trauma Screenings	\$ 60,000	\$ 30,000	\$ 30,000
Developmental Screenings	\$ 45,000	\$ 22,500	\$ 22,500
Total	\$ 105,000	\$ 52,500	\$ 52,500

Funding:

Prop 56 Healthcare Treatment Fund
Title XIX 100% FF

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 207
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Jerrold Anub
 FISCAL REFERENCE NUMBER: 2130

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$500,000,000
- 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	\$500,000,000
STATE FUNDS	\$0	\$50,000,000
FEDERAL FUNDS	\$0	\$450,000,000

DESCRIPTION

Purpose:

This policy change estimates the cost for providing supplemental payments for family planning services in both Medi-Cal Fee-For-Service (FFS) and Managed Care (MC).

Authority:

FY 2019-20 Budget Bill

Interdependent Policy Changes:

Not Applicable

Background:

Proposition 56 funds for FY 2017-18, FY 2018-19, and FY 2019-20 created supplemental payments for certain family planning codes in the Family Planning, Access, Care, Treatment (FPACT) program, as well as an increase in reimbursement in Medi-Cal FFS and MC for pregnancy termination codes.

The Estimate reflects a supplemental payment starting in FY 2019-20 for any office-based family planning service billed under specific CPT codes (99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214) to provide similar family planning payments in the Medi-Cal program. These supplemental payments in Medi-Cal family planning services are intended to help support the larger Medi-Cal population accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program.

Reason for Change from Prior Estimate:

This is a new policy change.

PROP 56 - MEDI-CAL FAMILY PLANNING

REGULAR POLICY CHANGE NUMBER: 207

Methodology:

1. A \$20.00 supplemental payment will be paid in both Medi-Cal FFS and Managed Care for family planning office visits billed under 8 specified CPT codes.
2. Assumes approximately 25,000,000 claims annual in Medi-Cal FFS and MC for these codes.
3. A directed payment would be necessary for the Managed Care component.
4. Expenditures for FY 2019-20 are estimated to be:

(Dollars in Thousands)

FY 2019-20	TF	Prop 56	FF
Family Planning Services	\$ 500,000	\$ 50,000	\$ 450,000

Funding:

90% FF Family Planning (4260-101-0890)

Prop 56 Healthcare Treatment Fund

WHOLE PERSON CARE HOUSING SERVICES

REGULAR POLICY CHANGE NUMBER: 208
 IMPLEMENTATION DATE: 7/2019
 ANALYST: Jerrold Anub
 FISCAL REFERENCE NUMBER: 2131

	FY 2018-19	FY 2019-20
FULL YEAR COST - TOTAL FUNDS	\$0	\$100,000,000
- STATE FUNDS	\$0	\$100,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$100,000,000
STATE FUNDS	\$0	\$100,000,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the Whole Person Care (WPC) one-time augmentation for housing services.

Authority:

Welfare & Institutions Code Section 14184.60
 Proposed Budget Bill Language

Interdependent Policy Changes:

None

Background:

Medi-Cal's current Whole Person Care pilots provide funding to integrate sustainable services for high-risk, high-utilizing beneficiaries. The one-time augmentation will provide supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on people with mental illness. The \$100 million will be available for expenditure until June 30, 2025.

Reason for Change:

This is a new policy change.

Methodology:

- Funding will be made available to selected Whole Person Care pilots.

Fiscal Year	Total Expenditures
FY 2019-20	\$100,000,000

Funding:

General Fund (4260-101-0001)

**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,014,579,000	\$1,007,289,500	\$1,007,289,500	\$0
2	SAWS	\$125,700,000	\$125,700,000	\$0	\$0
3	CaWORKS APPLICATIONS	\$68,030,000	\$34,015,000	\$34,015,000	\$0
4	CASE MANAGEMENT FOR OTLICP	\$44,519,000	\$22,259,500	\$22,259,500	\$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,524,000	\$35,851,500	\$2,672,500	\$0
6	ENHANCED FEDERAL FUNDING	\$0	\$440,642,000	(\$440,642,000)	\$0
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	\$0	\$69,043,000	(\$69,043,000)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,291,352,000	\$1,738,800,500	\$552,551,500	\$0
	GRAND TOTAL	\$2,291,352,000	\$1,738,800,500	\$552,551,500	\$0

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2018-19**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	<u>OTHER</u>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,014,579,000	\$0	\$2,014,579,000	\$1,007,289,500
2	SAWS	\$125,700,000	\$0	\$0	\$0	\$125,700,000	\$0
3	CalWORKS APPLICATIONS	\$0	\$0	\$68,030,000	\$0	\$68,030,000	\$34,015,000
4	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$44,519,000	\$44,519,000	\$22,259,500
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$38,524,000	\$38,524,000	\$2,672,500
6	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$440,642,000)
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	\$0	\$0	\$0	\$0	\$0	(\$69,043,000)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$125,700,000	\$0	\$2,082,609,000	\$83,043,000	\$2,291,352,000	\$552,551,500
	GRAND TOTAL	\$125,700,000	\$0	\$2,082,609,000	\$83,043,000	\$2,291,352,000	\$552,551,500

**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<u>OTHER</u>				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,067,562,000	\$1,033,781,000	\$1,033,781,000	\$0
2	SAWS	\$127,600,000	\$127,600,000	\$0	\$0
3	CaWORKS APPLICATIONS	\$56,064,000	\$28,032,000	\$28,032,000	\$0
4	CASE MANAGEMENT FOR OTLICP	\$44,535,000	\$22,267,500	\$22,267,500	\$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,524,000	\$35,851,500	\$2,672,500	\$0
6	ENHANCED FEDERAL FUNDING	\$0	\$363,425,000	(\$363,425,000)	\$0
8	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	OTHER SUBTOTAL	\$2,334,285,000	\$1,614,957,000	\$719,328,000	\$0
	GRAND TOTAL	\$2,334,285,000	\$1,614,957,000	\$719,328,000	\$0

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE COST BREAKDOWN
FISCAL YEAR 2019-20**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	<u>OTHER</u>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,067,562,000	\$0	\$2,067,562,000	\$1,033,781,000
2	SAWS	\$127,600,000	\$0	\$0	\$0	\$127,600,000	\$0
3	CalWORKS APPLICATIONS	\$0	\$0	\$56,064,000	\$0	\$56,064,000	\$28,032,000
4	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$44,535,000	\$44,535,000	\$22,267,500
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$38,524,000	\$38,524,000	\$2,672,500
6	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$363,425,000)
8	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	OTHER SUBTOTAL	\$127,600,000	\$0	\$2,123,626,000	\$83,059,000	\$2,334,285,000	\$719,328,000
	GRAND TOTAL	\$127,600,000	\$0	\$2,123,626,000	\$83,059,000	\$2,334,285,000	\$719,328,000

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION ALLOCATION	\$2,014,579,000	\$1,007,289,500	\$2,014,579,000	\$1,007,289,500	\$0	\$0
3	2	SAWS	\$155,500,000	\$0	\$125,700,000	\$0	(\$29,800,000)	\$0
4	3	CalWORKS APPLICATIONS	\$65,206,000	\$32,603,000	\$68,030,000	\$34,015,000	\$2,824,000	\$1,412,000
5	4	CASE MANAGEMENT FOR OTLICP	\$44,451,000	\$22,225,500	\$44,519,000	\$22,259,500	\$68,000	\$34,000
6	5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,524,000	\$2,672,500	\$38,524,000	\$2,672,500	\$0	\$0
7	6	ENHANCED FEDERAL FUNDING	\$0	(\$345,130,000)	\$0	(\$440,642,000)	\$0	(\$95,512,000)
9	7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	\$0	\$163,170,000	\$0	(\$69,043,000)	\$0	(\$232,213,000)
8	8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
		OTHER SUBTOTAL	\$2,318,260,000	\$878,830,500	\$2,291,352,000	\$552,551,500	(\$26,908,000)	(\$326,279,000)
		COUNTY ADMINISTRATION GRAND TOTAL	\$2,318,260,000	\$878,830,500	\$2,291,352,000	\$552,551,500	(\$26,908,000)	(\$326,279,000)

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	OTHER						
1	COUNTY ADMINISTRATION ALLOCATION	\$2,014,579,000	\$1,007,289,500	\$2,067,562,000	\$1,033,781,000	\$52,983,000	\$26,491,500
2	SAWS	\$125,700,000	\$0	\$127,600,000	\$0	\$1,900,000	\$0
3	CaIWORKS APPLICATIONS	\$68,030,000	\$34,015,000	\$56,064,000	\$28,032,000	(\$11,966,000)	(\$5,983,000)
4	CASE MANAGEMENT FOR OTLICP	\$44,519,000	\$22,259,500	\$44,535,000	\$22,267,500	\$16,000	\$8,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$38,524,000	\$2,672,500	\$38,524,000	\$2,672,500	\$0	\$0
6	ENHANCED FEDERAL FUNDING	\$0	(\$440,642,000)	\$0	(\$363,425,000)	\$0	\$77,217,000
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS	\$0	(\$69,043,000)	\$0	\$0	\$0	\$69,043,000
8	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
	OTHER SUBTOTAL	\$2,291,352,000	\$552,551,500	\$2,334,285,000	\$719,328,000	\$42,933,000	\$166,776,500
	COUNTY ADMINISTRATION GRAND TOTAL	\$2,291,352,000	\$552,551,500	\$2,334,285,000	\$719,328,000	\$42,933,000	\$166,776,500

**MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX**

<u>POLICY CHANGE NUMBER</u>	<u>POLICY CHANGE TITLE</u>
	<u>OTHER</u>
1	COUNTY ADMINISTRATION ALLOCATION
2	SAWS
3	CALWORKS APPLICATIONS
4	CASE MANAGEMENT FOR OTLICP
5	LOS ANGELES COUNTY HOSPITAL INTAKES
6	ENHANCED FEDERAL FUNDING
7	COUNTY ADMINISTRATION CMS DEFERRED CLAIMS
8	SAVE

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1704

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$2,014,579,000	\$0	\$2,067,562,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,014,579,000	\$0	\$2,067,562,000
STATE FUNDS	\$0	\$1,007,289,500	\$0	\$1,033,781,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$2,014,579,000	\$0	\$2,067,562,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$2,014,579,000	\$0	\$2,067,562,000
STATE FUNDS	\$0	\$1,007,289,500	\$0	\$1,033,781,000

DESCRIPTION

Purpose:

This policy change reflects the allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. This estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

The allocation estimate consists of the costs identified for three sub-categories: (1) staff costs, (2) support costs, and (3) staff development costs.

1. Staff Costs

This amount includes the estimated costs for staff in three staff categories: eligibility workers and supervisors, clerical support staff, and administrative staff. The staff costs for each of the three categories will be allocated to individual counties to fund all Medi-Cal eligibility determination activities.

COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

2. Support Costs

Support costs are a combination of two types of expenditures: operating support costs and electronic data processing costs. These two types of expenditures are further divided into allocated costs and direct costs.

- a. Allocated costs are those that are shared across all programs and distributed to individual programs based on a ratio developed from the total expenditures for each program.
- b. Direct costs are specific to the Medi-Cal program only.

3. Staff Development Costs

Staff development costs are the costs of training Medi-Cal eligibility workers. The amount in this item includes:

- a. Trainers' salaries and benefits,
- b. Operating costs related to training,
- c. Trainees' salaries and benefits,
- d. Travel, per diem, supplies and tuition,
- e. Purchase of contracted training services.

Beginning in FY 2018-19, the Department includes funding for the implementation of the ACA in this policy change. The Department uses the projected California Price index (CPI) change to adjust the total dollars available and applies similar adjustments as the county eligibility systems move to a single Statewide Automated Welfare System (SAWS). With this increase, counties work to place beneficiaries into the correct aid codes based on changes in circumstances, increase the percentage of completed and accurate eligibility determinations and annual redeterminations, and provide timely eligibility and enrollment data and reports to the Department. The Department will not reallocate unspent funds to counties that overspend their allocation.

Reason for Change:

There is no change, from the previous estimate, for FY 2018-19. The change, in the current estimate, from FY 2018-19 to FY 2019-20, is due to the Department increasing the total allocation by 2.63% for the projected California Consumer Price Index, for an increase of \$53M.

Methodology:

1) The total rounded estimated FY 2018-19 and FY 2019-20 county administration costs are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Total Allocation	\$2,014,579	\$1,007,289	\$1,007,289

FY 2019-20	TF	GF	FF
Total Allocation	\$2,067,562	\$1,033,781	\$1,033,781

Funding:

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

Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 7/1987
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 214

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$125,700,000	\$0	\$127,600,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$125,700,000	\$0	\$127,600,000	\$0
STATE FUNDS	\$0	\$0	\$0	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$125,700,000	\$0	\$127,600,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$125,700,000	\$0	\$127,600,000	\$0
STATE FUNDS	\$0	\$0	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates and reimburses the California Department of Social Services (CDSS) federal financial participation (FFP) for automated Eligibility Determination and Automated Benefit Computation. This policy change also estimates the funds that the Department pays for the Los Angeles Eligibility Automated Determination Evaluation and Reporting System (LEADER) Replacement System (LRS) and the California Automated Consortium Eligibility System (CalACES).

Authority:

Welfare & Institutions Code 14154
 Interagency Agreement # 04-35639
 Interagency Agreement CalHEERS # 14-90510
 Affordable Care Act (ACA)

Interdependent Policy Changes:

Not Applicable

Background:

The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LRS, Consortium-IV (C-IV), and CalWORKs Information Network (CalWIN). SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

LRS is the automated system used in Los Angeles County and is currently in the maintenance and operations phase. The CalWIN consortium is used by 18 counties and the C-IV system is used by 39 counties. CalWIN and C-IV are currently in the maintenance and operation phase.

SAWS**COUNTY ADMIN. POLICY CHANGE NUMBER: 2**

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. LRS was developed using the C-IV system as the baseline. The process of migrating the C-IV counties to the LRS codebase is scheduled to begin July 2020, after modifications are made to meet C-IV county needs. The C-IV migration to a modified LRS, will result in a new consortium system called CalACES. CalACES will replace both LRS and C-IV.

The process of migrating the CalWIN counties to CalACES is scheduled to begin in 2023, after modifications are made to meet CalWIN county needs. The CalWIN migration to a modified CalACES will result in a new system called CalSAWS (California Statewide Automated Welfare Systems).

The Appeals Case Management System (ACMS) cost was removed from this policy change and is now located in the Department of Social Services Administrative Cost, Other Administration policy change.

Reason for Change:

The decrease from the prior estimate, for FY 2018-19, is primarily due to the removal of LRS C-IV Migration costs. The slight change in the current estimate, from FY 2018-19 to FY 2019-20, is an increase due to higher forecasted SB 1341 Automation costs in FY 2019-20.

Methodology:

1) The following estimate was provided by CDSS on a cash basis.

(Dollars in Thousands)

Line Item	FY 2018-19	FY 2019-20
Statewide Project Management	\$2,432	\$2,426
SB 1341 Medi-Cal/SAWS	\$2,883	\$8,439
WCDS-CalWIN	\$43,558	\$42,412
State Client Index	\$67	\$67
Inter-County Transfer	\$48	\$0
CalACES	\$76,711	\$74,256
Total	\$125,700	\$127,600

Funding:

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

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

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 217

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$68,030,000	\$0	\$56,064,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$68,030,000	\$0	\$56,064,000
STATE FUNDS	\$0	\$34,015,000	\$0	\$28,032,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$68,030,000	\$0	\$56,064,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$68,030,000	\$0	\$56,064,000
STATE FUNDS	\$0	\$34,015,000	\$0	\$28,032,000

DESCRIPTION

Purpose:

This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Since 1998, the Department shares in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to final caseload reports for FY 2017-18 showing more applications in FY 2017-18 than in FY 2016-17. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to lower expenditures in the most recent data.

CaIWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

Methodology:

1) The estimated costs for FY 2018-19 and FY 2019-20 were provided on a cash basis by CDSS.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$68,030	\$34,015	\$34,015
FY 2019-20	\$56,064	\$28,032	\$28,032

Funding:

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

Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1598

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$44,519,000	\$0	\$44,535,000
TOTAL FUNDS	\$0	\$44,519,000	\$0	\$44,535,000
STATE FUNDS	\$0	\$22,259,500	\$0	\$22,267,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$44,519,000	\$0	\$44,535,000
TOTAL FUNDS	\$0	\$44,519,000	\$0	\$44,535,000
STATE FUNDS	\$0	\$22,259,500	\$0	\$22,267,500

DESCRIPTION

Purpose:

This policy change budgets the county administration costs associated with the ongoing costs for case management and redetermination of Optional Targeted Low Income Children's Program (OTLICP) beneficiaries.

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent current subscribers' applications and information to the counties. The final group transitioned November 1, 2013. The program has since been renamed as the OTLICP.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to a slight increase in the estimated monthly caseload data. The change in the current estimate from FY 2018-19 to FY 2019-20 is due to the expected growth trend of OTLICP eligibles.

Methodology:

1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at \$4.00 Per Member Per Month (PMPM).

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

2. The estimated average monthly OTLICP eligibles for FY 2018-19 is 927,479 and 927,812 for FY 2019-20.
3. The estimated costs are:
(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$ 44,519	\$ 22,260	\$ 22,259
FY 2019-20	\$ 44,535	\$ 22,268	\$ 22,267

Funding:

50% Title XIX / 50% GF (4260-113-0890/0001)

Medicaid Management Information Systems Enhanced Funding identified in the Enhanced Federal Funding policy change

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 7/1994
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 213

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$38,524,000	\$0	\$38,524,000
TOTAL FUNDS	\$0	\$38,524,000	\$0	\$38,524,000
STATE FUNDS	\$0	\$2,672,500	\$0	\$2,672,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$38,524,000	\$0	\$38,524,000
TOTAL FUNDS	\$0	\$38,524,000	\$0	\$38,524,000
STATE FUNDS	\$0	\$2,672,500	\$0	\$2,672,500

DESCRIPTION

Purpose:

The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. Los Angeles County hospitals send applications processed by the PFSWs to the Los Angeles County Human Services Agency for final eligibility determination. Welfare & Institutions Code Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The Department passes through the federal share for any costs not covered by the DPSS rate to the county.

Reason for Change:

There is no change from the prior estimate, for FY 2018-19. There is no change in the current estimate, from FY 2018-19 to FY 2019-20.

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

- The reimbursement rate is \$268 for both current year and budget year. Assume in FY 2018-19 and FY 2019-20, PFSWs will continue processing a base caseload of 2,215 per month.

FY 2018-19: $2,215 \times \$268 \times 12 = \$7,123,000$ TF (\$3,561,500 GF)

FY 2019-20: $2,215 \times \$268 \times 12 = \$7,123,000$ TF (\$3,561,500 GF)

- The Department will complete the FY 2016-17 reconciliation in FY 2018-19 and the FY 2017-18 Reconciliation in FY 2019-20. The current FY 2016-17 and FY 2017-18 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2018-19			FY 2019-20		
	TF	GF	FF	TF	GF	FF
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2016-17 Recon.	\$14,812	(\$889)	\$15,701			
FY 2016-17 Pass.	\$16,589	\$0	\$16,589			
FY 2017-18 Recon.				\$14,812	(\$889)	\$15,701
FY 2017-18 Pass.				\$16,589	\$0	\$16,589
Total	\$38,524	\$2,672	\$35,852	\$38,524	\$2,672	\$35,852

Funding:

(Dollars in Thousands)

FY 2018-19	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$32,290	\$0	\$32,290
100% GF	4260-101-0001	(\$889)	(\$889)	\$0
Total		\$38,524	\$2,672	\$35,852

FY 2019-20	Fund Number	TF	GF	FF
50% Title XIX FF/ 50% GF	4260-101-0001/0890	\$7,123	\$3,561	\$3,562
100% Title XIX FF	4260-101-0890	\$32,290	\$0	\$32,290
100% GF	4260-101-0001	(\$889)	(\$889)	\$0
Total		\$38,524	\$2,672	\$35,852

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 1/2015
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1835

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$440,642,000	\$0	-\$363,425,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$440,642,000	\$0	-\$363,425,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:

Not Applicable

Interdependent Policy Changes:

County Administration Allocation
 CalWORKS Applications
 Case Management for OTLICP

Background:

Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare and Medicaid Services (CMS) published guidance that allows for federal funding at 75% for some of these activities. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance, and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

In order to secure the enhanced funding, there are various conditions required of a MMIS. Also, there are minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. In January 2014, the Department submitted an Advanced Planning Document (APD) to secure CMS approval. CMS approved the APD on September 29, 2014. The Department conducts an annual review of the APD

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

and submits an update to CMS. CMS approved the APD for FFY 2018 on September 1, 2017. The Department conducted an annual review of the APD and submitted an update to CMS in July of 2018 for FFY 2019.

Reason for Change:

The change from the previous estimate, for FY 2018-19, is due to the Department receiving two quarterly payments delayed from FY 2017-18 in FY 2018-19. Additionally, there are changes in the methodology and timing of claiming. FY 2018-19 will have three quarters of payments made with the updated methodology, for 5 total quarterly claims payments in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is primarily due to the Department claiming 5 quarters of enhanced funding in FY 2018-19 and 4 quarters in FY 2019-20.

Methodology:

1. The effective date for the Department's APD is September 29, 2017, with retroactivity for April-September 2017.
2. For FY 2018-19, the Department claimed payments for FY 2017-18 quarters 2 and 3 in August 2018. The methodology used to calculate the claim payments for these two quarters is to assume that 65% of county administration expenditure costs are eligible for enhanced funding because they are application, on-going case maintenance, and redetermination costs.
3. Beginning October 2018, the Department will receive reports from CDSS identifying actual expenditure costs eligible for enhanced funding.
4. The Department will claim payments for FY 2017-18 quarter 4, and FY 2018-19 quarters 1 and 2 using the updated methodology, for a total of 5 quarterly claim payments in FY 2018-19.
5. The Department will claim payments for FY 2018-19 quarters 3 and 4, and FY 2019-20 quarters 1 and 2 in FY 2019-20.
6. The savings are estimated to be:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX at 50% FFP	\$ (1,762,566)	\$ (881,283)	\$ (881,283)
Title XIX at 75% FFP	\$ 1,762,566	\$ 440,641	\$ 1,321,925
Total Difference	\$ -	\$ (440,642)	\$ 440,642

FY 2019-20	TF	GF	FF
Title XIX at 50% FFP	\$ (1,453,699)	\$ (726,850)	\$ (726,849)
Title XIX at 75% FFP	\$ 1,453,699	\$ 363,425	\$ 1,090,274
Total Difference	\$ -	\$ (363,425)	\$ 363,425

Funding:

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

75% Title XIX GF/ 25% GF (4260-101-0001/0890)

COUNTY ADMINISTRATION CMS DEFERRED CLAIMS

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 8/2018
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 2089

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$69,043,000	\$0	\$0	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$69,043,000	\$0	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the repayment of County Administration Enhanced Funding deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
 Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:

Not Applicable

Background:

CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

COUNTY ADMINISTRATION CMS DEFERRED CLAIMS

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

The County Administration Enhanced Funding deferral repayments and resolutions are included in this policy change and are separate from the CMS Deferred Claims policy change. See the CMS Deferred Claims policy change for more information.

Reason for Change:

The change in FY 2018-19 from the prior estimate, and from FY 2018-19 to FY 2019-20 in the current estimate, is due to the release of the deferred claims.

Methodology:

1. On July 3, 2018, CMS approved the release of the FFY 2016 Quarter 2 and FFY 2016 Quarter 3 deferrals and the funds to be made available for reclaiming.
2. The Department reclaimed \$69.043 million FF in August 2018.

Funding:

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

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

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 10/1988
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 215

	FY 2018-19		FY 2019-20	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0

DESCRIPTION**Purpose:**

The policy change estimates the technical adjustment in funding from Title XIX 50% Federal Financial Participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:

Welfare & Institutions Code 14154

Interdependent Policy Changes:

Not Applicable

Background:

The Immigration Reform and Control Act (IRCA) of 1986 required states to use the SAVE system to verify immigrant status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications. Beginning May of 2018, counties are federally required to use the web-based SAVE system for the third step of the SAVE process.

Reason for Change:

There is no change, from the previous estimate, for FY 2018-19. There is no change, in the current estimate, from FY 2018-19 to FY 2019-20.

SAVE**COUNTY ADMIN. POLICY CHANGE NUMBER: 8****Methodology:**

1. Reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.
2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

Fiscal Year	Actual	Fiscal Year	Estimated
FY 2014-15	\$6,618,661	FY 2017-18	\$8,000,000
FY 2015-16	\$7,553,372	FY 2018-19	\$8,000,000
FY 2016-17	\$8,004,000	FY 2019-20	\$8,000,000

3. Based on claims through June 2017, federal funds will be:
(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	(\$8,000)	(\$4,000)	(\$4,000)
100 % Title XIX FFP 4260-101-0890	\$8,000	\$0	\$8,000
Net Impact	\$0	(\$4,000)	\$4,000

FY 2019-20	TF	GF	FF
50% Title XIX /50% GF 4260-101-0001/0890	(\$8,000)	(\$4,000)	(\$4,000)
100% Title XIX FFP 4260-101-0890	\$8,000	\$0	\$8,000
Net Impact	\$0	(\$4,000)	\$4,000

Funding:

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

November 2018 Medi-Cal Estimate

**OTHER ADMINISTRATION
FUNDING SUMMARY**

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The Fiscal Intermediary Tab of the Medi-Cal Estimate has been moved to the Other Administration Tab. These items continue to be budgeted in the Medi-Cal's Fiscal Intermediary component. The policy changes related to the Fiscal Intermediary can be found under the following subsections: DHCS-MEDICAL FI, DHCS-HEALTH CARE OPTIONS, AND DHCS-DENTAL FI.

<u>FY 2018-2019 Estimate:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>General Funds</u>	<u>Other State Funds</u>
OTHER ADMINISTRATION				
County Administration	\$2,315,286,000	\$2,054,453,000	\$255,836,000	\$4,997,000
Fiscal Intermediary	\$367,706,000	\$192,408,000	\$175,298,000	\$0
Total Other Administration Tab	\$2,682,992,000	\$2,246,861,000	\$431,134,000	\$4,997,000

Management Summary:

COUNTY ADMINISTRATION	\$4,606,638,000	\$3,793,253,000	\$808,388,000	\$4,997,000
Shown in Other Administration Tab	\$2,315,286,000	\$2,054,453,000	\$255,836,000	\$4,997,000
Shown in County Administration Tab	\$2,291,352,000	\$1,738,800,000	\$552,552,000	\$0
FISCAL INTERMEDIARY	\$367,706,000	\$192,408,000	\$175,298,000	\$0
Shown in Other Administration Tab	\$367,706,000	\$192,408,000	\$175,298,000	\$0

<u>FY 2019-2020 Estimate:</u>	<u>Total Funds</u>	<u>Federal Funds</u>	<u>General Funds</u>	<u>Other State Funds</u>
OTHER ADMINISTRATION				
County Administration	\$1,987,228,000	\$1,795,179,000	\$187,460,000	\$4,589,000
Fiscal Intermediary	\$350,907,000	\$231,883,000	\$119,024,000	\$0
Total Other Administration Tab	\$2,338,135,000	\$2,027,062,000	\$306,484,000	\$4,589,000

Management Summary:

COUNTY ADMINISTRATION	\$4,321,513,000	\$3,410,136,000	\$906,788,000	\$4,589,000
Shown in Other Administration Tab	\$1,987,228,000	\$1,795,179,000	\$187,460,000	\$4,589,000
Shown in County Administration Tab	\$2,334,285,000	\$1,614,957,000	\$719,328,000	\$0
FISCAL INTERMEDIARY	\$350,907,000	\$231,883,000	\$119,024,000	\$0
Shown in Other Administration Tab	\$350,907,000	\$231,883,000	\$119,024,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>DHCS-OTHER</u>				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$259,344,000	\$231,376,000	\$27,968,000	\$0
2	CCS CASE MANAGEMENT	\$187,225,000	\$124,419,810	\$62,805,190	\$0
3	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$143,481,000	\$142,363,000	\$1,118,000	\$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$140,697,000	\$140,697,000	\$0	\$0
5	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	\$86,463,000	\$86,463,000	\$0	\$0
6	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$35,788,000	\$34,796,000	\$992,000	\$0
7	EPSDT CASE MANAGEMENT	\$33,962,000	\$22,005,000	\$11,957,000	\$0
8	SMH MAA	\$30,803,000	\$30,803,000	\$0	\$0
9	ARRA HITECH INCENTIVE PROGRAM	\$29,823,000	\$28,538,000	\$0	\$1,285,000
10	SMHS COUNTY UR & QA ADMIN	\$28,862,000	\$27,919,000	\$943,000	\$0
11	POSTAGE & PRINTING	\$28,421,000	\$14,082,000	\$14,339,000	\$0
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$27,108,000	\$21,720,960	\$5,387,040	\$0
13	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$20,022,000	\$20,022,000	\$0	\$0
14	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$26,728,000	\$17,819,000	\$8,909,000	\$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$16,872,000	\$8,436,000	\$8,119,000	\$317,000
16	PAVE SYSTEM	\$16,260,000	\$8,731,600	\$7,528,400	\$0
17	PERFORMANCE OUTCOMES SYSTEM	\$6,816,000	\$3,754,000	\$3,062,000	\$0
18	MIS/DSS CONTRACT	\$12,251,000	\$9,002,000	\$3,249,000	\$0
19	SURS AND MARS SYSTEM REPLACEMENT	\$11,544,000	\$9,265,800	\$2,278,200	\$0
20	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,606,500	\$0
21	PASRR	\$9,925,000	\$7,443,750	\$2,481,250	\$0
22	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
23	MEDI-CAL RECOVERY CONTRACTS	\$9,049,000	\$6,786,750	\$2,262,250	\$0
24	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$3,850,000	\$0
25	MITA	\$6,188,000	\$5,429,200	\$758,800	\$0
26	MANAGED CARE REGULATIONS - MH PARITY	\$5,201,000	\$4,458,000	\$743,000	\$0
27	DMC COUNTY UR & QA ADMIN	\$5,099,000	\$5,099,000	\$0	\$0
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,000,000	\$3,585,000	\$1,415,000	\$0
29	CALIFORNIA HEALTH INTERVIEW SURVEY	\$4,850,000	\$1,100,000	\$3,750,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-OTHER</u>					
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,647,000	\$3,485,250	\$1,161,750	\$0
31	CLINICAL DATA COLLECTION	\$3,053,000	\$2,663,850	\$389,150	\$0
32	CA-MMIS MEDCOMPASS SOLUTION	\$2,674,000	\$2,285,000	\$389,000	\$0
33	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
34	MEDICARE BENEFICIARY IDENTIFIER	\$1,636,000	\$1,472,400	\$163,600	\$0
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,400,000	\$700,000	\$700,000	\$0
36	ELECTRONIC ASSET VERIFICATION PROGRAM	\$1,318,000	\$659,000	\$659,000	\$0
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$603,500	\$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$1,022,000	\$511,000	\$511,000	\$0
39	MOBILE VISION CARE SERVICES	\$1,000,000	\$0	\$1,000,000	\$0
40	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$0	\$950,000	\$0
41	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$375,000	\$0
42	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$592,000	\$296,000	\$296,000	\$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$342,000	\$342,000	\$0	\$0
45	VENDOR FOR AAC RATE STUDY	\$332,000	\$166,000	\$166,000	\$0
46	T-MSIS	\$271,000	\$203,250	\$67,750	\$0
47	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$200,000	\$100,000	\$100,000	\$0
48	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	\$131,000	\$98,250	\$32,750	\$0
	DHCS-OTHER SUBTOTAL	\$1,240,525,000	\$1,045,684,370	\$193,238,630	\$1,602,000
<u>DHCS-MEDICAL FI</u>					
49	MEDICAL FI OPERATIONS	\$64,694,000	\$43,928,500	\$20,765,500	\$0
50	MEDICAL FI COST REIMBURSEMENT	\$40,775,000	\$30,102,250	\$10,672,750	\$0
51	MEDICAL FI HOURLY REIMBURSEMENT	\$22,955,000	\$17,966,250	\$4,988,750	\$0
52	MEDICAL FI OTHER ESTIMATED COSTS	\$9,817,000	\$6,842,000	\$2,975,000	\$0
53	MEDICAL FI SRP RELEASE 1 HOSTING	\$7,042,000	\$6,018,300	\$1,023,700	\$0
54	MEDICAL FI MISCELLANEOUS EXPENSES	\$2,975,000	\$2,071,250	\$903,750	\$0
55	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	\$1,679,000	\$1,511,100	\$167,900	\$0
56	MEDICAL FI CHANGE ORDERS	\$456,000	\$342,000	\$114,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<u>DHCS-MEDICAL FI</u>					
103	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	(\$83,092,000)	\$83,092,000	\$0
	DHCS-MEDICAL FI SUBTOTAL	\$150,393,000	\$25,689,650	\$124,703,350	\$0
<u>DHCS-HEALTH CARE OPT</u>					
66	HCO OPERATIONS 2017 CONTRACT	\$27,935,000	\$14,498,360	\$13,436,640	\$0
67	HCO COST REIMBURSEMENT 2017 CONTRACT	\$27,040,000	\$14,033,760	\$13,006,240	\$0
68	HCO COST REIMBURSEMENT	\$13,582,000	\$7,049,780	\$6,532,220	\$0
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$9,304,000	\$4,828,700	\$4,475,300	\$0
70	HCO OPERATIONS	\$9,103,000	\$4,723,640	\$4,379,360	\$0
71	HCO - ENROLLMENT CONTRACTOR COSTS	\$5,638,000	\$2,926,160	\$2,711,840	\$0
72	HCO TAKEOVER	\$5,231,000	\$2,615,500	\$2,615,500	\$0
73	HCO ESR HOURLY REIMBURSEMENT	\$4,824,000	\$2,503,580	\$2,320,420	\$0
74	HCO CCI - CAL MEDICCONNECT AND MLTSS	\$4,816,000	\$2,408,000	\$2,408,000	\$0
75	HCO TURNOVER	\$1,436,000	\$718,000	\$718,000	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$108,909,000	\$56,305,480	\$52,603,520	\$0
<u>DHCS-DENTAL FI</u>					
76	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$60,773,000	\$38,929,500	\$21,843,500	\$0
77	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$24,066,000	\$17,486,500	\$6,579,500	\$0
78	DENTAL FI TAKEOVER 2016 CONTRACT	\$9,760,000	\$7,320,000	\$2,440,000	\$0
79	DENTAL FI CD-MMIS COSTS	\$7,152,000	\$5,364,000	\$1,788,000	\$0
80	DENTAL ASO TAKEOVER 2016 CONTRACT	\$2,192,000	\$1,644,000	\$548,000	\$0
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	\$1,656,000	\$828,000	\$828,000	\$0
	DHCS-DENTAL FI SUBTOTAL	\$105,599,000	\$71,572,000	\$34,027,000	\$0
<u>OTHER DEPARTMENTS</u>					
82	PERSONAL CARE SERVICES	\$361,790,000	\$361,790,000	\$0	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2018-19**

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
OTHER DEPARTMENTS					
83	HEALTH-RELATED ACTIVITIES - CDSS	\$391,657,000	\$391,657,000	\$0	\$0
84	CALHEERS DEVELOPMENT	\$126,756,000	\$100,503,670	\$26,252,330	\$0
85	CDDS ADMINISTRATIVE COSTS	\$54,998,000	\$54,998,000	\$0	\$0
86	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$41,379,000	\$0	\$0
87	MATERNAL AND CHILD HEALTH	\$37,556,000	\$37,556,000	\$0	\$0
88	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,747,000	\$28,747,000	\$0	\$0
89	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$14,891,000	\$11,496,000	\$0	\$3,395,000
90	CLPP CASE MANAGEMENT SERVICES	\$6,536,000	\$6,536,000	\$0	\$0
92	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,533,000	\$4,533,000	\$0	\$0
93	CALIFORNIA SMOKERS' HELPLINE	\$2,562,000	\$2,562,000	\$0	\$0
94	KIT FOR NEW PARENTS	\$1,197,000	\$1,197,000	\$0	\$0
95	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
96	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$950,000	\$950,000	\$0	\$0
97	CHHS AGENCY HIPAA FUNDING	\$849,000	\$849,000	\$0	\$0
98	VITAL RECORDS DATA	\$736,000	\$736,000	\$0	\$0
99	CDPH I&E PROGRAM AND EVALUATION	\$711,000	\$711,000	\$0	\$0
100	MERIT SYSTEM SERVICES FOR COUNTIES	\$236,000	\$118,000	\$118,000	\$0
101	PIA EYEWEAR COURIER SERVICE	\$382,000	\$191,000	\$191,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$1,077,566,000	\$1,047,609,670	\$26,561,330	\$3,395,000
	GRAND TOTAL	\$2,682,992,000	\$2,246,861,170	\$431,133,830	\$4,997,000

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
	<u>DHCS-OTHER</u>				
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$148,634,000	\$148,634,000	\$0	\$0
2	CCS CASE MANAGEMENT	\$171,710,000	\$115,175,720	\$56,534,280	\$0
3	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$114,394,000	\$114,394,000	\$0	\$0
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$144,828,000	\$144,828,000	\$0	\$0
5	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	\$33,353,000	\$33,353,000	\$0	\$0
6	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$23,312,000	\$22,454,000	\$858,000	\$0
7	EPSDT CASE MANAGEMENT	\$33,962,000	\$22,005,000	\$11,957,000	\$0
8	SMH MAA	\$30,159,000	\$30,159,000	\$0	\$0
9	ARRA HITECH INCENTIVE PROGRAM	\$11,760,000	\$10,830,000	\$0	\$930,000
10	SMHS COUNTY UR & QA ADMIN	\$29,802,000	\$28,819,000	\$983,000	\$0
11	POSTAGE & PRINTING	\$28,421,000	\$14,082,000	\$14,339,000	\$0
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$25,239,000	\$18,455,990	\$6,783,010	\$0
14	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$24,457,000	\$16,305,000	\$8,152,000	\$0
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$17,055,000	\$8,527,500	\$8,118,500	\$409,000
16	PAVE SYSTEM	\$8,151,000	\$5,603,750	\$2,547,250	\$0
17	PERFORMANCE OUTCOMES SYSTEM	\$16,867,000	\$9,627,750	\$7,239,250	\$0
18	MIS/DSS CONTRACT	\$11,507,000	\$8,457,500	\$3,049,500	\$0
19	SURS AND MARS SYSTEM REPLACEMENT	\$10,835,000	\$8,571,300	\$2,263,700	\$0
20	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,606,500	\$0
21	PASRR	\$9,950,000	\$7,462,500	\$2,487,500	\$0
22	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
23	MEDI-CAL RECOVERY CONTRACTS	\$9,372,000	\$7,029,000	\$2,343,000	\$0
24	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$3,850,000	\$0
25	MITA	\$6,516,000	\$5,664,400	\$851,600	\$0
26	MANAGED CARE REGULATIONS - MH PARITY	\$19,760,000	\$16,937,000	\$2,823,000	\$0
27	DMC COUNTY UR & QA ADMIN	\$4,884,000	\$4,884,000	\$0	\$0
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,000,000	\$3,585,000	\$1,415,000	\$0
29	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,100,000	\$1,100,000	\$0	\$0
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,660,000	\$3,495,000	\$1,165,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-OTHER</u>					
31	CLINICAL DATA COLLECTION	\$2,794,000	\$2,430,750	\$363,250	\$0
32	CA-MMIS MEDCOMPASS SOLUTION	\$2,686,000	\$2,295,800	\$390,200	\$0
33	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
34	MEDICARE BENEFICIARY IDENTIFIER	\$640,000	\$576,000	\$64,000	\$0
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,400,000	\$700,000	\$700,000	\$0
36	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,007,000	\$1,503,500	\$1,503,500	\$0
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$603,500	\$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$954,000	\$477,000	\$477,000	\$0
41	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$375,000	\$0
42	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$586,000	\$293,000	\$293,000	\$0
45	VENDOR FOR AAC RATE STUDY	\$332,000	\$166,000	\$166,000	\$0
46	T-MSIS	\$249,000	\$186,750	\$62,250	\$0
48	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	\$169,000	\$126,750	\$42,250	\$0
	DHCS-OTHER SUBTOTAL	\$991,680,000	\$835,782,460	\$154,558,540	\$1,339,000
<u>DHCS-MEDICAL FI</u>					
49	MEDICAL FI OPERATIONS	\$38,382,000	\$26,073,500	\$12,308,500	\$0
50	MEDICAL FI COST REIMBURSEMENT	\$16,638,000	\$12,201,550	\$4,436,450	\$0
51	MEDICAL FI HOURLY REIMBURSEMENT	\$13,773,000	\$10,779,750	\$2,993,250	\$0
52	MEDICAL FI OTHER ESTIMATED COSTS	\$5,890,000	\$4,105,000	\$1,785,000	\$0
53	MEDICAL FI SRP RELEASE 1 HOSTING	\$4,225,000	\$3,610,900	\$614,100	\$0
54	MEDICAL FI MISCELLANEOUS EXPENSES	\$1,779,000	\$1,238,250	\$540,750	\$0
56	MEDICAL FI CHANGE ORDERS	\$228,000	\$171,000	\$57,000	\$0
57	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$21,615,000	\$16,211,250	\$5,403,750	\$0
58	MEDICAL FI BO & IT CHANGE ORDERS	\$16,608,000	\$12,456,000	\$4,152,000	\$0
59	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$15,593,000	\$11,694,750	\$3,898,250	\$0
60	MEDICAL FI BO & IT COST REIMBURSEMENT	\$12,300,000	\$9,172,300	\$3,127,700	\$0
61	MEDICAL FI BO OTHER ESTIMATED COSTS	\$10,890,000	\$7,715,750	\$3,174,250	\$0
62	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$8,161,000	\$5,792,250	\$2,368,750	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>DHCS-MEDICAL FI</u>					
63	MEDICAL FI BUSINESS OPERATIONS	\$7,132,000	\$5,349,000	\$1,783,000	\$0
64	MEDICAL FI BO HOURLY REIMBURSEMENT	\$6,681,000	\$5,010,750	\$1,670,250	\$0
65	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$5,100,000	\$3,747,750	\$1,352,250	\$0
	DHCS-MEDICAL FI SUBTOTAL	\$184,995,000	\$135,329,750	\$49,665,250	\$0
<u>DHCS-HEALTH CARE OPT</u>					
66	HCO OPERATIONS 2017 CONTRACT	\$40,873,000	\$21,036,660	\$19,836,340	\$0
67	HCO COST REIMBURSEMENT 2017 CONTRACT	\$40,619,000	\$20,906,140	\$19,712,860	\$0
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$13,259,000	\$6,824,280	\$6,434,720	\$0
	DHCS-HEALTH CARE OPT SUBTOTAL	\$94,751,000	\$48,767,080	\$45,983,920	\$0
<u>DHCS-DENTAL FI</u>					
76	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$45,742,000	\$29,313,000	\$16,429,000	\$0
77	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,358,000	\$15,447,750	\$5,910,250	\$0
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	\$1,206,000	\$603,000	\$603,000	\$0
	DHCS-DENTAL FI SUBTOTAL	\$68,306,000	\$45,363,750	\$22,942,250	\$0
<u>OTHER DEPARTMENTS</u>					
82	PERSONAL CARE SERVICES	\$366,060,000	\$366,060,000	\$0	\$0
83	HEALTH-RELATED ACTIVITIES - CDSS	\$291,859,000	\$291,859,000	\$0	\$0
84	CALHEERS DEVELOPMENT	\$148,090,000	\$115,047,620	\$33,042,380	\$0
85	CDDS ADMINISTRATIVE COSTS	\$58,670,000	\$58,670,000	\$0	\$0
86	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$41,379,000	\$0	\$0
87	MATERNAL AND CHILD HEALTH	\$37,558,000	\$37,558,000	\$0	\$0
88	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$21,842,000	\$21,842,000	\$0	\$0
89	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$13,881,000	\$10,631,000	\$0	\$3,250,000
90	CLPP CASE MANAGEMENT SERVICES	\$4,200,000	\$4,200,000	\$0	\$0
92	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$6,494,000	\$6,494,000	\$0	\$0
93	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$2,400,000	\$0	\$0
94	KIT FOR NEW PARENTS	\$1,223,000	\$1,223,000	\$0	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES
FISCAL YEAR 2019-20**

<u>NO.</u>	<u>POLICY CHANGE TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<u>OTHER DEPARTMENTS</u>					
95	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
96	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$983,000	\$983,000	\$0	\$0
97	CHHS AGENCY HIPAA FUNDING	\$849,000	\$849,000	\$0	\$0
98	VITAL RECORDS DATA	\$673,000	\$673,000	\$0	\$0
99	CDPH I&E PROGRAM AND EVALUATION	\$558,000	\$558,000	\$0	\$0
100	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
101	PIA EYEWEAR COURIER SERVICE	\$394,000	\$197,000	\$197,000	\$0
	OTHER DEPARTMENTS SUBTOTAL	\$998,403,000	\$961,818,620	\$33,334,380	\$3,250,000
	GRAND TOTAL	\$2,338,135,000	\$2,027,061,660	\$306,484,340	\$4,589,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		DHCS-OTHER						
1	1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$154,118,000	\$136,412,000	\$259,344,000	\$27,968,000	\$105,226,000	(\$108,444,000)
2	2	CCS CASE MANAGEMENT	\$190,884,000	\$63,819,120	\$187,225,000	\$62,805,190	(\$3,659,000)	(\$1,013,930)
5	3	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$95,200,000	\$1,118,000	\$143,481,000	\$1,118,000	\$48,281,000	\$0
4	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$130,354,000	\$0	\$140,697,000	\$0	\$10,343,000	\$0
3	5	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	\$119,816,000	\$0	\$86,463,000	\$0	(\$33,353,000)	\$0
27	6	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$27,767,000	\$373,000	\$35,788,000	\$992,000	\$8,021,000	\$619,000
6	7	EPSDT CASE MANAGEMENT	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
8	8	SMH MAA	\$33,834,000	\$0	\$30,803,000	\$0	(\$3,031,000)	\$0
9	9	ARRA HITECH INCENTIVE PROGRAM	\$27,180,000	\$0	\$29,823,000	\$0	\$2,643,000	\$0
11	10	SMHS COUNTY UR & QA ADMIN	\$28,667,000	\$953,000	\$28,862,000	\$943,000	\$195,000	(\$10,000)
14	11	POSTAGE & PRINTING	\$26,786,000	\$13,521,000	\$28,421,000	\$14,339,000	\$1,635,000	\$818,000
7	12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$32,835,000	\$8,767,720	\$27,108,000	\$5,387,040	(\$5,727,000)	(\$3,380,680)
55	13	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$26,745,000	\$0	\$20,022,000	\$0	(\$6,723,000)	\$0
10	14	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$22,507,000	\$7,502,000	\$26,728,000	\$8,909,000	\$4,221,000	\$1,407,000
15	15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$16,872,000	\$8,119,000	\$16,872,000	\$8,119,000	\$0	\$0
13	16	PAVE SYSTEM	\$14,511,000	\$7,675,500	\$16,260,000	\$7,528,400	\$1,749,000	(\$147,100)
12	17	PERFORMANCE OUTCOMES SYSTEM	\$14,321,000	\$6,414,250	\$6,816,000	\$3,062,000	(\$7,505,000)	(\$3,352,250)
17	18	MIS/DSS CONTRACT	\$11,331,000	\$3,004,750	\$12,251,000	\$3,249,000	\$920,000	\$244,250
19	19	SURS AND MARS SYSTEM REPLACEMENT	\$9,077,000	\$2,086,250	\$11,544,000	\$2,278,200	\$2,467,000	\$191,950
18	20	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$11,213,000	\$5,606,500	\$0	\$0
16	21	PASRR	\$12,706,000	\$3,176,500	\$9,925,000	\$2,481,250	(\$2,781,000)	(\$695,250)
21	22	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<u>DHCS-OTHER</u>						
20	23	MEDI-CAL RECOVERY CONTRACTS	\$9,339,000	\$2,334,750	\$9,049,000	\$2,262,250	(\$290,000)	(\$72,500)
22	24	NEWBORN HEARING SCREENING PROGRAM	\$8,225,000	\$4,112,500	\$7,700,000	\$3,850,000	(\$525,000)	(\$262,500)
32	25	MITA	\$5,274,000	\$527,400	\$6,188,000	\$758,800	\$914,000	\$231,400
109	26	MANAGED CARE REGULATIONS - MH PARITY	\$20,799,000	\$2,971,000	\$5,201,000	\$743,000	(\$15,598,000)	(\$2,228,000)
24	27	DMC COUNTY UR & QA ADMIN	\$5,811,000	\$0	\$5,099,000	\$0	(\$712,000)	\$0
25	28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,000,000	\$1,328,500	\$5,000,000	\$1,415,000	\$0	\$86,500
35	29	CALIFORNIA HEALTH INTERVIEW SURVEY	\$8,600,000	\$3,750,000	\$4,850,000	\$3,750,000	(\$3,750,000)	\$0
23	30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$5,488,000	\$1,372,000	\$4,647,000	\$1,161,750	(\$841,000)	(\$210,250)
26	31	CLINICAL DATA COLLECTION	\$2,474,000	\$322,400	\$3,053,000	\$389,150	\$579,000	\$66,750
31	32	CA-MMIS MEDCOMPASS SOLUTION	\$1,576,000	\$229,300	\$2,674,000	\$389,000	\$1,098,000	\$159,700
30	33	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
28	34	MEDICARE BENEFICIARY IDENTIFIER	\$1,636,000	\$163,600	\$1,636,000	\$163,600	\$0	\$0
34	35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,500,000	\$750,000	\$1,400,000	\$700,000	(\$100,000)	(\$50,000)
29	36	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,328,000	\$1,664,000	\$1,318,000	\$659,000	(\$2,010,000)	(\$1,005,000)
36	37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
38	38	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$926,000	\$463,000	\$1,022,000	\$511,000	\$96,000	\$48,000
115	39	MOBILE VISION CARE SERVICES	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	\$0	\$0
37	40	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$950,000	\$950,000	\$0	\$0
39	41	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
40	42	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$696,000	\$348,000	\$592,000	\$296,000	(\$104,000)	(\$52,000)
44	44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$342,000	\$0	\$342,000	\$0	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>								
43	45	VENDOR FOR AAC RATE STUDY	\$332,000	\$166,000	\$332,000	\$166,000	\$0	\$0
42	46	T-MSIS	\$276,000	\$69,000	\$271,000	\$67,750	(\$5,000)	(\$1,250)
45	47	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$300,000	\$150,000	\$200,000	\$100,000	(\$100,000)	(\$50,000)
--	48	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	\$0	\$0	\$131,000	\$32,750	\$131,000	\$32,750
41	--	IRS REPORTING FOR MIN. ESSENTIAL COVERAGE	\$684,000	\$342,000	\$0	\$0	(\$684,000)	(\$342,000)
48	--	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$0	\$0	(\$100,000)	\$0
49	--	TAR POSTAGE	\$32,000	\$16,000	\$0	\$0	(\$32,000)	(\$16,000)
116	--	RECONCILIATION TO BUDGET ACT	\$0	\$0	\$0	\$0	\$0	\$0
117	--	HEALTH INFORMATION EXCHANGE EXPANSION	\$50,000,000	\$5,000,000	\$0	\$0	(\$50,000,000)	(\$5,000,000)
DHCS-OTHER SUBTOTAL			\$1,189,636,000	\$315,666,040	\$1,240,525,000	\$193,238,630	\$50,889,000	(\$122,427,410)
<u>DHCS-MEDICAL FI</u>								
56	49	MEDICAL FI OPERATIONS	\$77,098,000	\$24,731,750	\$64,694,000	\$20,765,500	(\$12,404,000)	(\$3,966,250)
57	50	MEDICAL FI COST REIMBURSEMENT	\$36,151,000	\$10,319,000	\$40,775,000	\$10,672,750	\$4,624,000	\$353,750
58	51	MEDICAL FI HOURLY REIMBURSEMENT	\$27,546,000	\$5,986,500	\$22,955,000	\$4,988,750	(\$4,591,000)	(\$997,750)
59	52	MEDICAL FI OTHER ESTIMATED COSTS	\$11,080,000	\$3,220,000	\$9,817,000	\$2,975,000	(\$1,263,000)	(\$245,000)
111	53	MEDICAL FI SRP RELEASE 1 HOSTING	\$8,450,000	\$1,228,700	\$7,042,000	\$1,023,700	(\$1,408,000)	(\$205,000)
60	54	MEDICAL FI MISCELLANEOUS EXPENSES	\$2,392,000	\$790,000	\$2,975,000	\$903,750	\$583,000	\$113,750
62	55	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	\$1,679,000	\$167,900	\$1,679,000	\$167,900	\$0	\$0
61	56	MEDICAL FI CHANGE ORDERS	\$544,000	\$136,000	\$456,000	\$114,000	(\$88,000)	(\$22,000)
--	103	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$0	\$0	\$83,092,000	\$0	\$83,092,000
DHCS-MEDICAL FI SUBTOTAL			\$164,940,000	\$46,579,850	\$150,393,000	\$124,703,350	(\$14,547,000)	\$78,123,500

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-HEALTH CARE OPT</u>								
70	66	HCO OPERATIONS 2017 CONTRACT	\$27,935,000	\$13,436,640	\$27,935,000	\$13,436,640	\$0	\$0
71	67	HCO COST REIMBURSEMENT 2017 CONTRACT	\$27,040,000	\$13,006,240	\$27,040,000	\$13,006,240	\$0	\$0
63	68	HCO COST REIMBURSEMENT	\$13,582,000	\$6,532,220	\$13,582,000	\$6,532,220	\$0	\$0
72	69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$9,304,000	\$4,475,300	\$9,304,000	\$4,475,300	\$0	\$0
64	70	HCO OPERATIONS	\$9,103,000	\$4,379,360	\$9,103,000	\$4,379,360	\$0	\$0
65	71	HCO - ENROLLMENT CONTRACTOR COSTS	\$5,638,000	\$2,711,840	\$5,638,000	\$2,711,840	\$0	\$0
68	72	HCO TAKEOVER	\$5,231,000	\$2,615,500	\$5,231,000	\$2,615,500	\$0	\$0
66	73	HCO ESR HOURLY REIMBURSEMENT	\$4,824,000	\$2,320,420	\$4,824,000	\$2,320,420	\$0	\$0
67	74	HCO CCI - CAL MEDICONNECT AND MLTSS	\$4,816,000	\$2,408,000	\$4,816,000	\$2,408,000	\$0	\$0
69	75	HCO TURNOVER	\$1,436,000	\$718,000	\$1,436,000	\$718,000	\$0	\$0
DHCS-HEALTH CARE OPT SUBTOTAL			\$108,909,000	\$52,603,520	\$108,909,000	\$52,603,520	\$0	\$0
<u>DHCS-DENTAL FI</u>								
75	76	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$38,138,000	\$13,832,250	\$60,773,000	\$21,843,500	\$22,635,000	\$8,011,250
78	77	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,505,000	\$5,439,000	\$24,066,000	\$6,579,500	\$3,561,000	\$1,140,500
74	78	DENTAL FI TAKEOVER 2016 CONTRACT	\$5,856,000	\$1,464,000	\$9,760,000	\$2,440,000	\$3,904,000	\$976,000
80	79	DENTAL FI CD-MMIS COSTS	\$1,279,000	\$319,750	\$7,152,000	\$1,788,000	\$5,873,000	\$1,468,250
79	80	DENTAL ASO TAKEOVER 2016 CONTRACT	\$939,000	\$234,750	\$2,192,000	\$548,000	\$1,253,000	\$313,250
81	81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	\$1,895,000	\$947,500	\$1,656,000	\$828,000	(\$239,000)	(\$119,500)
DHCS-DENTAL FI SUBTOTAL			\$68,612,000	\$22,237,250	\$105,599,000	\$34,027,000	\$36,987,000	\$11,789,750
<u>OTHER DEPARTMENTS</u>								
87	82	PERSONAL CARE SERVICES	\$393,693,000	\$0	\$361,790,000	\$0	(\$31,903,000)	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2018 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2018-19**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2018-19 APPROPRIATION		NOV. 2018 EST. FOR 2018-19		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
OTHER DEPARTMENTS								
88	83	HEALTH-RELATED ACTIVITIES - CDSS	\$330,365,000	\$0	\$391,657,000	\$0	\$61,292,000	\$0
89	84	CALHEERS DEVELOPMENT	\$126,987,000	\$26,302,170	\$126,756,000	\$26,252,330	(\$231,000)	(\$49,840)
90	85	CDDS ADMINISTRATIVE COSTS	\$52,686,000	\$0	\$54,998,000	\$0	\$2,312,000	\$0
92	86	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$0	\$41,379,000	\$0	\$0	\$0
91	87	MATERNAL AND CHILD HEALTH	\$37,555,000	\$0	\$37,556,000	\$0	\$1,000	\$0
93	88	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$31,853,000	\$0	\$28,747,000	\$0	(\$3,106,000)	\$0
94	89	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$14,195,000	\$0	\$14,891,000	\$0	\$696,000	\$0
96	90	CLPP CASE MANAGEMENT SERVICES	\$4,200,000	\$0	\$6,536,000	\$0	\$2,336,000	\$0
97	92	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,279,000	\$0	\$4,533,000	\$0	\$254,000	\$0
99	93	CALIFORNIA SMOKERS' HELPLINE	\$2,200,000	\$0	\$2,562,000	\$0	\$362,000	\$0
100	94	KIT FOR NEW PARENTS	\$1,119,000	\$0	\$1,197,000	\$0	\$78,000	\$0
101	95	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
103	96	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$813,000	\$0	\$950,000	\$0	\$137,000	\$0
102	97	CHHS AGENCY HIPAA FUNDING	\$849,000	\$0	\$849,000	\$0	\$0	\$0
98	98	VITAL RECORDS DATA	\$922,000	\$0	\$736,000	\$0	(\$186,000)	\$0
104	99	CDPH I&E PROGRAM AND EVALUATION	\$562,000	\$0	\$711,000	\$0	\$149,000	\$0
105	100	MERIT SYSTEM SERVICES FOR COUNTIES	\$194,000	\$97,000	\$236,000	\$118,000	\$42,000	\$21,000
107	101	PIA EYEWEAR COURIER SERVICE	\$341,000	\$170,500	\$382,000	\$191,000	\$41,000	\$20,500
OTHER DEPARTMENTS SUBTOTAL			\$1,045,292,000	\$26,569,670	\$1,077,566,000	\$26,561,330	\$32,274,000	(\$8,340)
OTHER ADMINISTRATION TOTAL			\$2,577,389,000	\$463,656,330	\$2,682,992,000	\$431,133,830	\$105,603,000	(\$32,522,500)
GRAND TOTAL COUNTY AND OTHER ADMINISTRATION			\$4,895,649,000	\$1,342,486,830	\$4,974,344,000	\$983,685,330	\$78,695,000	(\$358,801,500)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>							
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$259,344,000	\$27,968,000	\$148,634,000	\$0	(\$110,710,000)	(\$27,968,000)
2	CCS CASE MANAGEMENT	\$187,225,000	\$62,805,190	\$171,710,000	\$56,534,280	(\$15,515,000)	(\$6,270,920)
3	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$143,481,000	\$1,118,000	\$114,394,000	\$0	(\$29,087,000)	(\$1,118,000)
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$140,697,000	\$0	\$144,828,000	\$0	\$4,131,000	\$0
5	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	\$86,463,000	\$0	\$33,353,000	\$0	(\$53,110,000)	\$0
6	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$35,788,000	\$992,000	\$23,312,000	\$858,000	(\$12,476,000)	(\$134,000)
7	EPSDT CASE MANAGEMENT	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
8	SMH MAA	\$30,803,000	\$0	\$30,159,000	\$0	(\$644,000)	\$0
9	ARRA HITECH INCENTIVE PROGRAM	\$29,823,000	\$0	\$11,760,000	\$0	(\$18,063,000)	\$0
10	SMHS COUNTY UR & QA ADMIN	\$28,862,000	\$943,000	\$29,802,000	\$983,000	\$940,000	\$40,000
11	POSTAGE & PRINTING	\$28,421,000	\$14,339,000	\$28,421,000	\$14,339,000	\$0	\$0
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$27,108,000	\$5,387,040	\$25,239,000	\$6,783,010	(\$1,869,000)	\$1,395,970
13	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$20,022,000	\$0	\$0	\$0	(\$20,022,000)	\$0
14	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$26,728,000	\$8,909,000	\$24,457,000	\$8,152,000	(\$2,271,000)	(\$757,000)
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$16,872,000	\$8,119,000	\$17,055,000	\$8,118,500	\$183,000	(\$500)
16	PAVE SYSTEM	\$16,260,000	\$7,528,400	\$8,151,000	\$2,547,250	(\$8,109,000)	(\$4,981,150)
17	PERFORMANCE OUTCOMES SYSTEM	\$6,816,000	\$3,062,000	\$16,867,000	\$7,239,250	\$10,051,000	\$4,177,250
18	MIS/DSS CONTRACT	\$12,251,000	\$3,249,000	\$11,507,000	\$3,049,500	(\$744,000)	(\$199,500)
19	SURS AND MARS SYSTEM REPLACEMENT	\$11,544,000	\$2,278,200	\$10,835,000	\$2,263,700	(\$709,000)	(\$14,500)
20	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$11,213,000	\$5,606,500	\$0	\$0
21	PASRR	\$9,925,000	\$2,481,250	\$9,950,000	\$2,487,500	\$25,000	\$6,250
22	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
23	MEDI-CAL RECOVERY CONTRACTS	\$9,049,000	\$2,262,250	\$9,372,000	\$2,343,000	\$323,000	\$80,750

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-OTHER</u>							
24	NEWBORN HEARING SCREENING PROGRAM	\$7,700,000	\$3,850,000	\$7,700,000	\$3,850,000	\$0	\$0
25	MITA	\$6,188,000	\$758,800	\$6,516,000	\$851,600	\$328,000	\$92,800
26	MANAGED CARE REGULATIONS - MH PARITY	\$5,201,000	\$743,000	\$19,760,000	\$2,823,000	\$14,559,000	\$2,080,000
27	DMC COUNTY UR & QA ADMIN	\$5,099,000	\$0	\$4,884,000	\$0	(\$215,000)	\$0
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,000,000	\$1,415,000	\$5,000,000	\$1,415,000	\$0	\$0
29	CALIFORNIA HEALTH INTERVIEW SURVEY	\$4,850,000	\$3,750,000	\$1,100,000	\$0	(\$3,750,000)	(\$3,750,000)
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$4,647,000	\$1,161,750	\$4,660,000	\$1,165,000	\$13,000	\$3,250
31	CLINICAL DATA COLLECTION	\$3,053,000	\$389,150	\$2,794,000	\$363,250	(\$259,000)	(\$25,900)
32	CA-MMIS MEDCOMPASS SOLUTION	\$2,674,000	\$389,000	\$2,686,000	\$390,200	\$12,000	\$1,200
33	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
34	MEDICARE BENEFICIARY IDENTIFIER	\$1,636,000	\$163,600	\$640,000	\$64,000	(\$996,000)	(\$99,600)
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,400,000	\$700,000	\$1,400,000	\$700,000	\$0	\$0
36	ELECTRONIC ASSET VERIFICATION PROGRAM	\$1,318,000	\$659,000	\$3,007,000	\$1,503,500	\$1,689,000	\$844,500
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$1,022,000	\$511,000	\$954,000	\$477,000	(\$68,000)	(\$34,000)
39	MOBILE VISION CARE SERVICES	\$1,000,000	\$1,000,000	\$0	\$0	(\$1,000,000)	(\$1,000,000)
40	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$0	\$0	(\$950,000)	(\$950,000)
41	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
42	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$592,000	\$296,000	\$586,000	\$293,000	(\$6,000)	(\$3,000)
44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$342,000	\$0	\$0	\$0	(\$342,000)	\$0
45	VENDOR FOR AAC RATE STUDY	\$332,000	\$166,000	\$332,000	\$166,000	\$0	\$0
46	T-MSIS	\$271,000	\$67,750	\$249,000	\$62,250	(\$22,000)	(\$5,500)
47	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$200,000	\$100,000	\$0	\$0	(\$200,000)	(\$100,000)
48	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT	\$131,000	\$32,750	\$169,000	\$42,250	\$38,000	\$9,500
DHCS-OTHER SUBTOTAL		\$1,240,525,000	\$193,238,630	\$991,680,000	\$154,558,540	(\$248,845,000)	(\$38,680,100)

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-MEDICAL FI</u>							
49	MEDICAL FI OPERATIONS	\$64,694,000	\$20,765,500	\$38,382,000	\$12,308,500	(\$26,312,000)	(\$8,457,000)
50	MEDICAL FI COST REIMBURSEMENT	\$40,775,000	\$10,672,750	\$16,638,000	\$4,436,450	(\$24,137,000)	(\$6,236,300)
51	MEDICAL FI HOURLY REIMBURSEMENT	\$22,955,000	\$4,988,750	\$13,773,000	\$2,993,250	(\$9,182,000)	(\$1,995,500)
52	MEDICAL FI OTHER ESTIMATED COSTS	\$9,817,000	\$2,975,000	\$5,890,000	\$1,785,000	(\$3,927,000)	(\$1,190,000)
53	MEDICAL FI SRP RELEASE 1 HOSTING	\$7,042,000	\$1,023,700	\$4,225,000	\$614,100	(\$2,817,000)	(\$409,600)
54	MEDICAL FI MISCELLANEOUS EXPENSES	\$2,975,000	\$903,750	\$1,779,000	\$540,750	(\$1,196,000)	(\$363,000)
55	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES	\$1,679,000	\$167,900	\$0	\$0	(\$1,679,000)	(\$167,900)
56	MEDICAL FI CHANGE ORDERS	\$456,000	\$114,000	\$228,000	\$57,000	(\$228,000)	(\$57,000)
57	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$0	\$0	\$21,615,000	\$5,403,750	\$21,615,000	\$5,403,750
58	MEDICAL FI BO & IT CHANGE ORDERS	\$0	\$0	\$16,608,000	\$4,152,000	\$16,608,000	\$4,152,000
59	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$0	\$0	\$15,593,000	\$3,898,250	\$15,593,000	\$3,898,250
60	MEDICAL FI BO & IT COST REIMBURSEMENT	\$0	\$0	\$12,300,000	\$3,127,700	\$12,300,000	\$3,127,700
61	MEDICAL FI BO OTHER ESTIMATED COSTS	\$0	\$0	\$10,890,000	\$3,174,250	\$10,890,000	\$3,174,250
62	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$0	\$0	\$8,161,000	\$2,368,750	\$8,161,000	\$2,368,750
63	MEDICAL FI BUSINESS OPERATIONS	\$0	\$0	\$7,132,000	\$1,783,000	\$7,132,000	\$1,783,000
64	MEDICAL FI BO HOURLY REIMBURSEMENT	\$0	\$0	\$6,681,000	\$1,670,250	\$6,681,000	\$1,670,250
65	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$0	\$0	\$5,100,000	\$1,352,250	\$5,100,000	\$1,352,250
103	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$83,092,000	\$0	\$0	\$0	(\$83,092,000)
	DHCS-MEDICAL FI SUBTOTAL	\$150,393,000	\$124,703,350	\$184,995,000	\$49,665,250	\$34,602,000	(\$75,038,100)
<u>DHCS-HEALTH CARE OPT</u>							
66	HCO OPERATIONS 2017 CONTRACT	\$27,935,000	\$13,436,640	\$40,873,000	\$19,836,340	\$12,938,000	\$6,399,700
67	HCO COST REIMBURSEMENT 2017 CONTRACT	\$27,040,000	\$13,006,240	\$40,619,000	\$19,712,860	\$13,579,000	\$6,706,620
68	HCO COST REIMBURSEMENT	\$13,582,000	\$6,532,220	\$0	\$0	(\$13,582,000)	(\$6,532,220)
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$9,304,000	\$4,475,300	\$13,259,000	\$6,434,720	\$3,955,000	\$1,959,420

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>DHCS-HEALTH CARE OPT</u>							
70	HCO OPERATIONS	\$9,103,000	\$4,379,360	\$0	\$0	(\$9,103,000)	(\$4,379,360)
71	HCO - ENROLLMENT CONTRACTOR COSTS	\$5,638,000	\$2,711,840	\$0	\$0	(\$5,638,000)	(\$2,711,840)
72	HCO TAKEOVER	\$5,231,000	\$2,615,500	\$0	\$0	(\$5,231,000)	(\$2,615,500)
73	HCO ESR HOURLY REIMBURSEMENT	\$4,824,000	\$2,320,420	\$0	\$0	(\$4,824,000)	(\$2,320,420)
74	HCO CCI - CAL MEDICONNECT AND MLTSS	\$4,816,000	\$2,408,000	\$0	\$0	(\$4,816,000)	(\$2,408,000)
75	HCO TURNOVER	\$1,436,000	\$718,000	\$0	\$0	(\$1,436,000)	(\$718,000)
	DHCS-HEALTH CARE OPT SUBTOTAL	\$108,909,000	\$52,603,520	\$94,751,000	\$45,983,920	(\$14,158,000)	(\$6,619,600)
<u>DHCS-DENTAL FI</u>							
76	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$60,773,000	\$21,843,500	\$45,742,000	\$16,429,000	(\$15,031,000)	(\$5,414,500)
77	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$24,066,000	\$6,579,500	\$21,358,000	\$5,910,250	(\$2,708,000)	(\$669,250)
78	DENTAL FI TAKEOVER 2016 CONTRACT	\$9,760,000	\$2,440,000	\$0	\$0	(\$9,760,000)	(\$2,440,000)
79	DENTAL FI CD-MMIS COSTS	\$7,152,000	\$1,788,000	\$0	\$0	(\$7,152,000)	(\$1,788,000)
80	DENTAL ASO TAKEOVER 2016 CONTRACT	\$2,192,000	\$548,000	\$0	\$0	(\$2,192,000)	(\$548,000)
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN	\$1,656,000	\$828,000	\$1,206,000	\$603,000	(\$450,000)	(\$225,000)
	DHCS-DENTAL FI SUBTOTAL	\$105,599,000	\$34,027,000	\$68,306,000	\$22,942,250	(\$37,293,000)	(\$11,084,750)
<u>OTHER DEPARTMENTS</u>							
82	PERSONAL CARE SERVICES	\$361,790,000	\$0	\$366,060,000	\$0	\$4,270,000	\$0
83	HEALTH-RELATED ACTIVITIES - CDSS	\$391,657,000	\$0	\$291,859,000	\$0	(\$99,798,000)	\$0
84	CALHEERS DEVELOPMENT	\$126,756,000	\$26,252,330	\$148,090,000	\$33,042,380	\$21,334,000	\$6,790,060
85	CDDS ADMINISTRATIVE COSTS	\$54,998,000	\$0	\$58,670,000	\$0	\$3,672,000	\$0
86	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$0	\$41,379,000	\$0	\$0	\$0
87	MATERNAL AND CHILD HEALTH	\$37,556,000	\$0	\$37,558,000	\$0	\$2,000	\$0
88	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,747,000	\$0	\$21,842,000	\$0	(\$6,905,000)	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2018-19 AND 2019-20**

NO.	POLICY CHANGE TITLE	NOV. 2018 EST. FOR 2018-19		NOV. 2018 EST. FOR 2019-20		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<u>OTHER DEPARTMENTS</u>							
89	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$14,891,000	\$0	\$13,881,000	\$0	(\$1,010,000)	\$0
90	CLPP CASE MANAGEMENT SERVICES	\$6,536,000	\$0	\$4,200,000	\$0	(\$2,336,000)	\$0
92	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,533,000	\$0	\$6,494,000	\$0	\$1,961,000	\$0
93	CALIFORNIA SMOKERS' HELPLINE	\$2,562,000	\$0	\$2,400,000	\$0	(\$162,000)	\$0
94	KIT FOR NEW PARENTS	\$1,197,000	\$0	\$1,223,000	\$0	\$26,000	\$0
95	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
96	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$950,000	\$0	\$983,000	\$0	\$33,000	\$0
97	CHHS AGENCY HIPAA FUNDING	\$849,000	\$0	\$849,000	\$0	\$0	\$0
98	VITAL RECORDS DATA	\$736,000	\$0	\$673,000	\$0	(\$63,000)	\$0
99	CDPH I&E PROGRAM AND EVALUATION	\$711,000	\$0	\$558,000	\$0	(\$153,000)	\$0
100	MERIT SYSTEM SERVICES FOR COUNTIES	\$236,000	\$118,000	\$190,000	\$95,000	(\$46,000)	(\$23,000)
101	PIA EYEWEAR COURIER SERVICE	\$382,000	\$191,000	\$394,000	\$197,000	\$12,000	\$6,000
	OTHER DEPARTMENTS SUBTOTAL	\$1,077,566,000	\$26,561,330	\$998,403,000	\$33,334,380	(\$79,163,000)	\$6,773,060
	OTHER ADMINISTRATION TOTAL	\$2,682,992,000	\$431,133,830	\$2,338,135,000	\$306,484,340	(\$344,857,000)	(\$124,649,490)
	GRAND TOTAL COUNTY AND OTHER ADMINISTRATION	\$4,974,344,000	\$983,685,330	\$4,672,420,000	\$1,025,812,340	(\$301,924,000)	\$42,127,010

**MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<u>DHCS-OTHER</u>
1	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
2	CCS CASE MANAGEMENT
3	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN
5	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS
6	DRUG MEDI-CAL COUNTY ADMINISTRATION
7	EPSDT CASE MANAGEMENT
8	SMH MAA
9	ARRA HITECH INCENTIVE PROGRAM
10	SMHS COUNTY UR & QA ADMIN
11	POSTAGE & PRINTING
12	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
13	INTERIM AND FINAL COST SETTLEMENTS-SMHS
14	MANAGED CARE REGULATIONS - MENTAL HEALTH
15	ACTUARIAL COSTS FOR RATE DEVELOPMENT
16	PAVE SYSTEM
17	PERFORMANCE OUTCOMES SYSTEM
18	MIS/DSS CONTRACT
19	SURS AND MARS SYSTEM REPLACEMENT
20	CCI-ADMINISTRATIVE COSTS
21	PASRR
22	LITIGATION RELATED SERVICES
23	MEDI-CAL RECOVERY CONTRACTS
24	NEWBORN HEARING SCREENING PROGRAM
25	MITA
26	MANAGED CARE REGULATIONS - MH PARITY
27	DMC COUNTY UR & QA ADMIN
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
29	CALIFORNIA HEALTH INTERVIEW SURVEY
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM
31	CLINICAL DATA COLLECTION
32	CA-MMIS MEDCOMPASS SOLUTION
33	SDMC SYSTEM M&O SUPPORT
34	MEDICARE BENEFICIARY IDENTIFIER
35	SSA COSTS FOR HEALTH COVERAGE INFO.
36	ELECTRONIC ASSET VERIFICATION PROGRAM
37	FAMILY PACT PROGRAM ADMIN.
38	MMA - DSH ANNUAL INDEPENDENT AUDIT

MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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40	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES
41	ENCRYPTION OF PHI DATA
42	POSTAGE AND PRINTING - THIRD PARTY LIAB.
44	CCT OUTREACH - ADMINISTRATIVE COSTS
45	VENDOR FOR AAC RATE STUDY
46	T-MSIS
47	MEDICARE BUY-IN QUALITY REVIEW PROJECT
48	STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT
	<u>DHCS-MEDICAL FI</u>
49	MEDICAL FI OPERATIONS
50	MEDICAL FI COST REIMBURSEMENT
51	MEDICAL FI HOURLY REIMBURSEMENT
52	MEDICAL FI OTHER ESTIMATED COSTS
53	MEDICAL FI SRP RELEASE 1 HOSTING
54	MEDICAL FI MISCELLANEOUS EXPENSES
55	MEDICAL FI OPTIONAL CONTRACTUAL SERVICES
56	MEDICAL FI CHANGE ORDERS
57	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
58	MEDICAL FI BO & IT CHANGE ORDERS
59	MEDICAL FI IT INFRASTRUCTURE SERVICES
60	MEDICAL FI BO & IT COST REIMBURSEMENT
61	MEDICAL FI BO OTHER ESTIMATED COSTS
62	MEDICAL FI BO TELEPHONE SERVICE CENTER
63	MEDICAL FI BUSINESS OPERATIONS
64	MEDICAL FI BO HOURLY REIMBURSEMENT
65	MEDICAL FI BO MISCELLANEOUS EXPENSES
103	CMS DEFERRED CLAIMS - OTHER ADMIN
	<u>DHCS-HEALTH CARE OPT</u>
66	HCO OPERATIONS 2017 CONTRACT
67	HCO COST REIMBURSEMENT 2017 CONTRACT
68	HCO COST REIMBURSEMENT
69	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT
70	HCO OPERATIONS
71	HCO - ENROLLMENT CONTRACTOR COSTS
72	HCO TAKEOVER

**MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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73	HCO ESR HOURLY REIMBURSEMENT
74	HCO CCI - CAL MEDICCONNECT AND MLTSS
75	HCO TURNOVER
	<u>DHCS-DENTAL FI</u>
76	DENTAL ASO ADMINISTRATION 2016 CONTRACT
77	DENTAL FI ADMINISTRATION 2016 CONTRACT
78	DENTAL FI TAKEOVER 2016 CONTRACT
79	DENTAL FI CD-MMIS COSTS
80	DENTAL ASO TAKEOVER 2016 CONTRACT
81	DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN
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SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 235

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$259,344,000	\$148,634,000
STATE FUNDS	\$27,968,000	\$0
FEDERAL FUNDS	\$231,376,000	\$148,634,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of Local Governmental Agencies (LGAs), Local Educational Consortia (LECs) and Local Educational Agencies (LEAs).

Authority:

AB 2377 (Chapter 147, Statutes of 1994)

AB 2780 (Chapter 310, Statutes of 1998)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

AB 2780 allowed LEAs (including school districts and County Offices of Education) the option of claiming MAA through either their LECs (one of the State's eleven administrative districts) or through their LGAs. In June 2012, the Centers for Medicare and Medicaid Services (CMS) deferred the School-Based MAA (SMAA) program retroactively to October 2011. During the deferral period, schools continued to submit invoices that were processed as an "Early Claim" in order to meet the two-year retrospective federal claiming limitation. In October 2014, the Department and CMS came to a settlement agreement to pay deferred invoices on a tiered basis and backcast the remaining balance once the Random Moment Time Study (RMTS) process had been in place for four quarters. The RMTS was implemented effective January 2015. In March 2015, the Department complied with all the necessary parameters set forth by CMS to resolve the deferral, which was lifted in April 2015. CMS approved the SMAA program to resume standard claiming beginning with fiscal year (FY) 2014-15 Quarter 3 (Q3) claims, payable in FY 2016-17.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a total fund increase and net General Fund (GF) decrease due to:

- Revising all previously assumed backcasting payments with actual claims, resulting in a decreased GF estimate for these payments,
- Updating the FY 2016-17 payments based on FY 2015-16 actual payments,

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

- The inclusion of FY 2017-18 Q1 – Q2 payments, and
- Additional pending payments that are over the two-year claiming limit to be paid with GF in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to:

- Completing all backcasting payments in FY 2018-19, and
- Paying fewer quarters of regular invoices in FY 2019-20.

Methodology:

1. The FY 2016-17 RMTS invoice amounts are based on FY 2015-16 actuals.
2. The FY 2017-18 RMTS invoices are based on FY 2016-17, with a 0.12% growth adjustment factor. It is expected that half of these invoices will be paid in FY 2018-19.
3. The backcasting RMTS invoice amounts for FY 2011-12, FY 2012-13, FY 2013-14 and FY 2014-15 Q1-Q2 are based on the actual invoices received. In addition, for invoices that remain outstanding, the Department assumed the interim settlement amounts after the application of the 2014 CMS settlement agreement. The Department will use GF to repay CMS for the outstanding amounts owed in order to satisfy the approved backcasting agreement according to the established timeline. To the extent a LEA has an outstanding balance owed to the federal government, the Department will apply one-time discretionary funding appropriated to those LEAs in FY 2018-19 toward the outstanding balance owed to the federal government to repay the state GF; and
4. The Department will utilize GF for additional pending payments for a total of \$1,746,000, as these claims exceed the federal two-year claiming limitation.

FY 2018-19	TF	GF	FF
FY 2016-17	\$139,960,000	\$0	\$139,960,000
FY 2017-18 Q1 – Q2	\$74,779,000	\$0	\$74,779,000
Backcasting Payment FY 2011-12	\$4,274,000	\$0	\$4,274,000
Backcasting Repayment FY 2011-12	\$0	\$7,331,000	(\$7,331,000)
Backcasting Payment FY 2012-13	\$15,003,000	\$0	\$15,003,000
Backcasting Repayment FY 2012-13	\$0	\$6,231,000	(\$6,231,000)
Backcasting Payment FY 2013-14	\$17,189,000	\$0	\$17,189,000
Backcasting Repayment FY 2013-14	\$0	\$2,402,000	(\$2,402,000)
Backcasting Payment FY 2014-15 Q1 – Q2	\$6,393,000	\$0	\$6,393,000
Backcasting Repayment FY 2014-15 Q1 – Q2	\$0	\$10,258,000	(\$10,258,000)
Pending Payments	\$1,746,000	\$1,746,000	\$0
Total	\$259,344,000	\$27,968,000	\$231,376,000

FY 2019-20	TF	FF
FY 2017-18 Q3 – Q4	\$74,810,000	\$74,810,000
FY 2018-19 Q1 – Q2	\$73,824,000	\$73,824,000
Total	\$148,634,000	\$148,634,000

SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Funding:

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

100% GF (4260-101-0001)

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 230

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$187,225,000	\$171,710,000
STATE FUNDS	\$62,805,190	\$56,534,280
FEDERAL FUNDS	\$124,419,810	\$115,175,720

DESCRIPTION

Purpose:

This policy change estimates the California Children's Services (CCS) case management cost.

Authority:

Health & Safety Code, sections 123800-123995

Interdependent Policy Changes:

Pediatric Palliative Care Expansion and Savings

Background:

CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating the medical need for specific services, and determining appropriate providers. The state shares case management activities administered by CCS state regional office employees in Sacramento, San Francisco, and Los Angeles for counties with populations less than 200,000 (dependent counties). The Children's Medical Services Net (CMS Net) automated system is utilized by the CCS Medi-Cal program to assure case management activities.

CCS Case Management for Pediatric Palliative Care (PPC) involves enrolling new CCS clients into the Palliative Care program including indirect services, administrative support, overhead, and program training. The PPC waiver will be ending December 31, 2018, and all PPC beneficiaries will be transitioned to Medi-Cal Managed Care Plans or Fee-for-Service Delivery Systems. Counties will no longer receive the PPC waiver allocation after January 1, 2019.

Starting July 1, 2018, the Department began transitioning some of the case management administrative functions from the county to the COHS health plans under the Whole Child Model.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to updated CMS Net amounts, the ending of the PPC waiver, and updated actual invoiced expenditure data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to updated CMS Net amounts, the ending of the PPC waiver, expected caseload changes, and an increase in Whole Child Model expenditures.

Methodology:

1. The county administrative estimate for the budget year is updated every May based on additional data collected.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

2. For FY 2018-19, the CCS case management costs are based on budgeted county expenditures of \$161,396,000 in the May 2018 Estimate.

For FY 2019-20, caseload is expected to increase 1.10% from FY 2018-19.

$$\$161,396,000 \times (1 + 1.10\%) = \$163,171,000$$

3. Assume administrative costs of \$1,057,000 in both FY 2018-19 and FY 2019-20 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.
4. The PPC waiver will be ending December 31, 2018. PPC Nurse Liaison costs for FY 2018-19 are estimated to be \$2,695,000.
5. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be \$2,006,000 in FY 2018-19 and \$1,998,000 in FY 2019-20.
6. Medi-Cal Optional Targeted Low Income Children Program (OTLICIP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICIP costs listed below do not include county share of cost:

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
County Administration:	\$31,837,000	\$31,971,000
County share of cost:	(\$964,000)	(\$1,658,000)
Total Medi-Cal OTLICIP:	\$30,873,000	\$30,313,000

7. County data processing costs associated with CMS Net for OTLICIP are estimated to be \$312,000 in FY 2018-19 and \$309,000 in FY 2019-20.
8. Beginning July 1, 2018, the Whole Child Model incorporated CCS services into the integrated care systems of select counties in existing managed care COHS (except Ventura County). Payments to the COHS under the Whole Child Model are applied against CCS Case Management. The expenditures using a cash basis accounting are estimated to be \$10,982,000 in FY 2018-19 and \$25,006,000 in FY 2019-20.
9. On July 1, 2018, Rady Children's Hospital – San Diego (Rady) started a demonstration pilot with San Diego County. Rady is paid 78% of the total San Diego County Case Management Allocation and the County of San Diego retains 22% of the Case Management Allocation.

Funding to be retained by San Diego County for 400 caseloads:

$$\text{\$168,000} \times 22\% = \text{\$37,000 (monthly \$3,083)}$$

Cost to CCS Case Management in FY 2018-19 and FY 2019-20:

$$\text{\$168,000} - \text{\$37,000} = \text{\$131,000 TF (monthly \$10,900)}$$

10. AB 1745 requires the Department to conduct a waiver pilot project to determine whether PPC should be provided as a benefit under the Medi-Cal program. These expenditures have been rolled into the CCS case management costs.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

11. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2018-19 and FY 2019-20.

FY 2018-19				
CCS Medi-Cal	TF	GF	FF	CF*
CCS Case Management	\$161,396,000	\$60,685,000	\$100,711,000	
Medi-Cal Expansion	\$1,057,000	\$1,057,000		
Pediatric Palliative Care	\$2,695,000	\$674,000	\$2,021,000	
CMS Net	\$2,006,000	\$1,003,000	\$1,003,000	
Subtotal	\$167,154,000	\$63,419,000	\$103,735,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	\$30,873,000	\$4,906,000	\$25,967,000	\$964,000
CMS Net	\$312,000	\$37,000	\$275,000	
Subtotal	\$31,185,000	\$4,943,000	\$26,242,000	\$964,000
Rady Children's Hospital	(\$132,000)	(\$66,000)	(\$66,000)	
WCM Implementation	(\$10,982,000)	(\$5,491,000)	(\$5,491,000)	
Total	\$187,225,000	\$62,805,000	\$124,420,000	\$964,000

FY 2019-20				
CCS Medi-Cal	TF	GF	FF	CF*
CCS Case Management	\$163,171,000	\$61,352,000	\$101,819,000	
Medi-Cal Expansion	\$1,057,000	\$1,057,000		
CMS Net	\$1,998,000	\$999,000	\$999,000	
Subtotal	\$166,226,000	\$63,408,000	\$102,818,000	
CCS Medi-Cal/OTLICP				
CCS Case Management	\$30,313,000	\$5,631,000	\$24,682,000	\$1,658,000
CMS Net	\$309,000	\$64,000	\$245,000	
Subtotal	\$30,622,000	\$5,695,000	\$24,927,000	\$1,658,000
Rady Children's Hospital	(\$132,000)	(\$66,000)	(\$66,000)	
WCM Implementation	(\$25,006,000)	(\$12,503,000)	(\$12,503,000)	
Total	\$171,710,000	\$56,534,000	\$115,176,000	\$1,658,000

* County Funds are not included in the Total Fund

** Totals may differ due to rounding

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

Funding:

FY 2018-19	TF	GF	FF	CF*
50% Title XIX / 50% GF (4260-101-0001/0890)	\$72,238,000	\$36,119,000	\$36,119,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	\$98,511,000	\$24,628,000	\$73,883,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	\$312,000	\$37,000	\$275,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	\$15,107,000	\$964,000	\$14,143,000	\$964,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000		
Total	\$187,225,000	\$62,805,000	\$124,420,000	\$964,000

FY 2019-20	TF	GF	FF	CF*
50% Title XIX / 50% GF (4260-101-0001/0890)	\$59,100,000	\$29,550,000	\$29,550,000	
75% Title XIX / 25% GF (4260-101-0001/0890)	\$96,823,000	\$24,206,000	\$72,617,000	
88% Title XXI / 12% GF (4260-113-0001/0890)	\$77,000	\$9,000	\$68,000	
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$231,000	\$54,000	\$177,000	
88% Title XXI / 6% GF / 6% CF (4260-113-0001/0890)	\$3,389,000	\$216,000	\$3,173,000	\$216,000
76.5% Title XXI / 11.75% GF / 11.75% CF (4260-113-0001/0890)	\$11,033,000	\$1,442,000	\$9,591,000	\$1,442,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000		
Total	\$171,710,000	\$56,534,000	\$115,176,000	\$1,658,000

* County Funds are not included in the Total Fund

** Totals may differ due to rounding

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1963

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$143,481,000	\$114,394,000
STATE FUNDS	\$1,118,000	\$0
FEDERAL FUNDS	\$142,363,000	\$114,394,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs) and Native American Indian tribes for Medicaid administrative activities.

Authority:

AB 2377 (Chapter 147, Statutes of 1994)
 SB 308 (Chapter 253, Statutes of 2003)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

SB 308 redefined LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows tribes to participate in the MAA program. Reimbursements for non-emergency and non-medical transportation expenditures are also available for Tribal entities.

In June 2011, the Centers for Medicare and Medicaid Services (CMS) approved the Department's request to allow LGAs participating in the County Medi-Cal Administrative Activities (CMAA) program to submit interim claims for MAA reimbursements utilizing FY 2009-10 time survey data for FY 2010-11, FY 2011-12, and FY 2012-13 claims. CMS also stipulated that CMAA program interim claims would require reconciliation. On May 3, 2013, CMS approved the revised CMAA Operational Plan, which included a new statistically valid time survey methodology. The CMAA program will use FY 2013-14 time survey data to backcast for FY 2010-11, FY 2011-12, and FY 2012-13.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net increase due to:

- The addition of FY 2009-10 through FY 2015-16 recoupments,
- Updated CMAA FY 2010-11 through FY 2012-13 backcasting payments and recoupments, resulting in a net payment,
- Partial shift in CMAA and TMAA payments from FY 2017-18 to FY 2018-19,
- An increase in the program growth factor from 10% to 11%, and

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3

- An additional quarter payment for FY 2017-18 occurring in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to:

- The remaining FY 2014-15 Q2 and FY 2015-16 Q3 CMAA invoices (\$1,118,000) that will be paid via the General Fund (GF) occurring in FY 2018-19,
- Estimating the completion of CMAA backcasting invoice payments occurring in FY 2018-19, and
- Higher prior year payments in FY 2018-19.

Methodology:

County Medi-Cal Administrative Activities

1. On January 9, 2018, the Department received CMS approval for the multiple Medi-Cal discount percentage methodology retroactive to July 1, 2017. All CMAA FY 2014-15 and 2015-16 invoices that were previously submitted utilizing multiple Medi-Cal discount percentages were resubmitted using a single Medi-Cal discount percentage, in accordance with the CMAA Operational Plan.
2. The CMAA FY 2018-19 estimate includes recoupments for FY 2009-10 through FY 2015-16 claims due to LGA self-audits as well as CMAA desk audits, completing FY 2010-11 through FY 2012-13 backcasting, GF payments for revised FY 2014-15 Q2 and FY 2015-16 Q3 invoices based on the new multiple Medi-Cal discount methodology, and all remaining FY 2016-17 claims, and FY 2017-18 Q1 and Q2 claims. FY 2017-18 base payments assume an 11% growth factor based on the CMAA growth from FY 2012-13 to FY 2015-16.

Estimated CMAA FY 2017-18: \$96,514,000 + 11% growth factor = \$107,130,000

CMAA FY 2018-19 Estimated Payments	
FY 2009-10 – FY 2015-16 Recoupments	(\$8,337,000)
FY 2010-11 – FY 2012-13 Backcasting	\$1,439,000
FY 2014-15 and FY 2015-16 (GF)	\$1,118,000
FY 2016-17 Remaining Claims	\$94,052,000
FY 2017-18 Q1-Q2	\$53,565,000
Total	\$141,837,000

3. The CMAA FY 2019-20 estimate includes the remaining FY 2017-18 claims and FY 2018-19 Q1-Q2 claims. The estimated base payments assume an 11% growth, based on CMAA growth from FY 2012-13 to FY 2015-16.

Estimated CMAA FY 2018-19: \$107,130,000 + 11% growth factor = \$118,914,000

CMAA FY 2019-20 Estimated Payments	
FY 2017-18 Q3-Q4	\$53,565,000
FY 2018-19 Q1-Q2	\$59,457,000
Total	\$113,022,000

COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3

Tribal Medi-Cal Administrative Activities

4. The TMAA FY 2018-19 estimate includes the remaining unpaid FY 2016-17 claims and FY 2017-18 Q1 and Q2 claims. FY 2017-18 estimated base payments assume an 11% growth, based on TMAA growth from FY 2012-13 to FY 2015-16

Estimated TMAA FY 2017-18: \$1,172,000 + 11% growth factor = \$1,301,000

TMAA FY 2018-19 Estimated Payments	
FY 2016-17	\$993,000
FY 2017-18 Q1-Q2	\$651,000
Total	\$1,644,000

5. The TMAA FY 2019-20 estimate includes the remaining FY 2017-18 claims and FY 2018-19 Q1-Q2 claims. The estimated base payments assume an 11% growth, based on FY 2012-13 through FY 2015-16 TMAA actuals.

Estimated TMAA FY 2018-19: \$1,301,000 + 11% growth factor = \$1,444,000

TMAA FY 2019-20 Estimated Payments	
FY 2017-18 Q3-Q4	\$650,000
FY 2018-19 Q1-Q2	\$722,000
Total	\$1,372,000

6. Total CMAA and TMAA reimbursements for FY 2018-19 and FY 2019-20 on a cash basis are:

FY 2018-19	TF	GF	FF
County MAA	\$141,837,000	\$1,118,000	\$140,719,000
Tribal MAA	\$1,644,000	\$0	\$1,644,000
Total	\$143,481,000	\$1,118,000	\$142,363,000

FY 2019-20	TF	FF
County MAA	\$113,022,000	\$113,022,000
Tribal MAA	\$1,372,000	\$1,372,000
Total	\$114,394,000	\$114,394,000

Funding:

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

100% GF (4260-101-0001)

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1721

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$140,697,000	\$144,828,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$140,697,000	\$144,828,000

DESCRIPTION

Purpose:

This policy change estimates the county administrative costs for the Specialty Mental Health Services (SMHS) in the Medi-Cal (MC) program and the Children's Health Insurance Program (CHIP) administered by county mental health departments.

Authority:

Welfare & Institutions Code 14711(c)

Interdependent Policy Changes:

Not Applicable

Background:

Counties may obtain federal reimbursement for costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

The responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to:

- Updated CPI percentages used for growth trends; and
- Updated payment lag factors based on more recent historical claims.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to;

- Updated payment lags and CPI percentages in FY 2019-20, and
- Updated Children's Health Insurance Program (CHIP) FMAP percentage to 76.5% Title XXI, beginning October 1, 2019.

COUNTY SPECIALTY MENTAL HEALTH ADMIN**OTHER ADMIN. POLICY CHANGE NUMBER: 4****Methodology:**

1. Mental Health administration costs are based on historical claims payment data. Based on historical claims received, assume 24% of each fiscal year claims will be paid in the year the services occur, 69% is paid in the following year, and 7% in the third year. The costs on an accrual and cash basis are:

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2018-19	FY 2019-20
MC	\$252,877	\$17,702	\$0
CHIP	\$12,191	\$853	\$0
FY 2016-17	\$265,068	\$18,555	\$0
MC	\$257,681	\$177,800	\$18,037
CHIP	\$12,423	\$8,572	\$870
FY 2017-18	\$270,104	\$186,372	\$18,907
MC	\$266,185	\$63,884	\$183,667
CHIP	\$12,833	\$3,080	\$8,855
FY 2018-19	\$279,018	\$66,964	\$192,522
MC	\$274,170	\$0	\$65,801
CHIP	\$13,218	\$0	\$3,172
FY 2019-20	\$287,388	\$0	\$68,973
Total		\$271,891	\$280,402

2. Mental Health administration costs are shared between federal funds (FF) and county funds (CF). MC claims are eligible for 50% federal reimbursement. CHIP claims are eligible for federal enhanced reimbursement. Beginning October 1, 2019, enhanced CHIP funding decreased from 88% to 76.5%.

(Dollars in Thousands)

Claim Type	FY 2018-19			FY 2019-20		
	TF	FF	CF	TF	FF	CF
MC	\$259,386	\$129,693	\$129,693	\$267,505	\$133,752	\$133,753
CHIP*	\$12,505	\$11,004	\$1,501	\$12,897	\$11,076	\$1,821
Total	\$271,891	\$140,697	\$131,194	\$280,402	\$144,828	\$135,574

Funding:

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

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

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 6/2019
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1589

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$86,463,000	\$33,353,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$86,463,000	\$33,353,000

DESCRIPTION

Purpose:

This policy change estimates federal funds for the administrative costs associated with the Health Care Coverage Initiative (HCCI) under the Medi-Cal/Uninsured Care Demonstration (MH/UCD) and the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:

AB 342 (Chapter 723, Statutes of 2010)
 AB 1066 (Chapter 86, Statutes of 2011)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:

Not Applicable

Background:

Under the MH/UCD, \$180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through 2009-10. The federal funds available will reimburse the HCCI. The HCCI was replaced by the LIHP, effective November 1, 2010 through December 31, 2013, which consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the Coverage Initiative (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the Section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 5

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to shifting the DY 2011-12 through DY 2013-14 final reconciliations to FY 2019-20 because the DY 2011-12 cost report audit is not expected to be completed until June 30, 2019.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to more demonstration period payments being completed in FY 2018-19.

Methodology:

1. Administrative payments were based on the CMS approved administrative cost claiming protocol and time study.
2. Administrative claiming is comprised of three payment categories.
 - Start-up costs
 - Regular program costs
 - Close-out costs
3. Start-up and close-out costs will be included in the reconciliations.
4. Estimated final reconciliations are expected to be as follows:

(Dollars in Thousands)

FY 2018-19	TF	LIHP-MCE FF
Reconciliation		
DY 2007-08	\$22,303	\$22,303
DY 2008-09	\$21,585	\$21,585
DY 2009-10	\$23,448	\$23,448
DY 2010-11	\$19,127	\$19,127
Total FY 2018-19	\$86,463	\$86,463

(Dollars in Thousands)

FY 2019-20	TF	LIHP-MCE FF
Reconciliation		
DY 2011-12	\$19,580	\$19,580
DY 2012-13	\$11,978	\$11,978
DY 2013-14	\$1,795	\$1,795
Total FY 2019-20	\$33,353	\$33,353

Funding:

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1813

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$35,788,000	\$23,312,000
STATE FUNDS	\$992,000	\$858,000
FEDERAL FUNDS	\$34,796,000	\$22,454,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services.

Authority:

State Plan Amendment #09-022
 Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Interdependent Policy Changes:

Not Applicable

Background:

The DMC program provides certain medically necessary substance use disorder (SUD) treatment services. These services are provided by providers under contract with the counties or with the State. This policy change budgets administrative costs for SUD services under the state plan and the DMC-ODS waiver.

Starting July 1, 2014, as instructed by the Centers for Medicare & Medicaid Services (CMS), the Department changed its process for reimbursing counties for their administrative expenses through a quarterly claims and cost settlement process. Prior to that, counties were paid for their DMC expenses (services and administration) through certified public expenditure (CPE) as part of an all-inclusive rate.

Effective FY 2014-15, the DMC county administrative reimbursement process was changed as follows:

- Quarterly Interim Claims – Counties send their quarterly claims invoices no later than 60 days after the end of the quarter and were reimbursed federal financial participation (FFP) based on their total expenses. This process is optional for participating counties.
- Annual Cost Settlement - At the end of the fiscal year, counties are required to submit their cost report and year-end administrative expense report. Cost settlements are based on comparing actual expenditures against the audited cost reports.
- Audit Settlement – The Department has the authority to audit the cost reports within three years of the cost settlement.

Starting with the FY 2014-15 annual cost report, settlement amounts for administrative cost reimbursements will be budgeted in this policy change. Annual cost settlements for administrative costs prior to FY 2014-15 were included in the Drug Medi-Cal Program Cost Settlement policy change.

DRUG MEDI-CAL COUNTY ADMINISTRATION**OTHER ADMIN. POLICY CHANGE NUMBER: 6****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is an increase due to delayed invoices for FY 2017-18 Q1-Q3 claims, previously budgeted in FY 2017-18, shifting to FY 2018-19. Interim claims received for FY 2017-18 were higher than previously projected, therefore, projections for FY 2018-19 claims increased based on actual claims data.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to FY 2018-19 including more prior year claims and two years of annual settlements.

Methodology:

1. Interim claims for the first three quarters (Q1 - Q3) are paid in the same fiscal year. The last quarter claims (Q4) are paid the following fiscal year.
2. Annual settlements for county administration claims for FY 2014-15 and FY 2015-16 will be paid in FY 2018-19.
3. Annual settlements for county administration claims for FY 2016-17 will be paid in FY 2019-20.
4. ODS waiver county administrative claims are included in the current estimate for counties that submit quarterly interim claims.
5. The estimated DMC county administration costs for FY 2018-19 and FY 2019-20 are:

FY 2018-19	County Admin Cost	General Fund	Title XIX	County Funds
FY 2014-15, Annual Admin Settlement	\$20,490,000	\$45,000	\$10,245,000	\$10,200,000
FY 2015-16, Annual Admin Settlement	\$21,514,000	\$47,000	\$10,757,000	\$10,710,000
FY 2017-18 Claims, Q1-Q4	\$11,454,000	\$314,000	\$5,727,000	\$5,413,000
FY 2018-19 Claims, Q1-Q3	\$16,134,000	\$586,000	\$8,067,000	\$7,481,000
Total for FY 2018-19	\$69,592,000	\$992,000	\$34,796,000	\$33,804,000

FY 2019-20	County Admin Cost	General Fund	Title XIX	County Funds
FY 2016-17, Annual Admin Settlement	\$22,590,000	\$49,000	\$11,295,000	\$11,246,000
FY 2018-19 Claims, Q4	\$5,378,000	\$195,000	\$2,689,000	\$2,494,000
FY 2019-20 Claims, Q1-Q3	\$16,940,000	\$614,000	\$8,470,000	\$7,856,000
Total for FY 2019-20	\$44,908,000	\$858,000	\$22,454,000	\$21,596,000

Funding:

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

100% GF (4260-101-0001)

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 7/1996
 ANALYST: Sasha Jetton
 FISCAL REFERENCE NUMBER: 229

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$33,962,000	\$33,962,000
STATE FUNDS	\$11,957,000	\$11,957,000
FEDERAL FUNDS	\$22,005,000	\$22,005,000

DESCRIPTION

Purpose:

This policy change estimates Medi-Cal's early and periodic screening case management allocation under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit/requirement.

Authority:

Health & Safety Code 124075(a), 124025-124110
 Welfare & Institutions Code 10507

Interdependent Policy Changes:

Not Applicable

Background:

Medi-Cal provides funding for the county administration of the Child Health and Disability Prevention (CHDP) program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX EPSDT provisions.

The EPSDT Case Management budget is allocated to individual counties and controlled on an accrual basis.

Reason for Change:

There is no change from the prior estimate for FY 2018-19 or between fiscal years.

Methodology:

1. The set allocation amount is \$33,962,000 (\$11,957,000 GF).

EPSDT CASE MANAGEMENT
OTHER ADMIN. POLICY CHANGE NUMBER: 7

Funding:

FY 2017-18	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$15,081,000	\$7,540,500	\$7,540,500
Title XIX (75% FF / 25% GF)	\$17,666,000	\$4,416,500	\$13,249,000
Title XIX (100% FF)	\$1,215,000	\$0	\$1,215,000
Total	\$33,962,000	\$11,957,000	\$22,005,000

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$15,081,000	\$7,540,500	\$7,540,500
Title XIX (75% FF / 25% GF)	\$17,666,000	\$4,416,500	\$13,249,000
Title XIX (100% FF)	\$1,215,000	\$0	\$1,215,000
Total	\$33,962,000	\$11,957,000	\$22,005,000

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1722

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$30,803,000	\$30,159,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$30,803,000	\$30,159,000

DESCRIPTION

Purpose:

This policy change budgets the federal funds (FF) for claims submitted on behalf of specialty mental health plans (MHPs) for Medi-Cal Administrative Activities (MAA).

Authority:

Welfare & Institutions Code 14132.47
 AB 2377 (Chapter 147, Statutes of 1994)

Interdependent Policy Changes:

Not Applicable

Background:

AB 2377 authorized the State to implement the Medi-Cal Administrative Activities Claiming Process. The Specialty Mental Health (SMH) waiver program submits claims on behalf of MHPs to obtain federal financial participation (FFP) for MAA necessary for the proper and efficient administration of the SMH waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of SMH services.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to:

- An decreased estimated accrual FY 2017-18 and FY 2018-19 expenditures, based on a lower growth factor;
- Shifting the Marin County reimbursement from FY 2017-18 to FY 2018-19,
- Updating the assumed percentage of skilled professional medical personnel and other personnel based on actual FY 2016-17 claims, and
- Updating the payment lags based on FY 2016-17 claims.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the addition of claims to be paid in FY 2019-20 based on projected costs and assuming the payment to Marin County is made in FY 2018-19.

Methodology:

1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.

SMH MAA**OTHER ADMIN. POLICY CHANGE NUMBER: 8**

- Assume total MH MAA claims will increase by 0.18% each fiscal year starting in FY 2017-18.
- For FY 2017-18, the Department projects to receive \$53,453,000 TF in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
2017-18	\$53,453	0.18%	\$96
2018-19	\$53,549	0.18%	\$96
2019-20	\$53,645		

- Based on historical claims received, assume 3.97% of fiscal year claims will be paid in the year the services occur. The remaining 96.03% will be paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2018-19	FY 2019-20
2017-18	\$53,453	\$51,332	\$0
2018-19	\$53,549	\$2,124	\$51,425
2019-20	\$53,645	\$0	\$2,128
Total	\$160,646	\$53,456	\$53,553

- Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement. Based on actual claims submitted for costs incurred in FY 2016-17, assume 25.28% of costs are eligible for 75% reimbursement and the remaining 74.72% are eligible for 50% reimbursement. MH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

Expenditures	FY 2018-19			FY 2019-20		
	TF	FF	CF	TF	FF	CF
SPMP (75/25)	\$13,512	\$10,134	\$3,378	\$13,536	\$10,152	\$3,384
Other (50/50)	\$39,944	\$19,972	\$19,972	\$40,015	\$20,007	\$20,008
Total	\$53,456	\$30,106	\$23,350	\$53,551	\$30,159	\$23,392

- Marin County will be reimbursed \$1,870,000 FF for multiple years of MH MAA claims. Marin County was reimbursed \$1,173,000 FF in FY 2017-18 and the \$697,000 FF remaining will be paid in FY 2018-19. Marin County's claiming plan has been approved, allowing the claims to be paid.

(Dollars in Thousands)

Cash Basis Expenditures	FY 2018-19		
	TF	FF	CF
SPMP (75/25)	\$443	\$332	\$111
Other (50/50)	\$729	\$365	\$364
Total	\$1,172	\$697	\$475

SMH MAA**OTHER ADMIN. POLICY CHANGE NUMBER: 8**

7. The estimated MH MAA costs are:

(Dollars in Thousands)

Expenditures	FY 2018-19			FY 2019-20		
	TF	FF	CF	TF	FF	CF
SPMP (75/25)	\$13,955	\$10,466	\$3,489	\$13,536	\$10,152	\$3,384
Other (50/50)	\$40,673	\$20,337	\$20,336	\$40,015	\$20,007	\$20,008
Total	\$54,628	\$30,803	\$23,825	\$53,551	\$30,159	\$23,392

Funding:

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

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1370

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$29,823,000	\$11,760,000
STATE FUNDS	\$1,285,000	\$930,000
FEDERAL FUNDS	\$28,538,000	\$10,830,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009.

Authority:

ARRA of 2009
 SB 945 (Chapter 433, Statutes of 2011)
 SB 870 (Chapter 40, SEC 15, Budget Act of 2014)
 SB 833 (Chapter 30, Sec 14, Budget Act of 2016)
 Welfare & Institutions Code, Sections 14046.1 and 14046.7
 SB 840 (Chapter 29, SEC 2, Budget Act of 2018)

Interdependent Policy Changes:

ARRA HITECH Provider Payments

Background:

The HITECH Act, a component of ARRA, authorizes federal funds for Medicare and Medicaid Incentive Programs from 2011 through 2021. The Department expects auditing and closeout of HITECH Act programs and initiatives to continue beyond 2021.

SB 945 authorized the Department to establish and administer the ARRA HITECH incentive programs with available federal funds. SB 833 authorized \$425,000 General Fund (GF) for administrative costs associated with the program. SB 870 appropriates an additional \$3,750,000 from the Major Risk Medical Insurance Fund (MRMIF) to the Health Care Services Plans Fines and Penalties Fund for HITECH projects. SB 840 appropriates \$50,000,000 (\$45,000,000 FF, \$5,000,000 GF) to support health information exchange (HIE) onboarding, as well as connecting HIEs to California's prescription drug monitoring program.

The Department annually submits an Implementation Advance Planning Document Update (IAPD-U) to CMS for approval of continued funding. CMS approved the Department's IAPD-U for FFY 2019 on November 28, 2018. The current IAPD-U will expire September 30, 2018.

CMS requires the Department to assess the current usage of and barriers to electronic health record (EHR) adoption and administration of the Incentive Program. Completion of these assessments requires multiple contracts. The Department, in collaboration with a wide variety of stakeholder organizations, developed a Medi-Cal EHR Incentive Program Project Book that identifies a series of projects to facilitate the ongoing development and evaluation of the program.

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 9

CMS also requires providers to meet Meaningful Use (MU) objectives to qualify for incentive payments, including reporting to immunization registries and electronic lab reporting. The Department administers the following projects to support MU of EHRs by eligible Medi-Cal professionals and hospitals:

- The California Provider Technical Assistance Program (CTAP) offers technical assistance to providers preparing to implement EHR systems and meet Adopt, Implement, or Upgrade (AIU) and/or MU objectives.
- California Immunization Registry (CAIR) Onboarding of Medicaid Providers CAIR facilitates immunization registry reporting, by exchanging immunization information to and receiving back, a statewide, consolidated record and recommendations from CAIR.
- California Reportable Disease Information Exchange (CalREDIE) electronic Case Reports (eCR)
- Health Information Technology for EMS (HITEMS) targets improvements on two critical components of the health care system, emergency medical services (EMS), and disaster response.
- Periodic EHR Incentive Program Surveys, required to refine the initial landscape assessment of EHR use, and to document activities. The Department plans to conduct the next survey in FY 2018-19.
- California Health Information Technology (HIT)/ HIE Stakeholder Summit, held annually in November.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to changes the Department made to CAIR on-boarding, CalREDIE eCR, and HITEMS project schedules.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the following:

- Year-three costs for CAIR Onboarding and CalREDIE in FY 2019-20 are lower than year-two costs in FY 2018-19;
- There is no forecasted cost for HITEMS in FY 2019-20;
- Provider technical assistance cost is lower in FY 2019-20 than FY 2018-19.

Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.
2. For the CAIR Onboarding, and CalREDIE eCR projects, the 10% non-federal share is budgeted by CDPH. This policy change budgets the Title XIX 90% FF that will be provided to CDPH per the contracts through an interagency agreement.
3. CTAP project costs are eligible for Title XIX 90% FF. The 10% non-federal share will be provided by the Health Care Services Plans Fines and Penalties Fund. The Department received approval for a two-year, no-cost contract extension for CTAP. CTAP will continue until June 30, 2020, with project reallocated to FY 2018-19 and FY 2019-20.
4. The HITEMS project costs are eligible for Title XIX 90% FF. The 10% non-federal share is budgeted by EMSA.
5. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share will be provided by outside entities.

ARRA HITECH INCENTIVE PROGRAM**OTHER ADMIN. POLICY CHANGE NUMBER: 9**

6. In FY 2018-19 and FY 2019-20, the 10% non-federal share for the other projects will be provided by outside entities.
7. The medical FI projects are eligible for ARRA HITECH funding under the FI contract.

FY 2018-19	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	\$1,692,000	\$0	\$0	\$1,692,000
CalREDIE eCR (90% FF/10% GF)	\$1,519,000	\$0	\$0	\$1,519,000
HITEMS (90% FF/10% GF)	\$13,763,000	\$0	\$0	\$13,763,000
Provider Technical Assist. (90% FF/10% SF)*	\$10,635,000	\$0	\$1,063,500	\$9,571,500
California HIT/HIE Summit (90% FF/10% GF)	\$349,000	\$35,000	\$0	\$314,000
California Physician's EHR Survey (90% FF/10% GF)	\$330,000	\$33,000	\$0	\$297,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$0	\$1,381,000
Total FY 2018-19	\$29,823,000	\$222,000	\$1,063,500	\$28,537,500

FY 2019-20	TF	Reimburs.	SF	FF
CAIR Onboarding (90% FF/10% GF)	\$1,613,000	\$0	\$0	\$1,613,000
CalREDIE eCR (90% FF/10% GF)	\$853,000	\$0	\$0	\$853,000
Provider Technical Assist. (90% FF/10% SF)*	\$7,080,000	\$0	\$708,000	\$6,372,000
California HIT/HIE Summit (90% FF/10% GF)	\$349,000	\$35,000	\$0	\$314,000
California Physician's EHR Survey (90% FF/10% GF)	\$330,000	\$33,000	\$0	\$297,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$0	\$1,381,000
Total FY 2019-20	\$11,760,000	\$222,000	\$708,000	\$10,830,000

Funding:

100% Title XIX (4260-101-0890)

100% Reimbursement (4260-601-0995)

100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)*

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1729

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$28,862,000	\$29,802,000
STATE FUNDS	\$943,000	\$983,000
FEDERAL FUNDS	\$27,919,000	\$28,819,000

DESCRIPTION

Purpose:

This policy change estimates the county utilization review (UR) and quality assurance (QA) administrative costs for Specialty Mental Health Services (SMHS).

Authority:

Welfare & Institutions Code 14711

Interdependent Policy Changes:

Not Applicable

Background:

UR and QA activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel claims.

The responsibility for SMHS was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds (GF).

Reason for Change:

The change from the prior estimate for FY 2018-19, is due to:

- Updated payment lag factors for UR & QA claims based on more recent historical claims, and
- Updated growth trends applied to the accrual years.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the payment lags.

Methodology:

1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF). Pursuant to Proposition 30, GF funding is provided for levels of service that are provided above those levels mandated by the 2011 Realignment.
2. Based on historical claims received from FY 2013-14 through FY 2015-16, assume 26% of each fiscal year claims will be paid in the year the services occur. Assume 70% is paid in the following year and 4% is paid in the third year.

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 10

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2018-19	FY 2019-20
2016-17	\$37,161	\$1,486	\$0
2017-18	\$37,867	\$26,507	\$1,515
2018-19	\$39,116	\$10,170	\$27,381
2019-20	\$40,290	\$0	\$10,475
Total SPMP & Other		\$38,163	\$39,371

3. SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.
4. Based on historical claims received, assume 75% are SPMP and the remaining 25% of the total claims are other personnel costs.
5. Beginning in the FY 2017-18 accrual year, costs are included for additional work, at the county level, to collect and report data elements and post Mental Health Plan (MHP) data on the county's website as specified by the Special Terms and Conditions (STC) related to the SMHS waiver.

(Dollars in Thousands)

STC	Accrual	FY 2018-19	FY 2019-20
FY 2017-18	\$3,075	\$2,152	\$123
FY 2018-19	\$3,075	\$800	\$2,152
FY 2019-20	\$3,075	\$0	\$800
Total for STC		\$2,952	\$3,075

6. Beginning in January 2017, counties will incur costs to certify 184 Foster Family Agencies (FFA) to provide SMHS. The estimate assumes counties will need a total of 40 hours to complete each certification. Assume staff certifying the FFAs are paid \$58.12 which was calculated using a wage of \$40 per hour and benefits are 45.296% of salaries and wages. The Department does not anticipate FY 2016-17 FFA costs based on claims received to date. Assume the payment lags in Methodology #2 for the FY 2017-18 and FY 2018-19 accrual year payments. The FFA costs, on a cash basis, are:

(Dollars in Thousands)

FFA	Rate	Accrual	FY 2018-19	FY 2019-20
FY 2017-18	\$58.12	\$428	\$300	\$17
FY 2018-19	\$58.12	\$428	\$111	\$300
FY 2019-20	\$58.12	\$428	\$0	\$111
Total for FFA			\$411	\$428

SMHS COUNTY UR & QA ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 10

7. On a cash basis, the estimated payments in FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)

FY 2018-19				
Personnel	TF	GF	FF	CF
SPMP	\$28,622	\$0	\$21,467	\$7,155
Other	\$9,541	\$0	\$4,770	\$4,771
STC	\$2,952	\$738	\$1,476	\$738
FFA	\$411	\$205	\$206	\$0
Total	\$41,526	\$943	\$27,919	\$12,664

(Dollars in Thousands)

FY 2019-20				
Personnel	TF	GF	FF	CF
SPMP	\$29,528	\$0	\$22,146	\$7,382
Other	\$9,843	\$0	\$4,922	\$4,921
STC	\$3,075	\$769	\$1,537	\$769
FFA	\$428	\$214	\$214	\$0
Total	\$42,874	\$983	\$28,819	\$13,072

Funding:

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

100% GF (4260-101-0001)

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 7/1993
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 231

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$28,421,000	\$28,421,000
STATE FUNDS	\$14,339,000	\$14,339,000
FEDERAL FUNDS	\$14,082,000	\$14,082,000

DESCRIPTION

Purpose:

This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

Authority:

Welfare & Institutions Code 14103.6, 14124.5, and 10725
 Title 42, Code of Federal Regulations (CFR), Section 435.905
 Title 45, Code of Federal Regulations (CFR), Section 164.520
 Title 26, Code of Federal Regulations (CFR), Section 1.6055

Interdependent Policy Changes:

Not Applicable

Background:

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item since these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees and to existing beneficiaries at least every 3 years. Postage and printing costs for the HIPAA NPP, Quarterly JvR ("Your Fair Hearing Rights"), Incarceration Verification Program, Earned Income Tax Credit (EITC), IRS Form 1095-B (1095-B), creation and mailing of the Notice for Requested Action (NFRA), Home Community Base Services and Waiver Personal Care Services notices, and Public Assistance Reporting Information System are included in this item. The NFRA is a letter that the Department sends to beneficiaries whose record contains inconsistent information that prevents it from being accepted by the Internal Revenue Service (IRS).

Medi-Cal beneficiaries receive health care services from medical or pharmacy providers enrolled in the Medi-Cal program. Providers must receive authorization from Medi-Cal in order to provide and/or be paid for some of these services. The form a provider uses to request authorization is called a Treatment Authorization Request (TAR).

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP and the printing of EITC notices are 100% general fund (GF). Costs associated with IRS Form 1095-B are 50% GF and 50% federal fund.

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 11

Reason for Change:

The change in FY 2018-19, from the prior estimate, is an increase due to an increase in the reported population for the 1095-B mailings as well as adding TAR postage costs to this policy change. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. Based on FY 2017-18 actuals and estimated increases to the reported population, assume that 18,000,000 1095-B mailings are conducted in each fiscal year.

2. Assume that the cost per mailing is \$0.539.

$$18,000,000 \text{ mailings} \times \$0.539 \text{ per mailing} = \$9,702,000 \text{ (rounded)}$$

3. Assume that 8% of 1095-B forms are resent due to beneficiary request for reprints or for corrected 1095-Bs. The cost to send a reprint/correction is \$0.557 per unit.

$$8\% \times 18,000,000 \text{ mailings} = 1,440,000 \text{ returned mailings}$$

$$1,440,000 \text{ returned mailings} \times \$0.557 \text{ per unit} = \$802,000 \text{ (rounded)}$$

4. Assume that NFRAs are sent to beneficiaries for IRS reported errors found on Form 1095-B. The cost to process the Form 1095-B notices is \$0.519 per unit and based on FY 2017-18 actuals, assume 163,000 mailers will be sent out to beneficiaries.

$$163,000 \text{ mailings} \times \$0.519 \text{ per mailing} = \$85,000 \text{ (rounded)}$$

5. TAR postage costs for Medi-Cal are assumed to be \$32,000 for FY 2018-19 and FY 2019-20.

6. For FY 2018-19, in order to maintain HIPAA compliance, the JvR will be mailed out as First Class Presort. Currently, the JvR is mailed out as Standard Presort at an average mail cost (per piece) of approximately \$0.17. Average mail cost (per piece) for FY 2018-19 base mass mailings are projected to increase to \$0.378.

7. The Department estimates the printing and postage costs for FY 2018-19 and FY 2019-20 are:

FY 2018-19	TF	GF	FF
Base Mass Mailing*	\$15,200,000	\$7,729,000	\$7,471,000
1095B			
1095 Mailings	\$9,702,000	\$4,851,000	\$4,851,000
Reprinted/Corrected Form 1095-B	\$802,000	\$401,000	\$401,000
Notice for Requested Action	\$85,000	\$43,000	\$42,000
1095 B Subtotal	\$10,589,000	\$5,295,000	\$5,294,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$32,000	\$16,000	\$16,000
Total	\$28,421,000	\$14,340,000	\$14,081,000

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 11

FY 2019-20	TF	GF	FF
Base Mass Mailing*	\$15,200,000	\$7,729,000	\$7,471,000
1095B			
1095 Mailings	\$9,702,000	\$4,851,000	\$4,851,000
Reprinted/Corrected Form 1095-B	\$802,000	\$401,000	\$401,000
Notice for Requested Action	\$85,000	\$43,000	\$42,000
1095 B Subtotal	\$10,589,000	\$5,295,000	\$5,294,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$32,000	\$16,000	\$16,000
Total	\$28,421,000	\$14,340,000	\$14,081,000

*Totals may differ due to rounding.

Funding:

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

100 % GF (4260-101-0001)*

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1748

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$27,108,000	\$25,239,000
STATE FUNDS	\$5,387,040	\$6,783,010
FEDERAL FUNDS	\$21,720,960	\$18,455,990

DESCRIPTION

Purpose:

This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP), Medi-Cal Access Program (MCAP), and Medi-Cal special populations.

Authority:

AB 1494 (Chapter 28, Statutes of 2012)
 Health Services Advisory Group, Inc. Contract 15-92200
 Maximus Contract 12-89315 A06

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS for Single Point of Entry (SPE) application services and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM) and Child Health and Disability Prevention (CHDP) Gateway.

HFP subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal eligibility determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of the federal poverty level began transitioning into Medi-Cal Access Infants Program beginning November 1, 2013. The transition ended on February 1, 2014. The AIM Program was transitioned from MRMIB to the Department as of July 1, 2014, and renamed MCAP.

The Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway effective as of January 1, 2014, and to refer applicants to the application portal and toll-free line at Covered California. Maximus completed the shutdown process in FY 2013-14.

Also effective as of July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. Since the transition, MAXIMUS has provided administrative vendor services for MCAP and OTLICP. Due to applications still available in the community, Maximus forwards any HFP applications it receives to the appropriate County Welfare Department for a determination without the benefit of screening for accelerated enrollment.

OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12

The Department transitioned the HFP and Children's Health Insurance Program (CHIP) into the Medi-Cal program in September 2013. The Title XXI CHIP program requires the State to contract with an External Quality Review Organization (EQRO) to validate performance measures, evaluate performance improvement projects, conduct focus studies, monitor encounter data activities, conduct an annual survey, and perform other EQRO activities for the duration of the contract. In July 2014, the Department became responsible for having the EQRO conduct the annual survey and other EQRO activities under the terms of the contract.

Administrative vendor services include costs for the following services: application processing, call center rate per minute, transaction forwarding fee, processing letters and notices, printing and courier fees, and implementation costs. Effective January 2017, administrative costs include publication costs for Medi-Cal special populations. Publication costs include developing, editing, updating, and performing readability evaluation of beneficiary materials as well as translation, printing, mailing, shipping, and focus group testing services that were previously budgeted in the HCO Cost Reimbursement policy change.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to the removal of anticipated contract fees from the Medi-Cal Special Populations costs, decreasing costs. Additionally, costs increased due to higher usage of phone minutes to notify subscribers living in disaster areas that the State is waiving their premium fees, after the implementation of the Disaster Relief SPA. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to updated estimated OTLICP program costs.

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.
2. Contract costs are eligible for Title XXI 88/12 FMAP and Title XIX 50/50 FMAP. The EQRO contract cost is eligible for Title XIX 50/50 FMAP only.
3. Administrative vendor services costs are eligible for Title XIX 50/50 FMAP.
4. Contract costs and administrative vendor service costs by program are as follows:

(Dollars in Thousands)

Program	FY 2018-19	FY 2019-20
OTLICP	\$ 22,487,099	\$ 20,816,766
MCAP	\$ 3,913,805	\$ 3,768,897
Medi-Cal Special Populations	\$ 707,240	\$ 652,837

OTLIP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 12

5. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Contract Costs	\$ 22,221	\$ 2,944	\$ 19,277
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	\$ 510	\$ 255	\$ 255
Call Minute Rate per Minute	\$ 1,670	\$ 835	\$ 835
Implementation Costs	\$ 2,000	\$ 1,000	\$ 1,000
Special Populations Publications	\$ 707	\$ 354	\$ 354
Total	\$ 27,108	\$ 5,387	\$ 21,721

FY 2019-20	TF	GF	FF
Contract Costs	\$ 20,601	\$ 4,464	\$ 16,137
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	\$ 443	\$ 222	\$ 222
Call Minute Rate per Minute	\$ 1,541	\$ 771	\$ 771
Implementation Costs	\$ 2,000	\$ 1,000	\$ 1,000
Special Populations Publications	\$ 653	\$ 326	\$ 326
Total	\$ 25,238	\$ 6,783	\$ 18,456

Funding:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$ 5,616	\$ 2,808	\$ 2,808
88% Title XXI / 12% GF (4260-113-0890/0001)	\$ 21,492	\$ 2,579	\$ 18,913
Total	\$ 27,108	\$ 5,387	\$ 21,721

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$ 5,370	\$ 2,685	\$ 2,685
88% Title XXI / 12% GF (4260-113-0890/0001)	\$ 4,967	\$ 596	\$ 4,371
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	\$ 14,902	\$ 3,502	\$ 11,400
Total	\$ 25,239	\$ 6,783	\$ 18,456

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1757

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$20,022,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$20,022,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the federal funds (FF) for the interim and final cost settlements on Specialty Mental Health Services (SMHS) administrative expenditures.

Authority:

Welfare & Institution Code 14705(c)

Interdependent Policy Changes:

Not Applicable

Background:

The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to:

- Additional recoupments for county cost settlements for FY 2010-11 and FY 2011-12 to be paid in FY 2018-19; and
- Adding audit settlement amounts for FY 2007-08 through FY 2010-11.

There are no cost settlements scheduled to be paid and recouped in FY 2019-20.

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 13

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.
3. Cost settlements for administration, UR/QA, and MH MAA are each determined separately.
4. The net FF to be reimbursed and/or recouped in FY 2018-19 for interim settlements and audit settlements are shown below:

Interim Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2006-07	\$88,000	\$86,000	\$2,000
FY 2007-08	\$99,000	\$96,000	\$3,000
FY 2008-09	\$59,000	\$56,000	\$3,000
FY 2009-10	\$103,000	\$98,000	\$5,000
FY 2010-11	(\$2,370,000)	(\$2,495,000)	\$125,000
FY 2011-12	\$27,998,000	\$27,723,000	\$275,000
Subtotal	\$25,977,000	\$25,564,000	\$413,000

Audit Settlements	Total FF	Title XIX FF	Title XXI FF
FY 2007-08	\$28,000	\$28,000	\$0
FY 2008-09	(\$30,000)	(\$78,000)	\$48,000
FY 2009-10	(\$2,000,000)	(\$2,023,000)	\$23,000
FY 2010-11	(\$3,953,000)	(\$3,857,000)	(\$96,000)
Subtotal	(\$5,955,000)	(\$5,930,000)	(\$25,000)
Total FY 2018-19	\$20,022,000	\$19,634,000	\$388,000

Funding:

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

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

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2019

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$26,728,000	\$24,457,000
STATE FUNDS	\$8,909,000	\$8,152,000
FEDERAL FUNDS	\$17,819,000	\$16,305,000

DESCRIPTION

Purpose:

This policy change estimates the costs to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of new federal managed care regulations (Final Rule CMS-2390-P).

Authority:

Title 42, Code of Federal Regulations Part 438

Interdependent Policy Changes:

Not Applicable

Background:

The new regulations amend and expand the requirements of Title 42, Code of Federal Regulations Part 438, pertaining to managed care. The Centers for Medicare and Medicaid Services (CMS) issued Final Rule CMS-2390-P on May 6, 2016. Final Rule 2390-P changes the Medicaid managed care regulations to reflect changes in the utilization of managed care delivery systems. It aligns the rules governing Medicaid managed care with those of other major sources of coverage; implements statutory provisions; changes actuarial payment provisions; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Program (CHIP) beneficiaries; strengthens beneficiary protections and policies related to program integrity; and requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

The regulations aim to standardize requirements for managed care plan types (i.e., managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs)), and they have system-wide impacts for the 56 Mental Health Plans (MHPs are considered PIHPs under the regulations). The Department is working with county partners to refine the extent and magnitude of both fiscal and administrative impacts to MHPs.

The responsibility for Specialty Mental Health Services (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. Federal requirements enacted after September 30, 2012 that have an overall effect on 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 at least fifty percent of the non-federal share of the increase in costs.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 14

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a due to shifting FY 2017-18 payments to FY 2018-19 and updating the payment lags for payments on a cash basis. This estimate assumes 95% of FY 2017-18 reimbursements will be paid in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to more prior year payments occurring in FY 2018-19.

Methodology:

The estimated costs of Managed Care and Parity Regulations are based on the seven categories below for 56 counties and assumes the non-federal share is funded with 50% County Funds (CF) and 50% General Funds (GF), consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

1. Assume counties will require, on average, one analyst each, at a cost of \$90,299 per analyst. The total estimated costs are \$5,057,000 TF for each of the following activities:
 - a. State Monitoring:
Compile data and information from a variety of state monitoring requirements such as the quality and performance rating system and compliance reviews.
 - b. Quality Measurement & Improvement; External Quality Review Organization (EQRO):
MHPs will need to contract with EQRO for local quality measurement and improvement activities necessary to comply.
 - c. Grievances and Appeals System:
Ongoing staffing impact to comply with 72-hour authorization upon notice of reversal of adverse benefit determination.
 - d. Program Integrity:
MHPs will need to conduct monitoring for contractor compliance, prepare and submit data, documentation, and information to the State.
2. Assume counties will require, on average, two analysts each for:
 - a. Network Adequacy:
Collect and submit detailed provider data to the State for federally required reporting of provider networks and provider capacity at a cost of \$90,299 per analyst. The total estimated annual costs are \$10,113,000 TF. Assume six months of cost for FY 2017-18 and a full year of cost for FY 2018-19 and FY 2019-20.
3. One-Time County IT Costs:
MHPs will need to begin collecting and reporting additional data to the State. The total estimated annual costs are \$5,880,000 TF. Assume 50% of the cost will be incurred in FY 2017-18 and 50% incurred in FY 2018-19.
4. One-Time County Translation Costs:
MHPs will need to translate at a minimum five beneficiary documents. The total estimated costs are \$840,000 TF. Assume 50% of the cost will be incurred in FY 2017-18 and 50% incurred in FY 2018-19.

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 14

5. On a cash basis for FY 2018-19, the Department will be paying for 95% of FY 2017-18 claims and 25% of the FY 2018-19 claims. For FY 2019-20, the Department will be paying 5% of FY 2017-18 claims, 70% of FY 2018-19 claims and 25% of the FY 2019-20 claims.

(Dollars in Thousands)

FY 2017-18	Accrual (TF)	FY 2018-19 (TF)	FY 2019-20 (TF)
State Monitoring	\$5,057	\$4,804	\$253
Network Adequacy	\$5,057	\$4,804	\$253
Quality Measurement & Improvement; External Quality Review	\$5,057	\$4,804	\$253
Grievances and Appeals	\$5,057	\$4,804	\$253
Program Integrity	\$5,057	\$4,804	\$253
County IT Costs	\$2,940	\$2,793	\$147
County Translation Costs	\$420	\$399	\$21
Total FY 2017-18	\$28,645	\$27,212	\$1,433
FY 2018-19			
State Monitoring	\$5,057	\$1,264	\$3,540
Network Adequacy	\$10,113	\$2,528	\$7,079
Quality Measurement & Improvement; External Quality Review	\$5,057	\$1,264	\$3,540
Grievances and Appeals	\$5,057	\$1,264	\$3,540
Program Integrity	\$5,057	\$1,264	\$3,540
County IT Costs	\$2,940	\$735	\$2,058
County Translation Costs	\$420	\$106	\$294
Total FY 2018-19	\$33,701	\$8,425	\$23,591
FY 2019-20			
State Monitoring	\$5,057	\$0	\$1,264
Network Adequacy	\$10,113	\$0	\$2,528
Quality Measurement & Improvement; External Quality Review	\$5,057	\$0	\$1,264
Grievances and Appeals	\$5,057	\$0	\$1,264
Program Integrity	\$5,057	\$0	\$1,264
County IT Costs	\$0	\$0	\$0
County Translation Costs	\$0	\$0	\$0
Total FY 2019-20	\$30,341	\$0	\$7,584
Grand Total		\$35,637	\$32,608

MANAGED CARE REGULATIONS - MENTAL HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 14

9. The estimated costs in FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	CF
State Monitoring	\$6,068	\$1,517	\$3,034	\$1,517
Network Adequacy	\$7,332	\$1,833	\$3,666	\$1,833
Quality Measurement & Improvement; External Quality Review	\$6,068	\$1,517	\$3,034	\$1,517
Grievances and Appeals	\$6,068	\$1,517	\$3,034	\$1,517
Program Integrity	\$6,068	\$1,517	\$3,034	\$1,517
County IT Costs	\$3,528	\$882	\$1,764	\$882
County Translation Costs	\$505	\$126	\$253	\$126
Total	\$35,637	\$8,909	\$17,819	\$8,909

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	CF
State Monitoring	\$5,057	\$1,265	\$2,528	\$1,264
Network Adequacy	\$9,860	\$2,466	\$4,929	\$2,465
Quality Measurement & Improvement; External Quality Review	\$5,057	\$1,264	\$2,529	\$1,264
Grievances and Appeals	\$5,057	\$1,264	\$2,529	\$1,264
Program Integrity	\$5,057	\$1,264	\$2,529	\$1,264
County IT Costs	\$2,205	\$551	\$1,103	\$551
County Translation Costs	\$315	\$78	\$158	\$79
Total	\$32,608	\$8,152	\$16,305	\$8,151

Funding:

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

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

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 8/2015
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1937

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$16,872,000	\$17,055,000
STATE FUNDS	\$8,436,000	\$8,527,500
FEDERAL FUNDS	\$8,436,000	\$8,527,500

DESCRIPTION

Purpose:

This policy change estimates the costs for contracted actuarial rate development services.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Federal requirements for obtaining federal financial participation (FFP) require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Rates are developed in accordance with generally accepted actuarial principles,
- Practices are appropriate for the populations to be covered,
- The services to be furnished under the contract,
- Rates have been certified by actuaries who meet the qualification standards established by the American Academy of actuaries, and
- Follow the practice standards established by the Actuarial Standards Board.

The Department entered into a contract with an actuarial services consultant to ensure development of actuarially sound capitation rates.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to additional costs associated with actuarial services for the managed care Hospital Quality Assurance Fee (HQAF) program.

Methodology:

1. This policy change collectively budgets for all actuarial services received for different managed care programs.
2. Per payment terms, 10% of the contractor's fees are withheld for six months pending completion of outstanding projects.
3. Per payment terms, the contractor fees overlap fiscal years due to billing for projects in the subsequent invoice month.

ACTUARIAL COSTS FOR RATE DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 15

4. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Affordable Care Act (ACA) Expansion, Health Homes Program, and HQAF program); however, ongoing actuarial services are needed as these, and other new programs are integrated into the overall managed care delivery system rate setting process.

The FY 2018-19 and FY 2019-20 amounts on an accrual basis are estimated to be:

Policy	FY 2018-19	FY 2019-20
CCI - Administrative Costs	\$1,010,000	\$1,010,000
ACA Expansion Admin Costs	\$517,000	\$517,000
Health Homes Program - Contractor Costs	\$650,000	\$650,000
Ongoing Actuarial Services	\$15,100,000	\$15,100,000
HQAF Program	\$0	\$200,000
Total	\$17,277,000	\$17,477,000

The FY 2018-19 and FY 2019-20 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

	TF	GF	HHP Fund	FF	HQAF
FY 2018-19	\$16,872	\$8,119	\$317	\$8,436	\$0
FY 2019-20	\$17,055	\$8,119	\$317	\$8,527	\$92

Funding:

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

50% HHP Fund (4260-601-0942)

Hospital Quality Assurance Revenue Fund (4260-611-3158)

PAVE SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 16
IMPLEMENTATION DATE: 4/2016
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 1932

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$16,260,000	\$8,151,000
STATE FUNDS	\$7,528,400	\$2,547,250
FEDERAL FUNDS	\$8,731,600	\$5,603,750

DESCRIPTION

Purpose:

This policy change estimates the costs for the implementation and ongoing operations of the Provider Application and Validation for Enrollment (PAVE) system.

Authority:

Title 42, Code of Federal Regulations 455 Subpart E – Provider Screening and Enrollment

Interdependent Policy Changes:

Not Applicable

Background:

The Department is deploying an enrollment portal and associated business processes to automate provider management activities to comply with provider integrity mandates under the Affordable Care Act (ACA). Some of the requirements are:

- Perform monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing (ORP) providers that bill claims to Medi-Cal;
- Periodic checks of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File; and
- Revalidation of all providers every five years.

With the initial implementation of PAVE in November 2016, eighty percent of Medi-Cal Fee-For-Service (FFS) providers have the option to enroll and/or update their enrollment via an intuitive, web-based, interactive, and secure portal. The remaining twenty percent can use PAVE with the next release. Prior to PAVE, provider enrollment utilized a paper-based process.

The remaining provider populations enrolled will be included in the release scheduled for implementation in September 2018. PAVE is expected to enter the certified Maintenance and Operations (M&O) phase in FY 2018-19.

The Department reimbursed the Centers for Medicare and Medicaid Services (CMS) in FY 2018-19 as a result of improperly claimed enhanced Federal Financial Participation (FFP). The Department did not receive pre-approval from CMS to commence activities in preparation for PAVE integration and incorrectly claimed enhanced FFP for design, development, and implementation (DD&I) and M&O activities. Upon CMS' certification of PAVE, the Department will be reimbursed for M&O activities that occurred prior to certification and become eligible for enhanced FFP for M&O.

PAVE SYSTEM**OTHER ADMIN. POLICY CHANGE NUMBER: 16****Reason for Change:**

The change from the prior estimate, for FY 2018-19, is an increase due to postponement of Release 3.0 implementation which shifts implementation, consultant, and M&O costs to FY 2018-19. Although the current estimate is a net increase for FY 2018-19, the cost for the federal fund reimbursement decreased.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to accounting for M&O costs only, in FY 2019-20.

Methodology:

1. The FY 2018-19 and FY 2019-20 costs are as follows:

FY 2018-19	TF	GF	FF
Implementation (90% Title XIX / 10% GF)	\$8,288,000	\$829,000	\$7,459,000
Consultants (90% Title XIX / 10% GF)	\$491,000	\$49,000	\$442,000
M&O (50% Title XIX / 50% GF)	\$7,481,000	\$3,741,000	\$3,740,000
Federal Fund Reimbursement (100% GF / FF)	\$0	\$2,910,000	(\$2,910,000)
Total	\$16,260,000	\$7,529,000	\$8,731,000

FY 2019-20	TF	GF	FF
M&O (50% Title XIX / 50% GF)	\$2,038,000	\$1,019,000	\$1,019,000
M&O Post Certification (75% Title XIX / 25% GF)	\$6,113,000	\$1,528,000	\$4,585,000
Total	\$8,151,000	\$2,547,000	\$5,604,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

100% GF (4260-101-0001)

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

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1948

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$6,816,000	\$16,867,000
STATE FUNDS	\$3,062,000	\$7,239,250
FEDERAL FUNDS	\$3,754,000	\$9,627,750

DESCRIPTION

Purpose:

This policy change estimates the cost to the State to reimburse mental health plans the cost they incur to capture and report new functional assessment data. County mental health plans will collect, manage, use, and report additional functional assessment data to inform performance dashboards as part of the Performance Outcomes System for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services.

Authority:

Welfare & Institutions Code 14707.5

Interdependent Policy Changes:

Not Applicable

Background:

W&I Code, Section 14707.5 requires the Department to develop a performance dashboard for EPSDT mental health services that will improve outcomes at the individual and system levels and to inform fiscal decision-making related to the purchase of services.

Through implementation of these performance dashboards, California will have a coordinated method for data collection, be able to evaluate specific measures of mental health services, and establish an ongoing process for quality improvement. The implementation plan for these performance dashboards consist of the following:

- Establishing the POS methodology,
- Initial performance outcomes reporting from existing Department databases,
- Functional assessment data reporting,
- Continuous quality improvement, and
- Tracking the continuum of care for children/youth.

In order to meet the milestones for this project, mental health plans will need to modify existing data systems to capture data from the new functional assessment tools and increase staff resources or enhance current staffing levels to implement the functional assessment tools.

After a study of the functional assessment tools and a recommendation by UCLA, the Department selected the Pediatric Symptom Checklist (PSC 35) and the Child and Adolescents Needs and Strengths (CANS) to be the tools that best measure child and youth functional outcomes. Mental health plans will not incur costs to purchase these tools but will incur costs to train clinicians to administer and complete CANS, and for technical changes to county data systems to collect CANS and PSC data.

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 17

The State realigned the responsibility for Specialty Mental Health Services (SMHS) 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.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease, due to:

- A net increase in the FY 2018-19 annual costs due to increased IT costs and decreased county staffing costs.
- On a cash basis, only 10% of payments for FY 2017-18 are estimated to be paid in FY 2018-19. The remaining FY 2017-18 claims are estimated to be billed through cost settlements and not included in this policy change; and
- Updating the payment lag of 30% for the reimbursement of FY 2018-19 claims in FY 2018-19 and 70% in FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to:

- A net decrease in FY 2019-20 annual costs due to decreased IT costs and additional county staffing costs for assessments and key data entry, based on the estimated number of beneficiaries to be assessed for FY 2019-20.
- Based on the payment lags, more prior year costs are estimated to be paid in FY 2019-20.

Methodology:

1. Training:

County personnel costs for training are estimated to be \$2,697,000 for FY 2017-18, \$745,000 for both FY 2018-19 and for FY 2019-20.

(Dollars in Thousands)	Accrual Estimate		
Training Costs	FY 2017-18	FY 2018-19	FY 2019-20
Training (75% FF / 25% GF)	\$2,447	\$495	\$495
Registration Fee (50% FF / 50% GF)	\$39	\$39	\$39
Training Sessions (75% FF / 25% GF)	\$211	\$211	\$211
Total Training Costs	\$2,697	\$745	\$745

2. Costs for IT work:

IT work includes costs for new hardware, software, and modifications to the Management Information System (MIS). Total costs for IT work is estimated at \$4,146,000 for FY 2017-18, \$5,465,000 for FY 2018-19 and \$1,256,000 for FY 2019-20.

(Dollars in Thousands)	Accrual Estimate		
IT Costs	FY 2017-18	FY 2018-19	FY 2019-20
DHCS costs to install hardware and software	\$204	\$267	\$0
MIS modifications	\$3,942	\$5,198	\$1,256
Total (rounded)	\$4,146	\$5,465	\$1,256

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 17

3. Costs to staff county POS:

- Clinical Staff will assess beneficiaries two times per year, for 30 minutes at each time. Assume the clinical staff will cost \$3,021,000 for FY 2018-19 and \$6,520,000 for FY 2019-20.
- Data Entry Staff will key data for beneficiaries into the POS. Assume the data entry staff will cost \$387,000 for FY 2018-19 and \$836,000 for FY 2019-20.
- IT Support Staff: Assume the IT support staff will cost \$7,514,000 for FY 2017-18, FY 2018-19, and FY 2019-20.
- Assume the IT work, training costs, and data entry staffing are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.

(Dollars in Thousands)	Accrual Estimate		
County Staffing Costs	FY 2017-18	FY 2018-19	FY 2019-20
Clinical Staff (75% FF / 25% GF)	\$0	\$3,021	\$6,520
Data Entry (50% FF / 50% GF)	\$0	\$387	\$836
IT Staff (50% FF / 50% GF)	\$7,514	\$7,514	\$7,514
Total	\$7,514	\$10,922	\$14,870

4. The estimated total costs on an accrual basis for FY 2017-18, FY 2018-19, and FY 2019-20 are:

(Dollars in Thousands)				
Accrual Basis	TF	Training	IT Costs	County Staffing
FY 2017-18	\$14,357	\$2,697	\$4,146	\$7,514
FY 2018-19	\$17,133	\$745	\$5,465	\$10,922
FY 2019-20	\$16,871	\$745	\$1,256	\$14,870

5. On a cash basis for FY 2017-18, a portion of the Department's IT cost to install hardware and software was paid. The remaining portion of installation cost will be paid in FY 2018-19. On a cash basis for FY 2018-19, the Department will pay, 10% of the FY 2017-18 claims, and 30% of FY 2018-19 claims. The remaining FY 2017-18 claims are expected to be billed through the cost settlement process. On a cash basis for FY 2019-20, the Department will pay, 30% of FY 2017-18 claims, 70% of FY 2018-19 claims, and 25% of FY 2019-20 claims.

(Dollars in Thousands)				
Cash Basis	TF	Training	IT Costs	County Staffing
FY 2017-18	\$1,489	\$270	\$468	\$751
FY 2018-19	\$5,327	\$223	\$1,827	\$3,277
Total FY 2018-19	\$6,816	\$493	\$2,295	\$4,028

PERFORMANCE OUTCOMES SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 17

(Dollars in Thousands)

Cash Basis	TF	Training	IT Costs	County Staffing
FY 2018-19	\$11,806	\$522	\$3,638	\$7,646
FY 2019-20	\$5,061	\$223	\$377	\$4,461
Total FY 2019-20	\$16,867	\$745	\$4,015	\$12,107

6. The cash basis payments in FY 2018-19 and FY 2019-20 are estimated to be:

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	\$493	\$127	\$366
IT Costs	\$2,295	\$1,148	\$1,147
County Staffing Costs	\$4,028	\$1,787	\$2,241
Total FY 2018-19	\$6,816	\$3,062	\$3,754

(Dollars in Thousands)

POS Costs	TF	GF	FF
Training	\$745	\$196	\$549
IT Costs	\$4,015	\$2,007	\$2,008
County Staffing Costs	\$12,107	\$5,036	\$7,071
Total FY 2019-20	\$16,867	\$7,239	\$9,628

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 18
IMPLEMENTATION DATE: 7/2002
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 252

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$12,251,000	\$11,507,000
STATE FUNDS	\$3,249,000	\$3,049,500
FEDERAL FUNDS	\$9,002,000	\$8,457,500

DESCRIPTION

Purpose:

The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. The system is used by the Department and other approved entities. The Department uses the system in various ways, including:

- The Medi-Cal Managed Care Division in its monitoring of health plan performance,
- The Third Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

Ongoing enhancement, maintenance, and operation of the MIS/DSS are accomplished through a multi-year contract. The Department has awarded a nine-year contract for the ongoing maintenance and operation of the MIS/DSS that began March 1, 2015. The contract requires the vendor to operate and maintain the MIS/DSS data warehouse by providing help desk support, training, and maintenance on the platform. Also, the MIS/DSS contract requires the contractor to refresh the hardware and software to help maintain peak performance and control support costs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to FY 2017-18 invoices being paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to FY 2018-19 including prior year expenditures.

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 18

Methodology:

1. It is estimated that the contractor will be paid the following amounts:

FY 2018-19	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	\$9,087,000	\$2,272,000	\$6,815,000
Additional Fixed Costs (50% FF / 50% GF)	\$745,000	\$372,000	\$373,000
Variable Costs (75% FF / 25% GF)	\$2,419,000	\$605,000	\$1,814,000
Total	\$12,251,000	\$3,249,000	\$9,002,000

FY 2019-20	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	\$8,697,000	\$2,174,000	\$6,523,000
Additional Fixed Costs (50% FF / 50% GF)	\$691,000	\$345,000	\$346,000
Variable Costs (75% FF / 25% GF)	\$2,119,000	\$530,000	\$1,589,000
Total	\$11,507,000	\$3,049,000	\$8,458,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 7/2016
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1980

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$11,544,000	\$10,835,000
STATE FUNDS	\$2,278,200	\$2,263,700
FEDERAL FUNDS	\$9,265,800	\$8,571,300

DESCRIPTION

Purpose:

The policy change estimates the Surveillance and Utilization Review Subsystem (SURS) and the Management Administration Reporting Subsystem (MARS) system replacement costs associated with the California Medicaid Management Information System (CA-MMIS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

System Replacement Project (SRP) constitutes the contractual responsibilities required for the Contractor to replace the existing CA-MMIS, which ensures timely and accurate claims processing for Medical providers. On October 13, 2015, Xerox announced it would not fully complete the implementation of the SRP. As a result of this announcement, the Department contracted with Optum Government Solutions, Inc. (Optum) for the development of the SURS and MARS, a component of the original SRP. Optum was the original subcontractor under the Xerox contract. Effective July 2016, this nine-year contract with Optum includes design, development, and implementation (DD&I) and ongoing maintenance and operations (M&O) of SURS and MARS.

The SURS is a post-payment statistical-based reporting system designed to identify provider and recipient service utilization, and potential fraud. The MARS maintains the data files necessary to build a database of historic information to support the Administration, Operation, Provider Relations, and Recipient Relations reports produced by this subsystem. These subsystems provide valuable tools for conducting research as well as for performing assessments of initiatives deployed to improve quality of service, minimize expenditures, and monitor operational performance.

The system replacement for SURS was implemented on April 3, 2017. The Department evaluated the system replacement for MARS and decided to take a two-phase implementation approach. Phase I is scheduled to be implemented by January 2019 and Phase II by July 2019.

SURS AND MARS SYSTEM REPLACEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to:

- A FY 2017-18 invoice being paid in FY 2018-19 for SURS M&O costs.
- A net increase in the MARS costs from revising the MARS project implementation plan to a two-phased approach. The MARS DD&I and M&O costs were revised and shifted according to the new implementation plan. Phase I costs are being paid in FY 2018-19 and Phase II costs are being paid in FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net decrease due to:

- A net increase in SURS costs from the SURS DD&I costs starting in FY 2019-20, offset by a decrease in SURS M&O costs.
- A net decrease in MARS costs due to an increase in M&O costs and decrease in DD&I costs.

Methodology:

1. The estimated breakdown of the SURS and MARS costs are:

SURS	FY 2018-19	FY 2019-20
DD&I Costs	\$0	\$838,000
Operational Costs	\$6,042,000	\$5,368,000
Total	\$6,042,000	\$6,206,000

2. The estimated breakdown of the MARS costs are:

MARS	FY 2018-19	FY 2019-20
DD&I Costs	\$4,052,000	\$2,129,000
Operational Costs	\$1,450,000	\$2,500,000
Total	\$5,502,000	\$4,629,000

3. The estimated total costs for SURS and MARS are:

SURS and MARS	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	\$4,052,000	\$405,000	\$3,647,000
Operational Costs (75% FF / 25% GF)	\$7,492,000	\$1,873,000	\$5,619,000
Total FY 2018-19	\$11,544,000	\$2,278,000	\$9,266,000

SURS and MARS	TF	GF	FF
DD&I Costs (90% FF / 10% GF)	\$2,967,000	\$297,000	\$2,670,000
Operational Costs (75% FF / 25% GF)	\$7,868,000	\$1,967,000	\$5,901,000
Total FY 2019-20	\$10,835,000	\$2,264,000	\$8,571,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

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

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1677

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$11,213,000	\$11,213,000
STATE FUNDS	\$5,606,500	\$5,606,500
FEDERAL FUNDS	\$5,606,500	\$5,606,500

DESCRIPTION

Purpose:

This policy change estimates the administrative costs for the Coordinated Care Initiative (CCI).

Authority:

SB 1008 (Chapter 33, Statutes of 2012)
 SB 1036 (Chapter 45, Statutes of 2012)
 SB 94 (Chapter 37, Statutes of 2013)
 SB 75 (Chapter 18, Statutes of 2015)
 SB 97 (Chapter 52, Statutes of 2017)

Interdependent Policy Changes:

Multipurpose Senior Services Program – CDA

Background:

In coordination with Federal and State Government, the CCI provides the benefits of coordinated care models to persons eligible for Medi-Cal. CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services are provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department hired contractors to do the following:

- Stakeholder and Advocate Outreach,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Evaluation,
- Project Management,
- Multipurpose Senior Services Program (MSSP) Transition,
- IT Project Management, and
- Data Outcomes and Evaluation Development (Encounter Data Quality and Performance Measures).

The 2017 Budget Act discontinued the CCI program effective January 1, 2018. Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except In-Home Supportive Services (IHSS), into managed care. IHSS has been removed from capitation rate payments effective January 1, 2018.

Pending the Centers for Medicare and Medicaid Services approval to extend the CCI to align with the

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 20

end of the Medi-Cal 2020 waiver, the transition of MSSP from a waiver benefit to a fully integrated managed care benefit will move from January 1, 2020 to January 1, 2021.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2019-20.
2. All costs for FY 2018-19 and FY 2019-20 will be funded at 50/50 FMAP.

FY 2018-19	TF	GF	FF
Stakeholder and Advocate Outreach	\$3,248,000	\$1,624,000	\$1,624,000
Encounter Data Quality & Perform. Measures	\$2,322,000	\$1,161,000	\$1,161,000
Evaluation	\$2,125,000	\$1,062,500	\$1,062,500
Technical Project Manager (IT)	\$1,034,000	\$517,000	\$517,000
Project Management	\$484,000	\$242,000	\$242,000
EQRO Monitoring	\$1,000,000	\$500,000	\$500,000
MSSP Transition	\$1,000,000	\$500,000	\$500,000
Total	\$11,213,000	\$5,606,500	\$5,606,500

FY 2019-20	TF	GF	FF
Stakeholder and Advocate Outreach	\$3,248,000	\$1,624,000	\$1,624,000
Encounter Data Quality & Perform. Measures	\$2,322,000	\$1,161,000	\$1,161,000
Evaluation	\$2,125,000	\$1,062,500	\$1,062,500
Technical Project Manager (IT)	\$1,034,000	\$517,000	\$517,000
Project Management	\$484,000	\$242,000	\$242,000
EQRO Monitoring	\$1,000,000	\$500,000	\$500,000
MSSP Transition	\$1,000,000	\$500,000	\$500,000
Total	\$11,213,000	\$5,606,500	\$5,606,500

Funding:

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

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 21
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1720

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$9,925,000	\$9,950,000
STATE FUNDS	\$2,481,250	\$2,487,500
FEDERAL FUNDS	\$7,443,750	\$7,462,500

DESCRIPTION

Purpose:

This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations, system build-out, and ongoing Maintenance and Operations (M&O) for the automated PASRR system.

Authority:

Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:

Not Applicable

Background:

Federal regulations mandate that the Department have an independent contractor complete all Level II PASRR evaluations. A service contract has been executed to engage Evaluators to travel to facilities and conduct Level II Evaluations on individuals with mental illness. A Level II Evaluation consists of a face-to-face mental status examination and psychosocial assessment for individuals identified with or suspected of having a mental illness upon admission to a nursing facility (NF). The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. The contractor's licensed clinical evaluators conduct the Level II Evaluations and enter their findings into the PASRR database.

The service contract to provide Level II Evaluations from January 2, 2015, through December 31, 2017, was terminated on October 31, 2017. A new contract was executed in March 2018.

The Department received funding to design, test, and implement a web-based automated system to bring PASRR into compliance with federally mandated regulations. The PASRR system replaced a mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The PASRR system:

- Allows NFs, hospitals, and evaluators to electronically submit Level I Screens and Level II Evaluations;
- Significantly reduces processing time for submissions;
- Eliminates paper submissions;
- Reduces the time a contractor takes to return completed evaluations;
- Increases efficiencies for PASRR clinicians by reducing processing time for determinations.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 21

The PASRR IT system build-out contract engages a program manager and software engineers to develop and implement changes to the PASRR system. In December 2018, the Department will award an IT contract to enhance the existing PASRR system with the following features:

- The Level I Screening will be updated for general acute care hospitals. The Level I Screening will also capture information requested by Centers for Medicaid and Medicare Services (CMS).
- Extend the existing functionality of the system to allow electronic exchange of PASRR information between hospitals and NFs.
- Enable evaluators to complete Level II Evaluations without requiring an internet connection. The evaluators can download the Evaluations to a laptop and then upload the information to PASRR.
- Enhanced Determination wizard and Determination Letter.
- New electronic Reconsideration process that ensures facilities and the Department have complete records for patient care plans by converting the manual process into an electronic process.
- Design a new dashboard.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to the cost of Level II Evaluation completion is estimated to be less than the previous contract and removing training costs. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to accounting for system build-out costs beyond the one-year contract and decreased Evaluations costs in FY 2019-20.

Methodology:

1. Expenditures for a Level II Evaluations contract began in February 2015 and ended in October 2017. Expenditures for the new Level II Evaluations contract began April 2018.
2. The PASRR IT system requires ongoing M&O. One M&O contract is effective through October 2018 and another through June 2019.
3. In FY 2018-19 and FY 2019-20, existing functionality of the PASRR system will be enhanced. Enhancements planned are a redesigned Level I Screening, the ability to allow general acute care hospitals and NFs to exchange PASRR information, and the ability for evaluators to download and upload Level II Evaluation material from and to the PASRR system.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 21

4. The PASRR payments on a cash basis are estimated at:

FY 2018-19	TF	GF	FF
Evaluations	\$9,000,000	\$2,250,000	\$6,750,000
Ongoing M&O Costs	\$350,000	\$88,000	\$262,000
System Build Out	\$575,000	\$143,000	\$432,000
Total	\$9,925,000	\$2,481,000	\$7,444,000

FY 2019-20	TF	GF	FF
Evaluations	\$8,450,000	\$2,113,000	\$6,337,000
Ongoing M&O Costs	\$350,000	\$88,000	\$262,000
System Build Out	\$1,150,000	\$287,000	\$863,000
Total	\$9,950,000	\$2,488,000	\$7,462,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1381

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$9,980,000	\$9,980,000
STATE FUNDS	\$4,990,000	\$4,990,000
FEDERAL FUNDS	\$4,990,000	\$4,990,000

DESCRIPTION

Purpose:

This policy change estimates the costs of litigation and actuarial consulting.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department continues to experience litigation cases challenging legislation implementing changes to the Medi-Cal program.

Ongoing litigation filed by managed care plans relating to capitation rates has resulted in significant time expended by actuarial staff in evaluating the cases and developing defense strategies.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be \$7,880,000 for both FY 2018-19 and FY 2019-20.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in both FY 2018-19 and FY 2019-20.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
Total	\$9,980	\$4,990	\$4,990

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 22

(Dollars in Thousands)

FY 2019-20	TF	GF	FF
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
Total	\$9,980	\$4,990	\$4,990

Funding:

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

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 2/2008
ANALYST: Jedidiah Warren
FISCAL REFERENCE NUMBER: 1551

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$9,049,000	\$9,372,000
STATE FUNDS	\$2,262,250	\$2,343,000
FEDERAL FUNDS	\$6,786,750	\$7,029,000

DESCRIPTION

Purpose:

This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible health insurance (HI). The policy change also includes online database contracts to access online activity and data matches in support of recovery.

Authority:

Contracts:

Dept. of Industrial Relations – Electronic Adjudication Management System (EAMS)	17-94002
Dept. of Industrial Relations – Workers’ Compensation Information System (WCIS)	14-90133 A01
Department of Public Health	14-90132 A01
Department of Social Services	15-92000
EDEX Information Systems Inc. (WC)	17-94425
EDEX Information Systems Inc. (WC)	18-95016
Health Management Systems Inc. (HI)	13-90283 A01
Health Management Systems Inc. (HI)	18-95310
RELX Inc.	17-94636

Interdependent Policy Changes:

Not Applicable

Background:

Since Medi-Cal is the payer of last resort, all legally responsible third parties must first be billed before the Medi-Cal program. The above contracts provide:

- Data matches between the Department’s Medi-Cal recipient eligibility file and the contractor’s policy holder/subscriber file,
- Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer,
- Online access to research database services for public records of Medi-Cal recipients,
- Access to certified copies of birth, death, marriage and divorce records of Medi-Cal recipients,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability,
- Cost avoidance activities,
- Electronic access to historical records from the previous WC contractor until December 31, 2018, and
- Online access to case records, case update notifications, hearing notices, and batch processing of liens.

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23

For contingency based contracts, when such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries, and may exceed the vendor's estimated recovery projections. Recoveries due to third party liability vendor activities are incorporated into the Base Recoveries policy change.

The new Health Insurance (HI) contract (18-95310) was awarded to Health Management Systems, Inc. (HMS) and will be effective from December 1, 2018, through November 30, 2023. The contingency fee will be 8.5 percent.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to the HMS HI contractor updating the recovery projections for FY 2018-19. HMS estimates a decrease in the projection, from the prior estimate, due to lower than anticipated recovery rates.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to:

- The HMS HI contractor estimating higher recoveries in FY 2019-20. HMS anticipates an increase in recovery rates from recovery efforts in FY 2019-20, and
- The expiration of the Department of Public Health contract (14-90132 A01) on June 30, 2019. The Department created a Department-wide contract (#18-95019) which will be utilized, effective July 1, 2019. See the Vital Records Data policy change for more information.

Methodology:

1. The amounts paid to the HMS contractor for HI is contingent upon recoveries. Assume the following recoveries for each fiscal year at the contracted contingency fee percentage. Assume the current HMS HI contract expires November 30, 2018, and the new HI recovery contract has an anticipated term date of December 1, 2018, through November 30, 2023.

Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2018-19 Recoveries	FY 2019-20 Recoveries	Contingency Fee %	FY 2018-19 Contingency Fee	FY 2019-20 Contingency Fee
HMS 13	\$43,750,000	\$0	8.5%	\$3,718,750	\$0
HMS 18	\$61,250,000	\$109,000,000	8.5%	\$5,206,250	\$9,265,000

2. The amounts paid to the Online Database contractors is based upon usage:

Online Database Contracts	FY 2018-19	FY 2019-20
Department of Industrial Relations - EAMS	\$4,000	\$4,000
Department of Industrial Relations – WCIS	\$2,000	\$2,000
Department of Social Services	\$11,000	\$11,000
RELX Inc.	\$85,000	\$85,000
CA Department of Public Health	\$17,000	\$0
EDEX Information Systems Inc. (WC)	\$5,000	\$5,000
Total	\$124,000	\$107,000

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 23

3. The payments shown below include recent recovery activity.

FY 2018-19	TF	GF	FF
Health Insurance	\$8,925,000	\$2,231,000	\$6,694,000
Online Database Contracts	\$124,000	\$31,000	\$93,000
Total	\$9,049,000	\$2,262,000	\$6,787,000

FY 2019-20	TF	GF	FF
Health Insurance	\$9,265,000	\$2,316,000	\$6,949,000
Online Database Contracts	\$107,000	\$27,000	\$80,000
Total	\$9,372,000	\$2,343,000	\$7,029,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1824

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$7,700,000	\$7,700,000
STATE FUNDS	\$3,850,000	\$3,850,000
FEDERAL FUNDS	\$3,850,000	\$3,850,000

DESCRIPTION

Purpose:

This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:

AB 2780 (Chapter 310, Statutes of 1998)
 Health & Safety Code Section 123975 and Sections 124115 - 124120.5
 Contract 15-92041
 Contract 18-95011

Interdependent Policy Changes:

Not Applicable

Background:

The NHSP contracts with Hearing Coordination Centers (HCC) to provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who refers on their initial hearing screening to assure they receive necessary follow-up services.

The NHSP has had a data management contract that supported the reporting activities of the program. The data management contract provided a database that assisted the NHSP in the collection and reporting of infant hearing screening data. The information collected included screening and diagnostic services provided to newborns and infants who are deaf or hard-of-hearing.

The data management and HCC contracts breakdowns are as follows:

- Data management contract
 - The data management contract #14-90182 began on December 19, 2014, and expired on November 30, 2016.
 - To remain in compliance with Health & Safety Codes Section 123975 and Sections 124115 through 124120.5 from November 30, 2016, through April 30, 2017, the Department reinstated the use of the Infant Reporting Form through April 30, 2017.
 - Beginning May 1, 2017, the prior vendor's data management service was extended through July 31, 2018, by a no-cost Letter of Intent (LOI) between DHCS and the vendor.
 - The California Department of Technology (CDT), on behalf of the Department, released a Request for Proposal (RFP) on March 7, 2018. CDT provided a Notification of Intent to Award to the current vendor on June 25, 2018.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 24

- Contract # 18-95011 is effective August 1, 2018, through July 31, 2021, with two 1-year options to renew.
- HCC contract #15-92041 began July 1, 2015, and expires May 31, 2020.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to the contract start-up role of Project Manager no longer being necessary due to continuing with the same vendor. There is no change from FY 2018-19 to FY 2019-20, in the current estimate.

Methodology:

1. The HCC contract for tracking and monitoring services costs for FY 2018-19 and FY 2019-20 are \$6,500,000.
2. The Data Management Contract for the use of a vendor's data management system cost for FY 2018-19 is \$1,200,000, and \$2,200,000 for FY 2019-20.
3. The cost of the IT project manager and business analyst to oversee the implementation of the data management system for FY 2019-20 is \$275,000
4. The cost of the test analyst for FY 2019-20 is \$250,000.
5. The estimated costs for FY 2018-19 and FY 2019-20 are as follows:

FY 2018-19	TF	GF	FF
HCC contract	\$6,500,000	\$3,250,000	\$3,250,000
Data Management Contract	\$1,200,000	\$600,000	\$600,000
Total	\$7,700,000	\$3,850,000	\$3,850,000

FY 2019-20	TF	GF	FF
HCC contract	\$6,500,000	\$3,250,000	\$3,250,000
Data Management Contract	\$1,200,000	\$600,000	\$600,000
Total	\$7,700,000	\$3,850,000	\$3,850,000

Funding:

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

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 1/2011
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1137

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$6,188,000	\$6,516,000
STATE FUNDS	\$758,800	\$851,600
FEDERAL FUNDS	\$5,429,200	\$5,664,400

DESCRIPTION

Purpose:

This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA) initiative sponsored by Centers for Medicare and Medicaid Services (CMS).

Authority:

42 Code of Federal Regulations 433.112(b)11
 42 Code of Federal Regulations 495.332(a)(2)
 Interagency Agreement (IA) 13-90390 A01

Interdependent Policy Changes:

Not Applicable

Background:

CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department will develop the ability to streamline the process to access information from various systems, which will result in cost effectiveness. CMS will not approve Advance Planning Documents (APDs) or provide enhanced federal funding to the Department without adherence to MITA.

To operate more effectively and efficiently, the Department must take steps to achieve the maturity goals of the MITA Framework and focus strategic planning, system changes, and upgrades around Department-wide business processes rather than focusing on separate program needs. These steps will prevent the Department from potentially duplicating efforts regarding hardware, software, and resources across the enterprise.

This MITA project will help mature the business processes and position the Department to be more flexible as it serves the growing number of members. Enacting the MITA Framework and associated governance will also allow the Department to more quickly and accurately react to federal and state laws. Additionally, the Department will be better prepared to use the immense amounts of Medicaid data collected daily to better manage the program.

The Department conducts an annual MITA State Self-Assessment (SS-A) required by CMS, which includes a State MITA roadmap. Recently, through enforcement of their Medicaid Certification regulations, CMS now requires the use of Enterprise Independent Verification and Validation (IV&V) resources and highly recommends a Medicaid Enterprise System Integrator (MESI) as it relates to the CMS enterprise certification process. Also integral in the Department's MITA governance is the Clarity application, which houses MITA data/roadmap information, and overall facilitates the Department's project portfolio and governance process. An additional technical consultant resource is needed to support the Clarity application.

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 25

Pursuant to an IA with the Regents of the University of California, San Diego (UCSD), an analyst and programmer will provide support for data management and analytics to assist the Department in reaching MITA maturity, beginning January 2019.

MITA planning activities to improve provider management information will occur and will assess efforts necessary for a consolidated provider data repository, improving consumer facing provider directories, and collecting provider network information from behavioral health and managed care dental plans.

Reason for Change:

The change for FY 2018-19, from the prior estimate, is an increase due to updated contract costs and the addition of payments for the IV&V resources, MESI, and Clarity application.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to additional contract costs in FY 2019-20, only six months of IV&V costs in FY 2019-20, increased MESI costs, and additional support needed for the Clarity application in FY 2019-20.

Methodology:

1. The FY 2018-19 and FY 2019-20 contract amounts are associated with the expansion of the MITA initiative throughout the Department in order to meet federal regulations and guidelines.
2. The MITA project will employ contracted positions to continue the implementation phase in FY 2018-19 and FY 2019-20.
3. The new MITA contract is effective December 2017 through December 2019. Payments for the contract began in January 2018.
4. Costs for an IA with UCSD to implement analytics as a service to support MITA are expected to begin February 2019.
5. The costs to support planning for MITA maturity advancement of provider management processes are \$1,036,000 TF (\$104,000 GF) for FY 2018-19 and \$847,000 TF (\$85,000 GF) for FY 2019-20.
6. FY 2018-19 and FY 2019-20 include costs to support the Enterprise IV&V, MESI, and Clarity application resources to help further support the MITA initiative.

MITA**OTHER ADMIN. POLICY CHANGE NUMBER: 25**

7. The projected costs are:

FY 2018-19	TF	GF	FF
MITA Contract	\$2,772,000	\$277,000	\$2,495,000
USCD IA	\$220,000	\$22,000	\$198,000
Enterprise IV&V	\$1,000,000	\$100,000	\$900,000
MESI	\$810,000	\$81,000	\$729,000
Clarity Consultant*	\$350,000	\$175,000	\$175,000
Provider Management	\$1,036,000	\$104,000	\$932,000
Total	\$6,188,000	\$759,000	\$5,429,000

FY 2019-20	TF	GF	FF
MITA Contract	\$2,772,000	\$277,000	\$2,495,000
USCD IA	\$457,000	\$46,000	\$411,000
Enterprise IV&V	\$500,000	\$50,000	\$450,000
MESI	\$1,440,000	\$144,000	\$1,296,000
Clarity Consultant*	\$500,000	\$250,000	\$250,000
Provider Management	\$847,000	\$85,000	\$762,000
Total	\$6,516,000	\$852,000	\$5,664,000

Funding:

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

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

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 10/2018
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 2076

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$5,201,000	\$19,760,000
STATE FUNDS	\$743,000	\$2,823,000
FEDERAL FUNDS	\$4,458,000	\$16,937,000

DESCRIPTION

Purpose:

This policy change estimates the County Mental Health Plans (MHP) costs for new prior authorization requirements to comply with the federal Parity Final Rule.

Authority:

CMS Final Rule (CMS-2333-F) (Parity Final Rule)

Interdependent Policy Changes:

Not Applicable

Background:

Final Rule 2390-P (Managed Care Rule) requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or Children's Health Insurance Program (CHIP) be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

The regulations aim to standardize requirements for managed care plan types (i.e., managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs), and they have system-wide impacts for the 56 Mental Health Plans (MHPs are considered PIHPs under the regulations).

On March 30, 2017, CMS the Parity Final Rule, to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Final Rule stipulates that treatment limitations and financial requirements applicable to mental health/substance use disorder Medicaid benefits cannot be more restrictive than those limitations applicable to medical/surgical Medicaid benefits. Parity applies to four benefit classifications: Inpatient, Outpatient, Emergency Care, and Pharmacy. To demonstrate compliance, the Department reviewed such treatment limitations, across the various Medi-Cal service delivery systems, which includes any managed care, mental health, substance use disorder and fee-for-service benefits available to an individual enrolled in a Managed Care Plan (MCP). The Department's Parity Compliance Plan submitted to CMS on October 2, 2017, details the required system changes to comply with the federal Parity Final Rule. The Parity Compliance Plan is also posted on the Department's website.

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 26

During its assessment of authorization policies across delivery systems, the Department identified inconsistencies between the application of standards and policies for authorization of services by Mental Health Plans (MHPs) and Managed Care Plans (MCPs). The inconsistencies identified were for authorization of outpatient and inpatient services. As a result, the Department will need to implement changes to authorization of SMHS policies for compliance with the Parity Final Rule. The statewide policy changes are summarized below:

For outpatient SMHS:

- The Department will adopt new requirements for prior authorization of SMHS, including:
 - the identification of services requiring prior authorization, and
 - the timeframes for making authorization decisions within five (5) business days of the request for authorization.

For inpatient SMHS:

- The Department will align the requirements for MHP authorizations of psychiatric inpatient hospital services with the concurrent authorization review requirements used by MCPs for inpatient hospital services.
- Similar to MCPs, MHPs will be expected to conduct concurrent review of treatment authorizations until discharge and complete the review within five (5) business days upon receipt of request.

These changes to authorization policies and procedures constitute a significant shift in local operations. The department continues to work with local partners to assess the extent and magnitude of impacts to operational and administrative processes. The 2011 Public Safety Realignment realigned the responsibility for SMHS to the counties. 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. Federal 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 at least fifty percent of the non-federal share of the increase in costs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to shifting FY 2018-19 payments to FY 2019-20 by applying payment lags for payments on a cash basis.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to incorporating additional FY 2018-19 payments based on the payment lags.

Methodology:

1. The estimated costs of Parity Regulations, related to pre-authorizations of outpatient services and concurrent reviews of inpatient admissions, are based on the estimated number of hours county staff would spend performing these reviews.
2. Outpatient services pre-authorizations and concurrent review for SMHS inpatient admissions must be conducted by a licensed mental health professional, which assumes a 75% / 25% Federal Medical Assistance Percentage (FMAP). The non-federal share is assumed to be funded with 50% County Funds (CF) and 50% General Funds (GF) pursuant to the California Constitution, Article 13, Section 36(c)(5)(A).

MANAGED CARE REGULATIONS - MH PARITY

OTHER ADMIN. POLICY CHANGE NUMBER: 26

3. MHPs will need to be compliant with the Parity Final Rule, beginning July 2018.
4. For outpatient reviews, assume counties will need an additional 15 minutes for 487,243 reviews at a cost of \$56.67 per hour, including benefits. The total estimated annual costs for outpatient pre-authorizations are \$6,902,000 TF.
5. For inpatient reviews, assume counties will need an additional 30 minutes for 595,394 reviews at a cost of \$56.67 per hour, including benefits. The total estimated annual costs for concurrent inpatient reviews are \$16,869,000 TF.
6. On a cash basis for FY 2018-19, the Department will be paying for 25% of FY 2018-19 claims. For FY 2019-20, the Department will be paying 70% of FY 2018-19 claims and 25% of FY 2019-20 claims.

(Dollars in Thousands)

Cash Basis	Accrual	FY 2018-19	FY 2019-20
FY 2018-19	TF	TF	TF
Outpatient Pre-Authorizations	\$6,902	\$1,726	\$4,831
Inpatient – Concurrent Review	\$16,869	\$4,217	\$11,808
Total FY 2018-19	\$23,771	\$5,943	\$16,639
FY 2019-20			
Outpatient Pre-Authorizations	\$6,902	\$0	\$1,726
Inpatient – Concurrent Review	\$16,869	\$0	\$4,217
Total FY 2019-20	\$23,771	\$0	\$5,943
Grand Total		\$5,943	\$22,582

7. The estimated cost in FY 2018-19 and FY 2019-20 are:

(Dollars in Thousands)

Treatment Plan Authorizations	TF	GF	FF	CF
Outpatient - Pre-Authorizations	\$1,726	\$216	\$1,295	\$215
Inpatient – Concurrent Review	\$4,217	\$527	\$3,163	\$527
FY 2018-19	\$5,943	\$743	\$4,458	\$742

(Dollars in Thousands)

Treatment Plan Authorizations	TF	GF	FF	CF
Outpatient - Pre-Authorizations	\$6,557	\$820	\$4,918	\$819
Inpatient – Concurrent Review	\$16,025	\$2,003	\$12,019	\$2,003
FY 2019-20	\$22,582	\$2,823	\$16,937	\$2,822

Funding:

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

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

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 27
 IMPLEMENTATION DATE: 5/2018
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1871

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$5,099,000	\$4,884,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,099,000	\$4,884,000

DESCRIPTION

Purpose:

This policy change estimates the federal fund reimbursement for Drug Medi-Cal (DMC) Utilization Review (UR) and Quality Assurance (QA) administrative costs under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.

Authority:

Welfare & Institutions Code, Section 14711 and Section 14124.24(a)(6)
 Drug Medi-Cal Organized Delivery System Waiver

Interdependent Policy Changes:

Not Applicable

Background:

The Drug Medi-Cal program currently covers the following Substance Use Disorder (SUD) services under the State Plan: Outpatient Drug-Free Treatment Services (ODF), Intensive Outpatient Treatment Services (IOT), Residential Treatment Services (RTS) for pregnant and postpartum women, and 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 waiver is a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a SUD.

DMC-ODS waiver services include the existing treatment modalities (ODF, IOT, NTP, and Perinatal RTS), and the additional new and expanded services. Participation in the waiver is voluntary for counties and implementation is estimated on a phase-in basis beginning February 2017. Counties that opt-in to participate in the DMC-ODS waiver may also opt-in to implement UR and QA activities to safeguard against unnecessary and inappropriate medical care and expenses. Federal funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to fewer waiver counties opting-in to provide UR and QA activities than previously projected.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to FY 2018-19 including more prior year payments, compared to FY 2019-20.

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 27

Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis. Of the 58 counties in California, 19 counties did not opt-in to implement the DMC-ODS waiver.
 - FY 2017-18 – 11 counties provided waiver services in FY 2017-18. From the 11 counties, nine counties provided UR and QA activities.
 - FY 2018-19 and FY 2019-20 – 28 additional counties (for a total of 39 counties) will begin providing waiver services in FY 2018-19 and FY 2019-20. Of the 39 total counties providing waiver services, 12 counties are projected to provide UR and QA activities.
2. UR and QA expenditures are shared between FF and county funds (CF). Payments began in May 2018.
3. For counties that started UR and QA activities in FY 2017-18, payments are expected to be processed in FY 2018-19.
4. For FY 2018-19 and FY 2019-20, for counties that will submit claims quarterly, assume claims for the first three quarters (Q1-Q3) will be paid in the same fiscal year. The last quarter claims (Q4) will be paid the following fiscal year.
5. For counties that submit claims annually, assume claims will be submitted and paid the following fiscal year.

(Dollars in Thousands)

	Accrual	FY 2018-19	FY 2019-20
FY 2017-18 Claims	\$4,845	\$4,845	\$0
FY 2018-19 Claims	\$7,104	\$2,572	\$4,532
FY 2019-20 Claims	\$7,804	\$0	\$2,572
Total		\$7,417	\$7,104

6. Assume 75% of the total claims are for SPMP costs and the remaining 25% are for other personnel costs.
7. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.
8. The estimated UR and QA administrative cost for FY 2018-19 and FY 2019-20 are:

FY 2018-19	TF	FFP	CF
SPMP	\$5,563,000	\$4,172,000	\$1,391,000
Other Personnel	\$1,854,000	\$927,000	\$927,000
Total	\$7,417,000	\$5,099,000	\$2,318,000

FY 2019-20	TF	FFP	CF
SPMP	\$5,328,000	\$3,996,000	\$1,332,000
Other Personnel	\$1,776,000	\$888,000	\$888,000
Total	\$7,104,000	\$4,884,000	\$2,220,000

DMC COUNTY UR & QA ADMIN
OTHER ADMIN. POLICY CHANGE NUMBER: 27

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

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 7/2009
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 1441

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$5,000,000	\$5,000,000
STATE FUNDS	\$1,415,000	\$1,415,000
FEDERAL FUNDS	\$3,585,000	\$3,585,000

DESCRIPTION

Purpose:

This policy change estimates the system development, maintenance and operations (M&O), and other department reimbursements for the Medi-Cal Eligibility Data System (MEDS).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

MEDS is a statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following:

- MEDS Master Client Index maintenance;
- Data matches from various federal and state agencies;
- Supplemental Security Income termination process support;
- Medi-Cal application alerts;
- Medicare Modernization Act Part D buy-in process improvements;
- Eligibility renewal process;
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination; and
- Supporting eligibility and enrollment functions.

The M&O funding supports MEDS operations and system enhancements. Operations include enabling counties to perform online statistical analysis and MEDS-alert reporting. The system's reporting tools track and report all county worker transactions for MEDS. Some of these system development and M&O costs are offset by reimbursements made from other departments.

MEDS generates Client Index Numbers (CIN) to uniquely identify Medi-Cal beneficiaries. CINs can be used to identify beneficiaries for public assistance programs, including Temporary Assistance for Needy Families (TANF), In Home Support Services (IHSS), and Covered California's Advance Premium Tax Credit (APTC).

The Department implements MEDS functionality to support enhancements driven by county consortia and state and county business partners.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 28

The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup costs. CDT invoices the Department on a monthly basis for the services provided.

Reason for Change:

There is no change from the prior estimate, for FY 2018-19, in total funds. However, the General Fund and Federal Fund change is due to removing the Other Department Reimbursement from this policy change.

There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. The projected costs for FY 2018-19 and FY 2019-20 are:

FY 2018-19	TF	GF	FF
System Development (50% FF / 50% GF)	\$660,000	\$330,000	\$330,000
Maintenance & Operations (75% FF / 25% GF)	\$4,340,000	\$1,085,000	\$3,255,000
Total	\$5,000,000	\$1,415,000	\$3,585,000

FY 2019-20	TF	GF	FF
System Development (50% FF / 50% GF)	\$660,000	\$330,000	\$330,000
Maintenance & Operations (75% FF / 25% GF)	\$4,340,000	\$1,085,000	\$3,255,000
Total	\$5,000,000	\$1,415,000	\$3,585,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

CALIFORNIA HEALTH INTERVIEW SURVEY

OTHER ADMIN. POLICY CHANGE NUMBER: 29
IMPLEMENTATION DATE: 7/2015
ANALYST: Katy
 Clay
FISCAL REFERENCE NUMBER: 1902

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$4,850,000	\$1,100,000
STATE FUNDS	\$3,750,000	\$0
FEDERAL FUNDS	\$1,100,000	\$1,100,000

DESCRIPTION

Purpose:

This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

Authority:

Interagency Agreement (IA) 15-92271 A01
 IA 18-95340
 IA 18-95338
 SB 856 (Budget Act of 2018)

Interdependent Policy Changes:

Not Applicable

Background:

CHIS is a random-dial telephone survey that asks questions on a wide range of health topics. CHIS is conducted on a continuous basis allowing it to provide a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups, as well as county-level information for most counties to aid with health planning, priority setting, and to compare health outcomes in numerous ways.

The University of California, Los Angeles (UCLA) Center for Health Policy Research conducts CHIS in collaboration with the California Department of Public Health (CDPH) and the Department. The Department contracts directly with UCLA to utilize CHIS for program needs and performance. The current contract is funded by federal funds (FF); the non-federal share is paid through certified public expenditures (CPEs). The Department's current contract with UCLA is effective from July 1, 2015, and will end on June 30, 2021.

Effective July 20, 2017, the IA contract was amended to increase the maximum amount reimbursable annually from \$1 million to \$1,100,000, to align the contract to updated salary costs and operating expenses for the CHIS contractors.

SB 856 provides additional funding for the collection and analysis of long-term support services (LTSS) data. Additionally, SB 856 authorizes funding for a pilot expansion of children and youth data collection through CHIS. The Department will implement IA 18-95340 and IA 18-95338 for these projects.

Reason for Change:

The change from the prior estimate for FY 2018-19 resulted from the Department removing \$3,750,000 in federal funds, previously thought to be available to match general funds authorized in SB 856. The

CALIFORNIA HEALTH INTERVIEW SURVEY**OTHER ADMIN. POLICY CHANGE NUMBER: 29**

change from FY 2018-19 to FY 2019-20, in the current estimate, results from the additional funds appropriated in SB 856 for FY 2018-19 only.

Methodology:

1. Assume UCLA will submit documentation of CPEs on the CHIS survey. Expenditures will consist of funds received by UCLA from non-federal sources.
2. In July 2017, the CHIS contract was amended to increase the annual reimbursement amount retroactive to FY 2015-16.
3. On an accrual basis, beginning FY 2015-16, the maximum reimbursable amount for California Health Interview Survey is \$1,100,000 FF annually.
4. On a cash basis, assume two quarters will be paid in the current fiscal year and the remaining two quarters will be paid in the subsequent fiscal year.
5. Beginning in FY 2018-19, SB 856 provides an additional \$3,000,000 GF for the collection and analysis of LTSS data. Additionally, it provides \$750,000 GF for the expansion of a pilot data collection effort on children and youth.
6. Assume the \$3,000,000 GF for the LTSS data project and the \$750,000 GF for the pilot expansion will be paid in FY 2018-19 as a lump sum grant.
7. The estimated administrative costs reimbursements for FY 2018-19 and FY 2019-20, on a cash basis, are:

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
FY 2017-18 Claims*	\$550	\$0	\$550
FY 2018-19 Claims*	\$550	\$0	\$550
Pilot Expansion Grant	\$3,000	\$3,000	\$0
LTSS Data Grant	\$750	\$750	\$0
Total	\$4,850	\$3,750	\$1,100

FY 2019-20	TF	FF
FY 2018-19 Claims	\$550	\$550
FY 2019-20 Claims	\$550	\$550
Total	\$1,100	\$1,100

Funding:

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

100% GF (4260-101-0001)

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 30
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1318

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$4,647,000	\$4,660,000
STATE FUNDS	\$1,161,750	\$1,165,000
FEDERAL FUNDS	\$3,485,250	\$3,495,000

DESCRIPTION

Purpose:

This policy change estimates the contract costs to make improvements, maintain, and operate the existing Health Insurance Portability and Accountability Act (HIPAA) Capitation Payment Reporting system (CAPMAN). The HIPAA imposes new transaction requirements (5010).

Authority:

45 CFR Part 162

Interdependent Policy Changes:

Not Applicable

Background:

The CAPMAN system was implemented by the Department in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the beneficiary level while increasing the effectiveness of monthly reconciliations and supporting research efforts to perform recoveries.

Due to the Affordable Care Act (ACA) and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to accommodate the influx of new beneficiaries. Modifications are being made to further enhance the system to incorporate a paperless accounting interface and accommodate the Coordinated Care Initiative (CCI) Duals Demonstration project. The accounting interface will increase the Department's efficiency to key the growing number of invoices. The system will have to be maintained on an ongoing basis, as new functionality is required.

A new three-year maintenance and operations (M&O) contract for CAPMAN was executed in June 2018, for the period of April 1, 2018 through March 31, 2021. The new contract has two, one-year optional extensions. This contractor will provide M&O services which include continuing enhancements and maintenance needed to keep up with current technology, new federal and state mandates, and paperless accounting interface.

In March 2018, an Interagency Agreement (IA) with the State Controller's Office (SCO) was executed for the period of December 14, 2017, through December 13, 2022, in order to submit claim schedules from the paperless accounting interface to SCO, and issue warrants in response to submitted claim schedules. This contract also includes a testing period with the SCO and allows for walkthroughs of existing and future systems within the Department.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 30

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to a delay in implementation for the new CAPMAN contracts from March 2018 to June 2018, increased project manager (PM) and Senior Systems Engineer (SSE) costs, and the addition of the SCO contract.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to higher PM and SSE costs in FY 2019-20.

Methodology:

1. The new CAPMAN contract for the period of April 1, 2018, through March 31, 2021, was executed June 27, 2018. The contract will cost \$4,140,000 in FY 2018-19 and \$4,140,000 in FY 2019-20.
2. The current CAPMAN PM contract expires October 2, 2018, and is expected to be renewed by November 2018. The estimated costs in FY 2018-19 are \$247,000 (\$60,000 for the remainder of the contract set to expire October 2, 2018, and \$187,000 for the new contract). Estimated costs in FY 2019-20 are \$250,000.
3. The current SSE contract expires July 31, 2019. The estimated costs in FY 2018-19 are \$240,000. Estimated costs in FY 2019-20 are \$250,000 (\$20,000 for current contract set to expire July 31, 2019, and \$230,000 for the new contract).
4. An IA exists with the SCO, which is estimated to cost \$20,000 in FY 2018-19 and \$20,000 in FY 2019-20.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2018-19	\$4,647	\$1,162	\$3,485
FY 2019-20	\$4,660	\$1,165	\$3,495

Funding:

75% HIPAA FFP / 25% HIPAA Fund (4260-117-0001/0890)

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 9/2016
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1972

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$3,053,000	\$2,794,000
STATE FUNDS	\$389,150	\$363,250
FEDERAL FUNDS	\$2,663,850	\$2,430,750

DESCRIPTION

Purpose:

This policy change estimates the costs to modify the Department's existing Post-Adjudicated Claims and Encounter System (PACES) to accept an industry standard file that will contain clinical data.

Authority:

Section 1903(i)(4) of the Social Security Act (SSA)
 Title 22 of the California Code of Regulations, Section 51476

Interdependent Policy Changes:

Not Applicable

Background:

Section 1903(i)(4) of the SSA precludes federal funding under Medicaid, for a hospital or skilled nursing facility that does not have a utilization review plan in effect that meets the requirements set forth in Section 1861(k) of the SSA. Section 1903(i)(4) also provides that these requirements may be waived when a State Medicaid Agency, such as the Department, demonstrates it has a utilization review procedure in place that is superior to the federal requirement.

The Centers for Medicare and Medicaid Services (CMS) has provided clear direction to California to transition from the current Treatment Authorization Request (TAR) model to an approach that allows hospitals to perform their own utilization reviews, while the Department provides monitoring and oversight. Currently, 21 Designated Public Hospitals in California already use this approach. This model will need to be expanded into approximately 350 more hospitals.

The Department received federal approval for renewal of the Superior Systems Waiver (SSW), effective October 1, 2017, to September 30, 2019. The SSW describes how the Department will begin, effective January 1, 2016, collaborating with all District Municipal Public Hospitals (DMPHs) and private hospitals to transition away from the TAR process to performing their own utilization review, followed by monitoring and oversight by the Department. The utilization management systems the hospitals will use (InterQual and MCG, formerly Milliman Care Guidelines) are nationally recognized compilations of evidence-based medical criteria that provide clinical decision support. Hospitals servicing Medicare patients are required to use InterQual.

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER: 31

To allow the Department to collect and review clinical information for selected Medi-Cal members admitted to acute care hospitals, the existing PACES will be modified to accept an industry standard file that will contain clinical data. The data will be accepted, validated, and made available to the Management Information System/Decision Support System (MIS/DSS) Data Warehouse. These efforts will fulfill Medicaid funding requirements and enable the Department to efficiently collect and review clinical medical records.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to additional technical contractor costs, decrease in business contractor costs due to a delayed start in the contract, increased design, development, and implementation (DD&I) Vendor and maintenance and operations (M&O) costs due to added staff, and an increase in hardware/software costs due to a shift in implementation from FY 2017-18.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to lower technical contractor costs in FY 2019-20, six months of the business contractor costs in FY 2018-19 compared to three months in FY 2019-20, and additional hardware/software costs beginning in FY 2019-20.

Methodology:

1. Effective November 1, 2017, a vendor concurrently provides DD&I and M&O services. The first phase of implementation is scheduled to be completed by December 2018.
2. A technical contractor, that began services August 2016, provided services until July 31, 2018. This technical contractor annually costs \$250,000. A separate technical contractor, who began services in July 2018, will provide services until September 30, 2020. This technical contractor annually costs \$250,000.
3. A business contractor, that commenced services February 2017, will provide services until September 30, 2019. This business contractor annually costs \$250,000.
4. A one-time hardware/software cost of \$500,000 is expected to be completed in FY 2018-19.
5. In FY 2019-20, approximately \$250,000 of additional one-time cloud infrastructure/software services costs are expected to occur, and ongoing health information exchange (HIE) software costs of \$100,000 annually are expected to begin.

CLINICAL DATA COLLECTION

OTHER ADMIN. POLICY CHANGE NUMBER: 31

6. Total costs are estimated to be:

FY 2018-19	TF	GF	FF
Technical Contractor	\$275,000	\$27,000	\$248,000
Business Contractor	\$167,000	\$17,000	\$150,000
DD&I Vendor	\$1,552,000	\$155,000	\$1,397,000
M&O*	\$559,000	\$140,000	\$419,000
Hardware/Software	\$500,000	\$50,000	\$450,000
Total	\$3,053,000	\$389,000	\$2,664,000

FY 2019-20	TF	GF	FF
Technical Contractor	\$250,000	\$25,000	\$225,000
Business Contractor	\$83,000	\$8,000	\$75,000
DD&I Vendor	\$1,552,000	\$155,000	\$1,397,000
M&O*	\$559,000	\$140,000	\$419,000
Hardware/Software	\$350,000	\$35,000	\$315,000
Total	\$2,794,000	\$363,000	\$2,431,000

Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)*

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 32
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1982

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$2,674,000	\$2,686,000
STATE FUNDS	\$389,000	\$390,200
FEDERAL FUNDS	\$2,285,000	\$2,295,800

DESCRIPTION

Purpose:

This policy change estimates the MedCompass system replacement costs associated with the California Medicaid Management Information System (CA-MMIS) Medical Fiscal Intermediary (FI) contract.

Authority:

Title XIX of the Federal Social Security Act 1903(a)(3)
 Contract # 16-93448

Interdependent Policy Changes:

Not Applicable

Background:

MedCompass was a component of the System Replacement Project (SRP) which was a contractual responsibility of the FI to replace the current medical claims processing system and subsystems. As a result of the FI not completing all development and implementation, the Department contracted directly with a new vendor to complete the remaining development and implement functionality. The new contract began July 1, 2017, and ends December 31, 2022.

The MedCompass solution is a tool used to bring case data from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and In-Home Health Operations (IHO) programs into a central database housing all beneficiary information. This central database provides common access to the data needed to transfer services from EPSDT to IHO after a beneficiary turns 21 years of age. MedCompass will also include capabilities for alerts, messaging, tasks, and queues that will provide immediate notifications to caseworkers to reach out to the beneficiaries more efficiently and enhance the services provided to them.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to additional scope and licenses being added to the MedCompass contract via the Non-Competitive Bid (NCB) process.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to additional contractor costs being added to the contract via the NCB amendment process in FY 2019-20.

Methodology:

1. The estimated costs are based upon the contract provisions.

CA-MMIS MEDCOMPASS SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 32

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$178,000	\$89,000	\$89,000
90% Title XIX / 10% GF	\$2,440,000	\$244,000	\$2,196,000
100% GF	\$56,000	\$56,000	\$0
Total FY 2018-19	\$2,674,000	\$389,000	\$2,285,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$178,000	\$89,000	\$89,000
90% Title XIX / 10% GF	\$2,452,000	\$245,000	\$2,207,000
100% GF	\$56,000	\$56,000	\$0
Total FY 2019-20	\$2,686,000	\$390,000	\$2,296,000

Funding:

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

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

FI 100% GF (4260-101-0001)

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 33
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1732

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$2,325,000	\$2,325,000
STATE FUNDS	\$1,162,500	\$1,162,500
FEDERAL FUNDS	\$1,162,500	\$1,162,500

DESCRIPTION

Purpose:

This policy change estimates the infrastructure and contractor's costs to perform the ongoing maintenance and operations (M&O) support for the Short-Doyle/Medi-Cal (SDMC) system.

Authority:

Contract OHC-11-077
 Contract #18-95231

Interdependent Policy Changes:

Not Applicable

Background:

The SDMC system adjudicates Medi-Cal claims for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS). The Department signed a two-year contract which began on July 1, 2014, and utilized the two one-year optional extensions. Due to the Affordable Care Act, Medi-Cal has experienced an increase in the volume of claims which has created a need for system upgrades, including application servers, reporting servers, middleware, database, and storage.

The Department secured a new two-year contract with two one-year optional extensions. The new contract began July 1, 2018 and ends June 30, 2022.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. The contractor cost for the new four-year contract, that began July 2018, is \$8,000,000.
2. Projections include the contractor cost related to processing SMHS and SUDS claims payments. M&O costs are related to system upgrades.

FY 2018-19	TF	GF	FF
Contractor cost	\$2,000,000	\$1,000,000	\$1,000,000
M&O	\$325,000	\$163,000	\$162,000
Total	\$2,325,000	\$1,163,000	\$1,162,000

SDMC SYSTEM M&O SUPPORT
OTHER ADMIN. POLICY CHANGE NUMBER: 33

FY 2019-20	TF	GF	FF
Contractor cost	\$2,000,000	\$1,000,000	\$1,000,000
M&O	\$325,000	\$163,000	\$162,000
Total	\$2,325,000	\$1,163,000	\$1,162,000

Funding:

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

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 34
 IMPLEMENTATION DATE: 7/2017
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 1997

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,636,000	\$640,000
STATE FUNDS	\$163,600	\$64,000
FEDERAL FUNDS	\$1,472,400	\$576,000

DESCRIPTION

Purpose:

This policy change estimates the costs for removing Social Security Numbers (SSN) from Medicare cards on the Department's systems and business processes in use, and remediation efforts to accommodate a new Medicare Beneficiary Identifier (MBI) by April 2018.

Authority:

H.R.2 Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015

Interdependent Policy Changes:

Not Applicable

Background:

On April 16, 2015, President Obama signed the MACRA of 2015, which stipulates federal SSN Removal Initiative (SSNRI) efforts. To decrease Medicare beneficiaries' exposure to identity theft, the SSN-based identifier referred to as the Health Insurance Claim Number (HICN) needs to be replaced by a randomly generated MBI on all Medicare cards.

The Centers for Medicare and Medicaid Services (CMS) and its program stakeholders have been using the SSN-based HICN when processing claims or exchanging data related to Medicare beneficiaries and programs. There will likely be many impacts to Department systems and business processes as a result of the transition to the MBI, including Medi-Cal Eligibility Data System (MEDS), California Medicaid Management Information System (CA-MMIS), Management Information System/Decision Support System (MIS/DSS), and Health Care Options (HCO) that include dual Medicare-Medi-Cal eligible members.

The Department made its systems and business processes ready for external integrated system testing with CMS and others by October 2017. The Department also provided an initial impact assessment to CMS. Removal of SSNs from all existing Medicare cards was completed by April 2018. The issuance of new Medicare cards with MBI will be completed by April 16, 2019.

The successful remediation of Department-sponsored systems and processes to accommodate the SSN removal from Medicare cards allows the Department to:

- Continue to successfully adjudicate Medicare-Medi-Cal crossover claims;
- Continue to reimburse providers on a timely basis;
- Continue to successfully exchange information about Medicare-Medi-Cal dual eligible members with the Department's partners;
- Support federal efforts to improve information security by limiting the exchange of SSNs; and

MEDICARE BENEFICIARY IDENTIFIER

OTHER ADMIN. POLICY CHANGE NUMBER: 34

- Reduce the risk of information security breaches.

Reason for Change:

There is no change for FY 2018-19 from the prior estimate. The change from FY 2018-19 to FY 2019-20 is a decrease due to costs in FY 2018-19 reflecting a full year of contract costs, whereas FY 2019-20 reflects anticipated post implementation costs.

Methodology:

1. The state MBI project assesses the impact of SSN removal from Medicare cards on the Department's systems and business processes and modifies these systems and processes to accommodate a new MBI.
2. The estimated contract costs for FY 2018-19 and FY 2019-20 are:

Fiscal Year	TF	GF	FF
FY 2018-19	\$1,636,000	\$164,000	\$1,472,000
FY 2019-20	\$640,000	\$64,000	\$576,000

Funding:

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

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 35
 IMPLEMENTATION DATE: 1/1989
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 237

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,400,000	\$1,400,000
STATE FUNDS	\$700,000	\$700,000
FEDERAL FUNDS	\$700,000	\$700,000

DESCRIPTION

Purpose:

This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:

Social Security Act 1634(a)

Interdependent Policy Changes:

Not Applicable

Background:

The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change:

The change for FY 2018-19, from the prior estimate, is a decrease due to updating the historical average with a more current full year of data.

There is no change from FY 2018-19 to FY 2019-20, in the current estimate.

Methodology:

- The following projections are based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2018-19	\$1,400,000	\$700,000	\$700,000
FY 2019-20	\$1,400,000	\$700,000	\$700,000

Funding:

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

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 12/2017
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 2002

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,318,000	\$3,007,000
STATE FUNDS	\$659,000	\$1,503,500
FEDERAL FUNDS	\$659,000	\$1,503,500

DESCRIPTION

Purpose:

This policy change estimates the administrative costs associated with implementing an electronic asset verification program.

Authority:

Welfare & Institutions Code, Section 14013.5
 Title 42 U.S. Code, Sections 1396w and 1383(e)(1)
 California Financial Code, Section 293
 State Plan Amendment 09-003

Interdependent Policy Changes:

Not Applicable

Background:

Section 1940 of the Social Security Act requires that the State implement an asset verification program for use in Non-Modified Adjusted Gross Income eligibility determinations or redeterminations for all Aged, Blind or Disabled (ABD) applicants and beneficiaries through requests to financial institutions. The law further stipulates that the program be consistent with the approach taken by the Social Security Administration (SSA) under 42 U.S. Code Section 1383(e)(1); this includes the requirement that the program be administered electronically. The State Plan Amendment 09-003, Asset Verification System, was approved on April 16, 2009, and State legislation (Welfare and Institutions Code, Section 14013.5 and Financial Code, Section 293) was enacted to implement the federal requirements.

Financial institutions provide data that could indicate assets and property not reported by the applicant or beneficiary. If information is obtained indicating unreported assets, the applicant or beneficiary must provide additional supporting documentation before an eligibility determination or redetermination is made.

The Department reimburses financial institutions when obtaining asset information for ABD beneficiaries. The reimbursement rate is based on volume, and varies from \$3.70 to \$4.20 per query.

Program expenditures are reduced when supplemental asset data increases the accuracy of eligibility determinations for the ABD population or detects unreported assets that result in the discontinuance of a beneficiary.

ELECTRONIC ASSET VERIFICATION PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 36

The Department conducted a pilot of the asset verification program in order to determine the success of the program in identifying unreported assets and to assist with the development of the program. The pilot concluded in April 2017, and implementation began in December 2017. The Department anticipates expanding the program to the entire ABD population by July 2019.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to a decrease in the estimated number of queries from 832,000 to 313,810, as well as an increase in the per query rate from \$4.00 to \$4.20. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to the expansion of the program to the entire ABD population, resulting in an estimated 804,010 queries at a rate of \$3.74 per query.

Methodology:

1. The policy does not apply to applicants or recipients of federal Supplemental Security Income/State Supplementary Payment (SSI/SSP), whose assets are collected and valued by SSA prior to making a determination of eligibility.
2. The Department is required to verify assets for the Non-MAGI ABD population at application, annual renewal, or whenever the Department determines an asset record is necessary.
3. Based on ABD enrollment data, assume the estimated number of asset verifications performed will be 313,810 in FY 2018-19 and 804,010 in FY 2019-20.
4. The reimbursement rate, based on estimated query volume, is estimated to be \$4.20 in FY 2018-19, and \$3.74 in FY 2019-20.
5. The estimated vendor cost are:

FY 2018-19: 313,810 asset verifications x \$4.20/query = **\$1,318,000 TF (\$659,000 GF)**

FY 2019-20: 804,010 asset verifications x \$3.74/query = **\$3,007,000 TF (\$1,503,500 GF)**

Funding:

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER: 37
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Katy Clay
 FISCAL REFERENCE NUMBER: 1675

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,207,000	\$1,207,000
STATE FUNDS	\$603,500	\$603,500
FEDERAL FUNDS	\$603,500	\$603,500

DESCRIPTION

Purpose:

This policy change estimates the cost for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:

Interagency Agreement 14-90487
 AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The Family PACT program has two main objectives. One is to increase access to services for low-income women and men, including adolescents. The other is to increase the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach;
- Provider enrollment, recruitment, and training;
- Training and technical assistance for medical and non-medical staff;
- Education and counseling services;
- Preventive clinical services;
- Sexually transmitted infection/HIV training and technical assistance services;
- And toll-free referral number.

Reason for Change:

There is no change.

Methodology:

1. The administrative costs for the Family PACT program are estimated in the table below:

Fiscal Year	TF	GF	FF
FY 2018-19	\$1,207,000	\$603,500	\$603,500
FY 2019-20	\$1,207,000	\$603,500	\$603,500

Funding:

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

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 266

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,022,000	\$954,000
STATE FUNDS	\$511,000	\$477,000
FEDERAL FUNDS	\$511,000	\$477,000

DESCRIPTION

Purpose:

This policy change estimates the administrative costs of contracting for the annual independent audit of the Disproportionate Share Hospital (DSH) program.

Authority:

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
 Title 42, Code of Federal Regulations, section 455.300 et. seq.

Interdependent Policy Changes:

Not Applicable

Background:

The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.
2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.
3. The Global Payment Program (GPP) is a pilot program within the Medi-Cal 2020 Waiver which began in FY 2015-16 and is scheduled to continue through FY 2019-20. The GPP is funded with the former 1115 Waiver's Safety Net Care Pool and the State's DSH allotment (related to DPHs). The Designated Public Hospitals participating in the GPP will not be subject to the DSH audit. Since the DSH audits are three years behind the current year, the decrease in the number of audits will not impact the contract until calendar year 2019.

The audits will be funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31st.

Reason for Change:

The increase in FY 2018-19, from the prior estimate, is due to updated data for May 2018 and June 2018 invoices.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to higher May 2018 and June 2018 invoice payments in FY 2018-19, and a slight increase in FY 2019-20 estimated invoices based on the remaining contract amount available.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 38

Methodology:

1. The amended contract amount is \$3,623,291 which extended the contract period by two years for a total of four years.
2. The contract was extended from January 1, 2016 through December 31, 2019.
3. It is assumed a new four-year contract will go to bid by June 2019, with an effective date from January 1, 2020 through December 31, 2023. The contract amount is expected to be similar to the current contract based on the net result of the decreased number of hospitals that will be audited during this contract period and the increased workload due to addendums needed from past years' audits.
4. In FY 2018-19, the Department will make the final payment for the FY 2014-15 audit and partial payment for the FY 2015-16 audit.
5. In FY 2019-20, the Department will make the final payment for the FY 2015-16 audit.

Fiscal Years	TF	GF	FF
FY 2018-19	\$1,022,000	\$511,000	\$511,000
FY 2019-20	\$954,000	\$477,000	\$477,000

Funding:

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

MOBILE VISION CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 39
IMPLEMENTATION DATE: 1/2019
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 2095

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,000,000	\$0
STATE FUNDS	\$1,000,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the payments to a contractor providing mobile vision care services.

Authority:

SB 840 (Chapter 29, Statutes of 2018)

Interdependent Policy Changes:

Not Applicable

Background:

SB 840 appropriates \$1,000,000 GF for direct payments to a mobile vision service provider that participated in the pilot program operated pursuant to Section 14087.9730 of the Welfare and Institutions (W&I) Code. The payments will be reimbursements for services previously covered under the pilot program pursuant to W&I Code 14087.9730 and not otherwise reimbursable under the Medi-Cal program for dates of service on or after July 1, 2018 to December 31, 2018.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There are no costs expected in FY 2019-20.

Methodology:

1. Payments will total \$1,000,000 GF in FY 2018-19.

(Dollars in Thousands)

FY 2018-19	TF	GF
Mobile Vision Care Services	\$1,000	1,000

Funding:

100% GF (4260-101-0001)

SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 40
 IMPLEMENTATION DATE: 7/2002
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 258

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$950,000	\$0
STATE FUNDS	\$950,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of the contract with the County of San Diego for administrative services.

Authority:

Welfare & Institutions Code, sections 14089(g) and 14089.05

Interdependent Policy Changes:

Not Applicable

Background:

The Department contracts with the County of San Diego to provide administrative services for the San Diego Geographic Managed Care program. The Department reimburses the County for staff, postage, printing, data center access, travel, health care options presentations to explain the enrollment and disenrollment process, customer assistance and problem resolution. Effective August 2003, these services are no longer eligible for federal match. The current contract with the County of San Diego ends June 30, 2019, and a contract renewal will not be sought.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with the County of San Diego ends June 30, 2019.

Methodology:

1. Based on contract provisions, the administrative activities costs will be \$950,000 for FY 2018-19.

Funding:

100% State GF (4260-101-0001)

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 41
 IMPLEMENTATION DATE: 5/2010
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1452

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$750,000	\$750,000
STATE FUNDS	\$375,000	\$375,000
FEDERAL FUNDS	\$375,000	\$375,000

DESCRIPTION

Purpose:

This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining electronic Protected Health Information (PHI).

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

The Department acquired hardware, supplies, and associated maintenance and support services to protect and secure electronic data stored on backup systems. These systems contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates.

The protection of these systems will:

- Secure and protect Department information assets from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;
- Prevent lawsuits from citizens for privacy violations;
- Avoid costs to notify millions of people if a large breach does occur; and
- Maintain the Department's public image and integrity for protecting the confidentiality and privacy of the information that it maintains on its customers.

The Department is continuing its effort in upgrading the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies, such as backup to disk, data de-duplication, offsite data replication, and data encryption. The maintenance and increasing amount of data involved with the migration of the Department with these technologies allows the Department to grow, support its virtualization infrastructure, and provide backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth;
- Provide additional backup, recovery, and storage for the business programs; and
- Enhance data security and management.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 41

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. The following amounts are based upon the latest projections of cost:

Fiscal Year	TF	GF	FF
FY 2018-19	\$750,000	\$375,000	\$375,000
FY 2019-20	\$750,000	\$375,000	\$375,000

Funding:

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

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 42
 IMPLEMENTATION DATE: 7/1996
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 240

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$592,000	\$586,000
STATE FUNDS	\$296,000	\$293,000
FEDERAL FUNDS	\$296,000	\$293,000

DESCRIPTION

Purpose:

This policy change estimates the Third Party Liability postage and printing costs.

Authority:

Government Code 7295.4
 AB 155 (Chapter 820, Statutes of 1999)

Interdependent Policy Changes:

Not Applicable

Background:

The Department uses direct mailers and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms printed and mailed, as well as the number of reports received, correlates to the Medi-Cal caseload. The Department uses a document folder/insert machine to automate and process the mailings in-house.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a net decrease due to:

- A one cent increase for postage, and
- A decline in Estate Recovery mail outs.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to an anticipated decrease in mail out activity for Worker's Compensation.

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 42

Methodology:

1. The cost breakdown is shown below:

FY 2018-19	Postage	Printing	Other	Total
Personal Injury	\$221,000	\$30,000	\$0	\$251,000
Worker's Compensation	\$12,000	\$1,000	\$0	\$13,000
Estate Recovery	\$32,000	\$270,000	\$0	\$302,000
Overpayments	\$7,000	\$2,000	\$0	\$9,000
Cost Avoidance	\$5,000	\$1,000	\$0	\$6,000
*AB 155 Invoices	\$1,000	\$0	\$0	\$1,000
**Document Folder Inserter	\$0	\$0	\$1,000	\$1,000
**New Document Folder Inserter	\$0	\$0	\$4,000	\$4,000
**New Copier	\$0	\$0	\$5,000	\$5,000
Total	\$278,000	\$304,000	\$10,000	\$592,000

FY 2019-20	Postage	Printing	Other	Total
Personal Injury	\$221,000	\$30,000	\$0	\$251,000
Worker's Compensation	\$6,000	\$1,000	\$0	\$7,000
Estate Recovery	\$32,000	\$270,000	\$0	\$302,000
Overpayments	\$7,000	\$2,000	\$0	\$9,000
Cost Avoidance	\$5,000	\$1,000	\$0	\$6,000
*AB 155 Invoices	\$1,000	\$0	\$0	\$1,000
**Document Folder Inserter	\$0	\$0	\$1,000	\$1,000
**New Document Folder Inserter	\$0	\$0	\$4,000	\$4,000
**Copier Maintenance	\$0	\$0	\$5,000	\$5,000
Total	\$272,000	\$304,000	\$10,000	\$586,000

*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.

** Cost of maintenance agreement for equipment used to process mailings in-house.

2. The estimated costs are:

Fiscal Year	TF	GF	FF
FY 2018-19	\$592,000	\$296,000	\$296,000
FY 2019-20	\$586,000	\$293,000	\$293,000

Funding:

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1556

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$342,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$342,000	\$0

DESCRIPTION

Purpose:

This policy change budgets the federal funding to cover administrative costs for increasing the California Community Transitions (CCT) enrollment.

Authority:

Money Follows the Person (MFP) Rebalancing Demonstration (42 USC 1396a)
 Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403

Interdependent Policy Changes:

Not Applicable

Background:

Pursuant to the ACA, on September 3, 2010 the Centers for Medicare and Medicaid Services (CMS) authorized the Department to draw down \$750,000 in MFP Rebalancing Demonstration supplemental grant funding. The Department allocated the supplemental grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify individuals who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase CCT enrollment. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

CMS granted the Department an extension of the supplemental grant through December 2015 to complete the objectives set forth in the grant.

Beginning January 1, 2016, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase CCT enrollment. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to DD transitions ending by June 30, 2018 and non-DD transitions ending December 31, 2018.

Methodology:

1. Assume \$342,000 from the MFP grant administrative funding is expected to be paid in FY 2018-19.

CCT OUTREACH - ADMINISTRATIVE COSTS**OTHER ADMIN. POLICY CHANGE NUMBER: 44**

2. Estimated costs are based on the approved contract budget which includes proposed expenditures for the following activities:

- ADRC planning and implementation,
- ADRC/MFP collaborative strategic planning,
- MDS 3.0 Section Q referrals policy development,
- MDS/Options counseling training sessions, and
- Home and Community-Based Advisory Workgroup Series.

FY 2018-19	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$10,308,000	\$1,521,000	\$8,787,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$24,545,000)	(\$12,273,000)	(\$12,272,000)
CCT Fund Transfer to CDSS & CDDS (PC 41)	\$1,365,000	\$0	\$1,365,000
CCT Outreach - Admin costs (OA 44)	\$342,000	\$0	\$342,000
Total of CCT PCs including pass through	(\$12,530,000)	(\$10,752,000)	(\$1,778,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

FY 2019-20	TF	GF	FF
CCT Costs (PC 34):			
Total Non-DD GF costs and Total FFP	\$548,000	\$137,000	\$411,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$2,562,000)	(\$1,281,000)	(\$1,281,000)
Total of CCT PCs including pass through	(\$2,014,000)	(\$1,144,000)	(\$870,000)

*The savings are included in the total, however, they are fully reflected in the base estimates.

Funding:

MFP Federal Grant (4260-106-0890)

VENDOR FOR AAC RATE STUDY

OTHER ADMIN. POLICY CHANGE NUMBER: 45
 IMPLEMENTATION DATE: 9/2015
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1483

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$332,000	\$332,000
STATE FUNDS	\$166,000	\$166,000
FEDERAL FUNDS	\$166,000	\$166,000

DESCRIPTION

Purpose:

This policy change estimates the costs related to contractors used for: (1) project management services related to the implementation of the Covered Outpatient Drug Final Rule and (2) a contract to survey drug price information from pharmacies and develop a new Professional Dispensing Fee (PDF).

Authority:

AB 102 (Chapter 29, Statutes of 2011)
 CMS Final Rule- 42 CFR Part 447 [CMS-2345-FC]

Interdependent Policy Changes:

Not Applicable

Background:

AB 102 authorized the Department to develop a reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC) to replace the Average Wholesale Price (AWP). Additionally, on February 1, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on Medicaid Covered Outpatient Drugs (COD) in the Federal Register. This rule revised requirements pertaining to Medicaid reimbursement for COD, including a requirement that states implement an AAC reimbursement methodology, as well as develop a new PDF which will reflect the cost of the pharmacist's professional services and cost to dispense the drug product to a Medicaid beneficiary. Both components of reimbursement are to be effective April 1, 2017. However, due to required system changes, implementation of this new reimbursement methodology is not expected until January 2019.

Additionally, in December 2016, CMS directed the Department to change its reimbursement methodology for blood factor products and services and submit these changes for federal approval via a State Plan Amendment (SPA).

Lucchese Consulting Solutions contract

On July 1, 2017, the Department entered into a contract with Lucchese Consulting Solutions, LLC to continue managing the work previously under way and coordinate the new work related to changes in blood factor product reimbursement. The Lucchese Consulting Solutions, LLC contract has a one-year term with the option for two one-year extensions. As work to implement the AAC reimbursement methodology and new PDF continues, the Department will execute the second one-year extension to maintain contractor services through FY 2019-20.

VENDOR FOR AAC RATE STUDY**OTHER ADMIN. POLICY CHANGE NUMBER: 45**Checkbox subscription

Pursuant to the Welfare and Institutions Code 14105.45(b)(2)(B), the Department adopted a new process where pharmacy providers must attest annually to total claim volume to be appropriately reimbursed a PDF for claims. It is estimated 4,000, of the 5,700 active providers, will attest annually. The Department purchased a subscription to Checkbox, a professional web-enabled survey software, to efficiently process and store provider attestations.

The Checkbox subscription and professional services to develop and implement the survey tool began October 2017. The software was ready for use on January 1, 2018. Based on the three-year subscription, the first year costs (FY 2017-18) of \$8,000 will be funded in the support budget. The remaining two years of the subscription are anticipated to cost \$7,000 annually and will be budgeted in the Medi-Cal local assistance estimate.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change in the current estimate from FY 2018-19 to FY 2019-20.

Methodology:

1. On July 1, 2017, the contract with Lucchese Consulting Solutions, LLC began to manage ongoing system changes, continue the AAC implementation efforts, and work on changes associated with the reimbursement of blood factor products. Assume the contract costs are \$325,000 for FY 2018-19 and FY 2019-20.
2. The three-year subscription with Checkbox began October 2017. The Medi-Cal local assistance portion of the subscription will cost \$7,000 annually starting in FY 2018-19.

Contractor Costs	TF	GF	FF
FY 2018-19	\$332,000	\$166,000	\$166,000
FY 2019-20	\$332,000	\$166,000	\$166,000

Funding:

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

T-MSIS

OTHER ADMIN. POLICY CHANGE NUMBER: 46
IMPLEMENTATION DATE: 9/2013
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 1768

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$271,000	\$249,000
STATE FUNDS	\$67,750	\$62,250
FEDERAL FUNDS	\$203,250	\$186,750

DESCRIPTION

Purpose:

This policy change estimates the cost for the maintenance and operations (M&O) of the Extract, Transform, and Load (ETL) data solution used to transmit data to the Transformed Medicaid Statistical Information System (T-MSIS).

Authority:

Affordable Care Act (ACA)
 Medicaid Managed Care Final Rule

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) require data in a standardized format from the states to review system projects related to the ACA. The Department implemented an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS T-MSIS. The project provides modern capabilities to improve business processes by collecting comprehensive data regarding cost, quantity, and quality of health care provided for Medi-Cal beneficiaries. Data transferred to the T-MSIS includes claims, eligibility, third party liability, managed care, and provider information.

In November 2017, CMS approved an Implementation Advance Planning Document Update (IAPDU) providing enhanced funding for software support as well as ETL system and training costs through Federal Fiscal Year (FFY) 2021 (Oct. 2020 to Sept. 2021). In June 2018, the Department submitted an Operational Advance Planning Document (OAPD) to CMS which provides funding for maintenance and operations (M&O) through FFY 2019 (Oct. 2018 to Sept. 2019). The software support renewals for Data Quality (data cleansing) and PowerCenter (data repository) are considered M&O costs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a reduction in training costs. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to a decrease in both software and training costs.

T-MSIS**OTHER ADMIN. POLICY CHANGE NUMBER: 46****Methodology:**

1. Support and maintenance for Data Quality was procured in February 2018 and will be re-procured annually. Data Quality is a module within the Informatica tool which validates system data.
2. The software maintenance renewal for Power Center will be re-procured in December 2018 with an optional one-year extension. PowerCenter is a separate module within the Informatica tool which extracts, transforms, and loads system data.
3. An IAPDU provides annual funding for training on software and industry data cleansing procedures through FFY 2021 (Oct. 2020 to Sept. 2021).

FY 2018-19	TF	GF	FF
Software	\$248,000	\$62,000	\$186,000
Training	\$23,000	\$6,000	\$17,000
Total	\$271,000	\$68,000	\$203,000

FY 2019-20	TF	GF	FF
Software	\$244,000	\$61,000	\$183,000
Training	\$5,000	\$1,000	\$4,000
Total	\$249,000	\$62,000	\$187,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 47
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 1590

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$200,000	\$0
STATE FUNDS	\$100,000	\$0
FEDERAL FUNDS	\$100,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of contracts with the University of Massachusetts Medical School (UMass) to identify potential overpayments to the Centers for Medicare and Medicaid Services (CMS) and Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual-eligible members.

Authority:

Welfare & Institutions Code 14124.92
 Contract 16-93204

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into a three-year contract (16-93204) with the UMass, with an effective date of September 1, 2016, to identify potential overpayments to CMS and Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual-eligible members. UMass assists the Department in auditing the invoices received from CMS to pay the Medicare premiums. Payments to UMass are contingent upon recovery of overpayments from CMS and Medicare providers. These payments are 10% of the amounts recovered.

The contract with the UMass was terminated, effective May 2018. There is a runout period of one year from the date of the cancellation in which work that is attributed to UMass, resulting in a recovery, will qualify for payment of the contingency fee. The Department is currently exploring options to replace these services with another vendor, or perform duties in-house.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is a decrease due to the termination of the contract in May 2018. In addition, in the prior estimate, there was a delay in case corrections for FY 2017-18 and it was assumed costs would be shifted to FY 2018-19; however, those payments were made in FY 2017-18. There are no longer any processing delays and projected recoveries reported by the contractor will continue at the historical level in the current estimate for FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the termination of the contract in May 2018. There is a runout period of one year from the date of cancellation in which work that is attributed to UMass, resulting in a recovery, will qualify for payment of the contingency fee. However, the runout period will expire before FY 2019-20, and as a result, FY 2019-20 will not have any costs.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 47

Methodology:

1. The cost of the contractor is 10% of the amount recovered. Recoveries are estimated to be \$2,000,000 TF annually.
2. Assume the estimated amount recovered on a cash basis, during the one-year runout period of the contract through May 2019, will be \$2,000,000 in FY 2018-19 and \$0 in FY 2019-20. As a result, the contractor cost is estimated to be \$200,000 in FY 2018-19 and \$0 in FY 2019-20.

FY 2018-19: \$2,000,000 x 10% = \$200,000 TF

FY 2019-20: \$0 TF

3. The estimated contractor costs are:

Fiscal Year	TF	GF	FF
FY 2018-19	\$200,000	\$100,000	\$100,000

Funding:

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

STATE CONTROLLER'S OFFICE INTERAGENCY AGREEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 11/2016
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2001

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$131,000	\$169,000
STATE FUNDS	\$32,750	\$42,250
FEDERAL FUNDS	\$98,250	\$126,750

DESCRIPTION

Purpose:

This policy change estimates the costs related to services that have been performed and will be performed by the State Controller's Office (SCO) related to the California Dental Medicaid Management Information (CD-MMIS) system changes needed for check write turnover to SCO.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Under guidance from the Centers for Medicare and Medicaid Services (CMS), the Department began work with SCO to alter the current check write function where the Fiscal Intermediary (FI) is responsible for processing claims.

The scope of work involves multiple phases in order to alter the current CD-MMIS to allow for SCO takeover of the check write function. Costs included for this agreement pertain to updating the CD-MMIS and enabling the ability to perform the check write function. The previous interagency agreement (IA) ended in December 31, 2017 for the initial work. The new IA is currently in the process of being negotiated.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to costs being included for the new IA. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to expected payment timing.

Methodology:

1. SCO estimated cost based on the number of funds (0912, 0555, and 0001) that DHCS will utilize to pay the check write and the types of files (EFT and warrant) that will be submitted to the SCO.
2. This project started October 2018 and will be completed by September 2019.
3. For FY 2018-19, the \$150,000 for services were divided into 8 equal payments. Based on the project timeline, the department will be making the first 7 payments starting in December 2018 and ending in June 2019.

**STATE CONTROLLER'S OFFICE INTERAGENCY
AGREEMENT**

OTHER ADMIN. POLICY CHANGE NUMBER: 48

4. For FY 2019-20, the last of the eight payments from FY 2018-19 services will be paid in July 2019. There will be three payments made from August 2019 to October 2019 for the remaining services.

Fiscal Year	TF	GF	FF
7 of 8 Payments	\$131,000	\$32,750	\$98,250
FY 2018-19 Total	\$131,000	\$32,750	\$98,250
8 of 8 Payments	\$19,000	\$4,750	\$14,250
Three payments of \$50,000	\$150,000	\$37,500	\$112,500
FY 2019-20 Total	\$169,000	\$42,250	\$126,750

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 49
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1916

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$64,694,000	\$38,382,000
STATE FUNDS	\$20,765,500	\$12,308,500
FEDERAL FUNDS	\$43,928,500	\$26,073,500

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Many functions of the Medical FI contract services are performed and paid under the Base Volume Method of Payment (BVMP) or All Volume Method of Payment (AVMP) processes. For BVMP categories, the contractor bids on fixed transaction volume ranges and a fixed rate for each range. For the AVMP categories, the contractor is paid a fixed rate per transaction. The Department receives a discount when total transactions fall below the base range and pays a premium when total transactions exceed the base range.

- The volume ranges and corresponding bid rates vary from year to year.
- The State Medi-Cal caseload also varies from year to year.

Operations constitute all contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- General Adjudicated Claim Lines (ACLs) – Lines of service associated with a Medi-Cal claim. Payments to the FI are based on the number of ACLs processed.
- Online Drug ACLs – Lines of service associated with a Medi-Cal online drug claim. Payments to the FI are based on the number of ACLs processed.

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 49

- Prospective Drug Use Review (DUR) – DUR is performed during adjudication of online pharmacy claims and is the process of utilization review and quality assessment of drug prescribing, dispensing, and educational intervention before and after the drug is dispensed.
- Retrospective DUR – Similar to Prospective DUR, “retrospective” reviews of claims data are done to identify patterns of improper use of drug program benefits among providers and recipients.
- Encounter Claim Lines (ECL) – Lines of service associated with encounters received from Managed Care Organizations (MCO) contracted to process Medi-Cal claims.
- California Eligibility Verification and Management Systems (CA-EVS/CMS) processing – A non-mainframe system that includes online, real-time processing of eligibility verification, share of cost, Medi-services, and pharmacy claims transaction using point of sale devices, Automated Eligibility Verification System (AEVS), Claims and Eligibility Real-Time System (CERTS), internet, or through approved user-developed/modified systems.
- Medicare Drug Discount Program – The processing of inquiries that consists of unique requests for Medicare prices for CA-EV/CMS by provider for the beneficiary for a date of service.
- Treatment Authorization Requests (TARS) – The process used by providers to request for authorization to provide specified service(s) to a beneficiary.
- Telephone Services Center (TSC) – Claim volume associated with contractor work activity and responsibility to telephone responses to provider and beneficiary inquiries received over telephone lines.
- Child Health and Disability Prevention Program (CHDP) – The program is moving out of Family Health and the Department has budgeted for the potential of straggler claims under the CA-MMIS operations policy change.

The FI has bid on State-specified volume ranges for each of the above categories. The Department estimates operations costs by applying these bid rates to the projected volumes for the current and budget year.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to shifting the end of FY 2018-19 costs to FY 2019-20.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the transition from the current FI to the successor FIs. In addition, CHDP claims costs have been added to this policy change.

Methodology:

1. Operation costs are fixed price rates based on volumes within the minimum and maximum ranges under the FI contract.
2. Costs are shared between Federal Funds (FF) and General Funds (GF).

MEDICAL FI OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 49

3. Medi-Cal Administration/Operations costs are funded at 75% FF and 25% GF or 50% FF and 50% GF.
4. Medicare Drug Discount and CHDP costs are funded at 100% GF.
5. Of the TSC costs, about 16.1% are funded at 50% GF and 83.9% are funded at 25% GF.

FY 2018-19	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	\$39,078,000	\$13,677,000	\$25,401,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	\$2,002,000	\$701,000	\$1,301,000
Prospective DUR (75% FF/25% GF)	\$267,000	\$67,000	\$200,000
Retrospective DUR (50% FF/50% GF)	\$83,000	\$42,000	\$41,000
Encounter Claim Lines (75% FF/25% GF)	\$667,000	\$167,000	\$500,000
CA-EVS/CMS Processing (75% FF/25% GF)	\$3,333,000	\$833,000	\$2,500,000
Medicare Drug Discount (100% GF)	\$14,000	\$14,000	\$0
TARS (75% FF/25% GF)	\$8,000,000	\$2,000,000	\$6,000,000
TSC (75% FF/25% GF, 50% FF/50% GF)	\$11,250,000	\$3,265,000	\$7,985,000
Total	\$64,694,000	\$20,766,000	\$43,928,000

FY 2019-20	TF	GF	FF
General ACLs (75% FF/25% GF, 50% FF/50% GF)	\$23,020,000	\$8,057,000	\$14,963,000
Online ACLs (75% FF/25% GF, 50% FF/50% GF)	\$1,192,000	\$417,000	\$775,000
Prospective DUR (75% FF/25% GF)	\$160,000	\$40,000	\$120,000
Retrospective DUR (50% FF/50% GF)	\$50,000	\$25,000	\$25,000
Encounter Claim Lines (75% FF/25% GF)	\$400,000	\$100,000	\$300,000
CA-EVS/CMS Processing (75% FF/25% GF)	\$2,000,000	\$500,000	\$1,500,000
Medicare Drug Discount (100% GF)	\$9,000	\$9,000	\$0
TARS (75% FF/25% GF)	\$4,800,000	\$1,200,000	\$3,600,000
TSC (75% FF/25% GF, 50% FF/50% GF)	\$6,750,000	\$1,959,000	\$4,791,000
CHDP (100% GF)	\$1,000	\$1,000	\$0
Total	\$38,382,000	\$12,308,000	\$26,074,000

Funding:

- FI 50% Title XIX / 50% GF (4260-101-0001/0890)
- FI 75% Title XIX / 25% GF (4260-101-0001/0890)
- FI 100% GF (4260-101-0001)
- FI 100% GF CHDP State Only (4260-111-001)

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 50
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1917

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$40,775,000	\$16,638,000
STATE FUNDS	\$10,672,750	\$4,436,450
FEDERAL FUNDS	\$30,102,250	\$12,201,550

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.
- Parcel Services and Common Carriers - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.
- Personal Computers, Monitors, Printers, Related Equipment, and Software – The installation and monthly charges for data lines; and the purchase, lease, installation, and maintenance of desktops for State staff at Field Office and Contractor facilities, or at the Direction of the Contracting Officer and Point-of-Sale (POS) devices.
- Printing – Costs to print the forms, documents, and other State program printing requests as directed by the State.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 50

- Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and beneficiaries, telephone lines for audio text equipment, computer media claims, TAR submissions, the print and distribution center, on-line pharmacy claims processing and on-line eligibility verification, and any other beneficiary or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.
- Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.
- Special Training Sessions – Payment for training sessions that exceeds the fixed price training bid.
- Facilities Improvement and Modifications – The direct costs for modifications and improvements to facilities, for the purposes of housing State or federal on-site audit and monitoring staff.
- Audits and Research – Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.
- Sales Tax – The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.
- Change Order and/or Amendments – Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.
- The Medi-Cal Print and Distribution Center – Contractor shall be reimbursed for the Medi-Cal Print and Distribution Center staff required to perform the functions of printing as described in the contract. The Department will also reimburse the contractor for all space, cost of equipment, fire suppressant system, cabinets, staff, printing, and distribution services.
- Drug Use Review (DUR) and Eligibility Verification Telecommunications – Real-time drug use approvals and eligibility verifications that take place via California POS.
- Field Office Automation Group (FOAG) equipment and furniture – Direct costs incurred for the purchase and maintenance of computer equipment and furniture for FOAG staff located in State offices. Excludes supplies, purchases, and maintenance for computer equipment and furniture in TAR Processing Centers.
- Independent Verification & Validation (IV&V) and Consultant Contracts – IV&V and consultant contracts utilized for operational project oversight that are paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 50

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase with increased estimates for consultant contracts and equipment/services; and decreases from shifting end of FY 2018-19 costs to FY 2019-20 and no audit/research costs in FY 2018-19.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to decreased consultant contract estimates and because of the transition from the current FI to the successor FIs.

Methodology:

1. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2018-19	TF	GF	FF
Postage (50% FF/50% GF)	\$1,553,000	\$776,000	\$777,000
Parcel Services & Common Carriers (50% FF/50% GF)	\$76,000	\$38,000	\$38,000
Equipment/Services (75% FF/25% GF)	\$5,533,000	\$1,383,000	\$4,150,000
Print/Distribution Center (50% FF/50% GF, 75% FF/25% GF)	\$947,000	\$379,000	\$568,000
P&D Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	\$1,909,000	\$716,000	\$1,193,000
Facilities Improvement & Modification (50% FF/50% GF)	\$540,000	\$270,000	\$270,000
Change Orders (50% FF/50% GF)	\$42,000	\$21,000	\$21,000
Sales Tax (75% FF/25% GF)	\$3,462,000	\$866,000	\$2,596,000
Consultant Contracts (50% FF/50%GF, 75% FF/25% GF, 90% FF/10% GF)	\$21,612,000	\$5,372,000	\$16,240,000
Telecommunication & Data Center Access (75% FF / 25% GF)	\$1,309,000	\$327,000	\$982,000
Other Cost Reimb. Items (50% FF/50% GF, 90% FF/10% GF)	\$3,792,000	\$525,000	\$3,267,000
Total	\$40,775,000	\$10,673,000	\$30,102,000

MEDICAL FI COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 50

FY 2019-20	TF	GF	FF
Postage (50% FF/50% GF)	\$932,000	\$466,000	\$466,000
Parcel Services & Common Carriers (50% FF/50% GF)	\$46,000	\$23,000	\$23,000
Equipment/Services (75% FF/25% GF)	\$2,599,000	\$650,000	\$1,949,000
Print/Distribution Center (50% FF/50% GF, 75% FF/25% GF)	\$509,000	\$204,000	\$305,000
P&D Other Direct Costs (50% FF/50% GF, 75% FF/25% GF)	\$1,145,000	\$429,000	\$716,000
Facilities Improvement & Modification (50% FF/50% GF)	\$324,000	\$162,000	\$162,000
Change Orders (50% FF/50% GF)	\$19,000	\$10,000	\$9,000
Sales Tax (75% FF/25% GF)	\$1,400,000	\$350,000	\$1,050,000
Consultant Contracts (50% FF/50%GF, 75% FF/25% GF, 90% FF/10% GF)	\$6,604,000	\$1,632,000	\$4,972,000
Telecommunication & Data Center Access (75% FF / 25% GF)	\$785,000	\$196,000	\$589,000
Other Cost Reimb. Items (50% FF/50% GF, 90% FF/10% GF)	\$2,275,000	\$315,000	\$1,960,000
Total	\$16,638,000	\$4,437,000	\$12,201,000

Funding:

FI 50% Title XIX/ 50% GF (4260-101-0001/0890)
 FI 75% Title XIX/ 25% GF (4260-101-0001/0890)
 FI 90% Title XIX/ 10% GF (4260-101-0001/0890)
 FI 50% HIPAA FF/ 50% GF (4260-117-0001/0890)
 FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)
 FI 90% HIPAA FF/ 10% GF (4260-117-0001/0890)

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1918

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$22,955,000	\$13,773,000
STATE FUNDS	\$4,988,750	\$2,993,250
FEDERAL FUNDS	\$17,966,250	\$10,779,750

DESCRIPTION

Purpose:

This policy change estimates the hourly reimbursement costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG) and Field Office Automation Group (FOAG) pharmacists. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the California Medicaid Management Information Systems (CA-MMIS). FOAG pharmacists administer processes and review drug Treatment Authorization Requests (TAR) in accordance with the Department's criteria, guidelines, and policy. They provide consultation services to contractor staff consultants, physicians, nurses, and field office personnel. FOAG pharmacists independently evaluate and adjudicate TARs, and maintain currency with continuously evolving healthcare practices, equipment, and technology.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to shifting end of FY 2018-19 costs to FY 2019-20. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the transition of the current FI to the successor FIs.

Methodology:

1. SG costs are based on the contract bid price for SG Hourly Reimbursements and the System Replacement Project settlement agreement.
2. Costs are shared between Federal Funds (FF) and General Funds (GF), based on the fixed price

MEDICAL FI HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 51

Base Volume Method of Payment (BVMP) bid rates.

FY 2018-19	TF	GF	FF
Non-HIPAA (75% FF / 25% GF, 90% FF / 10% GF)	\$12,500,000	\$3,062,000	\$9,438,000
HIPAA (75% FF / 25% GF, 90% FF / 10% GF)	\$10,000,000	\$1,813,000	\$8,187,000
System Group Total	\$22,500,000	\$4,875,000	\$17,625,000
FOAG Pharmacists (75% FF / 25% GF)	\$455,000	\$114,000	\$341,000
Total Hourly Reimbursement	\$22,955,000	\$4,989,000	\$17,966,000

FY 2019-20	TF	GF	FF
Non-HIPAA (75% FF / 25% GF, 90% FF / 10% GF)	\$7,667,000	\$1,854,000	\$5,813,000
HIPAA (75% FF / 25% GF, 90% FF / 10% GF)	\$5,833,000	\$1,071,000	\$4,762,000
System Group Total	\$13,500,000	\$2,925,000	\$10,575,000
FOAG Pharmacists (75% FF / 25% GF)	\$273,000	\$68,000	\$205,000
Total Hourly Reimbursement	\$13,773,000	\$2,993,000	\$10,780,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

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

FI HIPAA 75% FF / 25% GF (4260-117-0001/0890)

FI HIPAA 90% FF / 10% GF (4260-117-0001/0890)

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 52
IMPLEMENTATION DATE: 7/2015
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 1921

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$9,817,000	\$5,890,000
STATE FUNDS	\$2,975,000	\$1,785,000
FEDERAL FUNDS	\$6,842,000	\$4,105,000

DESCRIPTION

Purpose:

This policy change estimates the total of other estimated costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Costs under this category consist of payment to the contractor for other contract services, such as:

- Beneficiary Identification Cards (BIC) – Plastic cards issued by the Department to each Medi-Cal recipient.
- Health Access Program Cards (HAP) – Plastic cards issued by the Department to beneficiaries participating in Family Planning, Access, Care, and Treatment (FPACT) and other special health care programs.
- Rebate Accounting and Information System (RAIS) Medi-Cal – The processing of RAIS invoices/claims in fee-for-service.
- RAIS Managed Care Organizations (MCO) – The processing of RAIS invoices/claims for MCOs.
- Cost containment – Items brought to the attention of the Department by the contractor that result in savings in Medi-Cal program expenditures and which the contractor shares a portion of the savings.
- Fixed price hourly billable Systems Group (SG) – Projects such as International Classification of Diseases and 10th Revision (ICD-10).

MEDICAL FI OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 52

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net decrease due to shifting end of FY 2018-19 costs to FY 2019-20; and an increase in the Cost Containment estimate. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the transition of the current FI to the successor FIs.

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).
2. Payment calculated by a transaction rate multiplied by volume basis, based on contract year and General Adjudicated Claim Lines (ACL) volume.

FY 2018-19	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	\$834,000	\$209,000	\$625,000
Health Access Program Cards (75% FF / 25% GF)	\$233,000	\$58,000	\$175,000
RAIS Medi-Cal (75% FF / 25% GF)	\$1,250,000	\$312,000	\$938,000
RAIS MCO (75% FF / 25% GF)	\$5,417,000	\$1,354,000	\$4,063,000
Cost Containment (50% FF / 50% GF)	\$2,083,000	\$1,042,000	\$1,041,000
Total Costs	\$9,817,000	\$2,975,000	\$6,842,000

FY 2019-20	TF	GF	FF
Beneficiary ID Cards (75% FF / 25% GF)	\$500,000	\$125,000	\$375,000
Health Access Program Cards (75% FF / 25% GF)	\$140,000	\$35,000	\$105,000
RAIS Medi-Cal (75% FF / 25% GF)	\$750,000	\$187,000	\$563,000
RAIS MCO (75% FF / 25% GF)	\$3,250,000	\$813,000	\$2,437,000
Cost Containment (50% FF / 50% GF)	\$1,250,000	\$625,000	\$625,000
Total Costs	\$5,890,000	\$1,785,000	\$4,105,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER: 53
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1924

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$7,042,000	\$4,225,000
STATE FUNDS	\$1,023,700	\$614,100
FEDERAL FUNDS	\$6,018,300	\$3,610,900

DESCRIPTION

Purpose:

This policy change estimates the California Medicaid Management Information System (CA-MMIS) replacement costs.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

CA-MMIS is a mission critical system, which processes timely and accurate claims payments to providers within the Medi-Cal program. The Medical Fiscal Intermediary (FI) contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

The System Replacement Project (SRP) constitutes the contractual responsibilities required for the FI to replace the existing CA-MMIS. As a result of the SRP settlement agreement, the contractual responsibilities for the SRP have been removed from the FI contract with the exception of System Replacement Release I maintenance and operations (M&O). Release I, implemented in December 2014, established an online portal, single sign-on functionality, user administration functions, and related reporting. The Department compensates the FI for the continued hosting and M&O of Release I until the expiration of the FI contract.

Reason for Change:

The change from the prior estimate for, FY 2018-19, is a decrease due to shifting end of FY 2018-19 costs to FY 2019-20. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the transition of the current FI to the successor FIs.

MEDICAL FI SRP RELEASE 1 HOSTING

OTHER ADMIN. POLICY CHANGE NUMBER: 53

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2018-19	TF	GF	FF
50% Title XIX / 50% GF	\$468,000	\$234,000	\$234,000
90% Title XIX / 10% GF	\$6,427,000	\$643,000	\$5,784,000
100% GF	\$147,000	\$147,000	\$0
Total	\$7,042,000	\$1,024,000	\$6,018,000

FY 2019-20	TF	GF	FF
50% Title XIX / 50% GF	\$281,000	\$140,000	\$141,000
90% Title XIX / 10% GF	\$3,856,000	\$386,000	\$3,470,000
100% GF	\$88,000	\$88,000	\$0
Total	\$4,225,000	\$614,000	\$3,611,000

Funding:

- FI 50% Title XIX / 50% GF (4260-101-0001/0890)
- FI 90% Title XIX / 10% GF (4260-101-0001/0890)
- FI 100% GF (4260-101-0001)

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 54
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1922

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$2,975,000	\$1,779,000
STATE FUNDS	\$903,750	\$540,750
FEDERAL FUNDS	\$2,071,250	\$1,238,250

DESCRIPTION

Purpose:

This policy change estimates the cost of miscellaneous expenses of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interagency Agreement (IA) # 16-93264, 15-92027, 14-90507, 15-92026 & 17-94428

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Pursuant to an interagency agreement (IA) with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption. SCO also provides the Department various administrative and project activities as they relate to the electronic claims process for the Health Enterprise (HE) system.

Pursuant to an interagency agreement with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

Pursuant to an interagency agreement with the Office of Systems Integration (OSI), the Department utilizes one OSI Technical Architect (TA) and one Project Manager (PM) staff to provide California Medicaid Management Information Systems (CA-MMIS) modernization project management, oversight, procurement, and support services. The IA was finalized in March 2018.

The administrative costs for the Family Planning, Access, Care, and Treatment Family Pact (FPACT) program, which provides services at no cost to low-income residents of reproductive age, are included.

MEDICAL FI MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 54

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to higher SCO Warrants and RADs while all other costs decreased.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the transition of the current FI to the successor FIs.

Methodology:

1. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2018-19	TF	GF	FF
SCO - Warrants and RADs (75% FF / 25% GF)	\$2,271,000	\$568,000	\$1,703,000
SCO - Postage (50% FF / 50% GF)	\$515,000	\$258,000	\$257,000
SCO - HE Claims - Admin. (75% FF / 25% GF)	\$16,000	\$4,000	\$12,000
CSTO - Warrant Redemption (75% FF / 25% GF)	\$46,000	\$11,000	\$35,000
CDCA - Provider Verification File (75% FF / 25% GF)	\$2,000	\$1,000	\$1,000
FPACT (50% FF / 50% GF)	\$125,000	\$62,000	\$63,000
Total	\$2,975,000	\$904,000	\$2,071,000

FY 2019-20	TF	GF	FF
SCO - Warrants and RADs (75% FF / 25% GF)	\$1,363,000	\$341,000	\$1,022,000
SCO - Postage (50% FF / 50% GF)	\$309,000	\$154,000	\$153,000
SCO - HE Claims - Admin. (75% FF / 25% GF)	\$3,000	\$1,000	\$2,000
CSTO Warrant Redemption (75% FF / 25% GF)	\$28,000	\$7,000	\$21,000
CDCA -Provider Verification File (75% FF / 25% GF)	\$1,000	\$0	\$1,000
FPACT (50% FF / 50% GF)	\$75,000	\$38,000	\$39,000
Total	\$1,779,000	\$541,000	\$1,238,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 55
 IMPLEMENTATION DATE: 7/2018
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1923

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$1,679,000	\$0
STATE FUNDS	\$167,900	\$0
FEDERAL FUNDS	\$1,511,100	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of Optional Contractual Services (OCS) of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 09-86210

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS are not always part of the FI budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS. The identified costs are for the implementation of the Medicaid Incentive program, which provide incentives to providers who adopt and use Electronic Health Records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Due to the American Recovery and Reinvestment Act (ARRA) HITECH State Level Registry (SLR) work ending beyond the current FI contract end date, the Department intends to take over management of the SLR application from the FI. Remaining OCS costs will be paid to the FI once the System Development Notice is implemented. The final payment will be issued March 2019.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to the final payment for the SLR being issued in FY 2018-19 with no expected costs remaining under the current FI contract.

MEDICAL FI OPTIONAL CONTRACTUAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 55

Methodology:

Fiscal Year	TF	GF	FF
FY 2018-19	\$1,679,000	\$168,000	\$1,511,000

Funding:

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

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 56
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 1919

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$456,000	\$228,000
STATE FUNDS	\$114,000	\$57,000
FEDERAL FUNDS	\$342,000	\$171,000

DESCRIPTION

Purpose:

This policy change estimates the cost of Fiscal Medical Intermediary (FI) contract Change Orders (CO).

Authority:

Contract # 09-86210
 SB 853 (Chapter 717, Statutes of 2010)
 Welfare & Institutions (W&I) Code Section 14105.05

Interdependent Policy Changes:

Not Applicable

Background:

The FI contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The FI contract was awarded on December 8, 2009, and became effective on May 3, 2010, which began the takeover phase. The FI contract term originally ran through March 31, 2020. However, after a settlement agreement between Xerox and the Department was reached, the new contract end date is September 30, 2019. The new FI contract vendors are scheduled to assume operations October 1, 2019.

Modifications resulting in changes to contractor responsibilities are initiated by COs and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal fixed-price of the contract. The section below details the current CO in progress.

- Operations Code Conversion (OCC) Change Order:

To comply with the Health Insurance Portability and Accountability Act (HIPAA), W&I Code Section 14105.05 mandates the conversion of Healthcare Common Procedure Coding System (HCPCS) Level III codes (local codes) to HCPCS Level II codes (national codes). Thus, additional staff is required to effectively support provider-related activities from the beginning of conversions through implementation. Focused attention to the provider-related activities at the appropriate level, such as outreach, communication, and training, will ensure successful conversion implementations.

As COs are not originally known or knowable at the time the contract was procured, and require an increased level of work and effort, the Department has agreed to reimburse the FI for all documentable expenses that are a direct result of efforts detailed above.

MEDICAL FI CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 56

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to shifting end of FY 2018-19 costs to FY 2019-20. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to the transition of the current FI to the successor FIs.

Methodology:

1. Certain costs, such as software, travel expenses, etc., can be paid through cost reimbursement. These costs are budgeted in the Medical FI Cost Reimbursement policy change.
2. The contract allows for overhead and profit to be included in CO expenses (not to exceed thirty percent).
3. The estimated costs for FY 2018-19 and FY 2019-20 are:

OCC Change Order	TF	GF	FF
FY 2018-19	\$456,000	\$114,000	\$342,000
FY 2019-20	\$228,000	\$57,000	\$171,000

Funding:

FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)

MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 57
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2119

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$21,615,000
STATE FUNDS	\$0	\$5,403,750
FEDERAL FUNDS	\$0	\$16,211,250

DESCRIPTION

Purpose:

This policy change estimates the cost of Medical Fiscal Intermediary (FI) contract IT Operations and Development Services.

Authority:

Contract # 18-95302

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) contract is October 2019. The FI contract term is five years with two one-year optional extensions.

IT Development and Operations Services of the Medical FI IT Maintenance and Operations contract are performed and paid under either an hourly rate or a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. IT Development and Operations Services include the following services:

- Application Development Services
- Application Maintenance and Operations Services
- Project Management Office

Reason for Change:

This is a new policy change.

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.

**MEDICAL FI IT DEVELOPMENT AND OPERATIONS
SERVICES**

OTHER ADMIN. POLICY CHANGE NUMBER: 57

FY 2019-20	TF	GF	FF
Application Development Services	\$12,979,000	\$3,245,000	\$9,734,000
Application Maintenance and Operations Services	\$4,961,000	\$1,240,000	\$3,721,000
Project Management Office	\$3,675,000	\$919,000	\$2,756,000
Total:	\$21,615,000	\$5,404,000	\$16,211,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 58
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2117

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$16,608,000
STATE FUNDS	\$0	\$4,152,000
FEDERAL FUNDS	\$0	\$12,456,000

DESCRIPTION

Purpose:

This policy change estimates the cost of Fiscal Medical Intermediary (FI) contract Change Orders (CO).

Authority:

Contract # 16-93438

Contract # 18-95302

SB 853 (Chapter 717, Statutes of 2010)

Welfare & Institutions (W&I) Code Section 14105.05

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations and Information Technology Maintenance and Operations (IT M&O) FI contracts is October 2019. The Business Operations FI contract term is five years with five one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Modifications resulting in changes to contractor responsibilities are initiated by COs and billed separately from contract operations. A CO is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope and above the normal costs of the contract. Either or both of the FI contractors may be required to engage in a CO project and their respective scope is determined at the initiation phase.

As COs are not originally known or knowable at the time the contract was procured, and require an increased level of work and effort, the Department has agreed to reimburse the FI for all documentable expenses that are a direct result of Change Order efforts. The Business Operations FI costs are determined during the analysis phase of a CO. The IT Infrastructure, Development, and Operations costs are estimated based on the preliminary pricing bids that have been submitted by the IT M&O contractor.

Reason for Change:

This is a new policy change.

MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

Methodology:

1. Certain costs, such as software and travel expenses, can be paid through cost reimbursement. These costs are budgeted in the Medical FI BO & IT Cost Reimbursement policy change.
2. The contract allows for overhead and profit to be included in CO expenses (not to exceed thirty-percent). The FI itemizes the actual costs, overhead, and profit on the invoices submitted to the Department.
3. Takeover costs are not paid with Local Assistance funds.
4. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
5. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
IT Infrastructure Services	\$2,000,000	\$500,000	\$1,500,000
IT Development & Operations Services			
File Maintenance	\$1,017,000	\$254,000	\$763,000
Liaison	\$613,000	\$153,000	\$460,000
State Level Registry Application	\$737,000	\$184,000	\$553,000
ATG, Cognos, MS ProjAdmin, and Time Control	\$596,000	\$149,000	\$447,000
Security	\$2,455,000	\$614,000	\$1,841,000
Test Management and M&O Testing	\$1,337,000	\$335,000	\$1,002,000
SDN Hourly Testing	\$2,483,000	\$621,000	\$1,862,000
Change Order Allocation	\$5,370,000	\$1,342,000	\$4,028,000
Total:	\$16,608,000	\$4,152,000	\$12,456,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 59
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2118

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$15,593,000
STATE FUNDS	\$0	\$3,898,250
FEDERAL FUNDS	\$0	\$11,694,750

DESCRIPTION

Purpose:

This policy change estimates the cost of Medical Fiscal Intermediary (FI) contract Information Technology (IT) Infrastructure Services.

Authority:

Contract # 18-95302

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the FI IT Maintenance and Operations (IT M&O) contract is October 2019. The FI contract term is five years with two one-year optional extensions.

IT Infrastructure Services of the Medical FI IT Maintenance and Operations contract are performed and paid under a fixed price where the FI provides a set cost per contract year for the services provided under that portion of the contract. IT Infrastructure Services include the following services:

- Mainframe Data Center Operations Services
- Midrange Data Center Operations Services
- Midrange Storage Operations Services
- Managed Network Services
- Disaster Recovery
- Service Delivery Management, Asset Management, and Facilities
- Fixed Security Services
- Hardware and Refresh
- Software

Reason for Change:

This is a new policy change.

Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. Takeover costs are not paid with Local Assistance funds.

MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 59

3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Mainframe Data Center Operations Services	\$2,594,000	\$648,000	\$1,946,000
Midrange Data Center Operations Services	\$1,699,000	\$425,000	\$1,274,000
Midrange Storage Operations Services	\$124,000	\$31,000	\$93,000
Managed Network Services	\$1,916,000	\$479,000	\$1,437,000
Disaster Recovery	\$983,000	\$245,000	\$738,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$3,470,000	\$868,000	\$2,602,000
Fixed Security Services	\$1,335,000	\$334,000	\$1,001,000
Hardware and Refresh	\$303,000	\$76,000	\$227,000
Software	\$3,169,000	\$792,000	\$2,377,000
Total:	\$15,593,000	\$3,898,000	\$11,695,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2115

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$12,300,000
STATE FUNDS	\$0	\$3,127,700
FEDERAL FUNDS	\$0	\$9,172,300

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Medical Fiscal Intermediary (FI) contracts.

Authority:

Contract # 16-93438

Contract # 18-95302

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FIs to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations and Information Technology Maintenance and Operations (IT M&O) contracts is October 2019. The FI Business Operations contract term is five years with five one-year optional extensions. The IT M&O contract term is five years with two one-year optional extensions.

Various costs incurred by the contractor while performing responsibilities under the contract are reimbursed by the Department using a Cost Reimbursement, or Direct Cost, pricing methodology. These costs are not a part of the bid price of the contract and are paid dollar for dollar, with no overhead or profit included. Any of the following costs may be cost reimbursed under the contract:

- Postage
 - Postal rates utilized to mail documents to providers, beneficiaries, the State, the federal government, or any other Medi-Cal or State program-related business. Return envelope postage is also reimbursable.
- Parcel Services and Common Carriers
 - The actual charges paid for parcel services and common carriers for the delivery of: Medi-Cal and other health program claim and Treatment Authorization Request (TAR) forms to providers; and documents, materials, and equipment to providers, beneficiaries, and State or federal offices.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Equipment and Services
 - Personal Computers, Monitors, Printers, Related Equipment, and Software – The installation and monthly charges for data lines; and the purchase, lease, installation, and maintenance of desktops for State staff at Field Offices and Contractor facilities, or at the Direction of the Contracting Officer and Point-of-Sale (POS) devices.
- Facilities Improvement and Modifications
 - The direct costs for modifications and improvements to facilities, for the purposes of housing State or federal on-site audit and monitoring staff.
- Consultant Contracts
 - Consultant contracts utilized for operational project oversight that are paid through Cost Reimbursement.
- Telecommunications and Data Center
 - Telephone Toll Charges – Actual telecommunication charges paid for by the contractor for maintaining toll-free lines available to providers and beneficiaries, telephone lines for audio text equipment, computer media claims, TAR submissions, the print and distribution center, on-line pharmacy claims processing and on-line eligibility verification, and any other beneficiary or provider use lines. Excludes all other direct or indirect costs associated with telephone toll charges.
 - Data Center Access – Actual charges incurred by the contractor for access to records contained in the Medi-Cal Eligibility Data System and the utilization of the telecommunications network, as charged by the Department of Technology Services Data Center.
- Other Cost Reimbursable Items
 - Equipment and furniture for the Field Office Automation Group (FOAG).
 - The Department has established a rate policy which applies to the contract and defines lodging, mileage, and meal expense reimbursement for travel expenses.
 - Drug Use Review (DUR) work performed on behalf of the Department to provide DUR research, articles for DUR publication, attend conferences, and submit monthly/quarterly reports.
 - Special Training which falls outside the required training scope, as defined by the contract, and directly relates to California Medicaid Management Information System (CA-MMIS) support activities.
- Sales Tax
 - The Department will reimburse the contractor only for the actual sales and/or use tax paid by the Contractor to the California Board of Equalization for the operations of this contract.
- Audits and Research
 - Annual audits for the Electronic Data Processing Application System shall be cost reimbursed for the direct cost of the audit as paid to the independent auditor by the contractor, excluding procurement costs or effort expended by the contractor.

MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

- Change Order and/or Amendments
 - Certain costs associated with Contract Change Orders/Amendments can be paid through Cost Reimbursement.

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Reason for Change:

This is a new policy change.

Methodology:

1. Costs for Audits and Research and Change Orders are not estimated to occur in FY 2019-20.
2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Contract costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Postage (50% FF/50% GF)	\$932,000	\$466,000	\$466,000
Parcel Services & Common Carriers (50% FF/50% GF)	\$46,000	\$23,000	\$23,000
Equipment & Services (75% FF/25% GF)	\$2,237,000	\$559,000	\$1,678,000
Facilities Improvement & Modification (50% FF/50% GF)	\$324,000	\$162,000	\$162,000
Consultant Contracts (50% FF/50% GF, 75% FF/25% GF, 90% FF/10% GF)	\$3,647,000	\$893,000	\$2,754,000
Telecommunications & Data Center (75% FF/25% GF)	\$785,000	\$196,000	\$589,000
Other Cost Reimbursable Items (50% FF/50% GF, 90% FF/10% GF)	\$2,275,000	\$315,000	\$1,960,000
Sales Tax (75% FF/25% GF)	\$2,054,000	\$514,000	\$1,540,000
Total:	\$12,300,000	\$3,128,000	\$9,172,000

Funding:

FI 50% Title XIX/ 50% GF (4260-101-0001/0890)
 FI 75% Title XIX/ 25% GF (4260-101-0001/0890)
 FI 90% Title XIX/ 10% GF (4260-101-0001/0890)
 FI 50% HIPAA FF/ 50% GF (4260-117-0001/0890)
 FI 75% HIPAA FF/ 25% GF (4260-117-0001/0890)
 FI 90% HIPAA FF/ 10% GF (4260-117-0001/0890)

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 61
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2112

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$0	\$10,890,000
STATE FUNDS	\$0	\$3,174,250
FEDERAL FUNDS	\$0	\$7,715,750

DESCRIPTION

Purpose:

This policy change estimates the other estimated costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 16-93438

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract is October 2019. The FI contract term is five years with five one-year optional extensions.

Some functions and services of the Medical FI contract are performed and paid using a Fixed Price payment methodology. For Fixed Price categories, the Contractor is paid a fixed rate for certain annual services.

Costs under this category consist of payment to the contractor for contract services, such as:

- Process Appeals - The Contractor reviews the appeal documents and the claim history, and either rejects the appeal or approves and resubmits the claim for processing. The Contractor regularly provides information to the providers regarding claim appeal status, denial reasons, and estimated payment dates, as appropriate. All appeal information is recorded in the California Medicaid Management Information System (CA-MMIS) Appeals subsystem.
- Support Audits - The Contractor is required to plan, track, and coordinate audit support tasks, gather data or other information requested for the audit, and obtain all information necessary to present a complete and accurate audit response to the Department for review and approval.
- Process Drug Rebates – The Contractor processes drug rebates in order to create invoices submitted to manufacturers which generate revenue received by the Department in excess of \$4 billion annually.
- Provide Litigation Support - The Contractor's litigation support includes, but is not limited to, planning, tracking, and coordinating litigation support tasks, developing responses to subpoenas and other legal requests, and providing written and oral testimony on behalf of the Department.

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 61

- Service Delivery Support – The Contractor performs broad management, administrative, and supporting services that apply to the delivery of all Business, IT, and Facilities Services while conforming to standardized process, protocols, templates, and tools as prescribed by the Department.
- Publish Provider Communications – The Contractor assists with the development and distribution of provider communications related to provider billing as well as related processes and procedures. Provider communications take many forms, such as bulletins targeted to the different provider types, forms, public content forums, Provider Manual changes, Medi-Cal website content, provider letters, news articles, system alerts, user guides, technical documents, and education and training opportunities.
- Conduct Provider Outreach and Education – The Contractor conducts centralized and regional provider outreach and education activities, and provides on-site support resources and specialists focused on small providers, and out-of-state providers to address specific provider issues.
- Print and Mail Medi-Cal Information - The Department requires the Contractor to print and mail information of any type, as approved by the Department, to audiences, identified by the Department, on a scheduled and ad hoc basis. The Contractor is also required to create, update, and manage forms, including developing and maintaining a Master Index of Forms. The Contractor prints 1099s, Departmental standard forms, ad hoc forms as requested, and reports monthly regarding these activities.
- Perform Proactive Provider Research - The Contractor conducts research and reviews provider customer services data from multiple sources to identify trends, systemic issues, needs, and concerns. The findings lead to recommendations for development of provider communication materials, provider educational materials, policy changes, and process and procedural improvements for review by the Department. The Contractor prepares position papers, problem statements, and reports for review and approval by the Department prior to taking any action. The Contractor also develops and submits content changes directly to Outreach and Training teams for inclusion in ongoing services.

Reason for Change:

This is a new policy change.

Methodology:

1. Other Estimated Costs are paid using Fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.
2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Costs are shared between Federal Funds (FF) and General Funds (GF).

MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 61

FY 2019-20	TF	GF	FF
Process Appeals (75% FF/25% GF)	\$374,000	\$94,000	\$280,000
Support Audits (75% FF/25% GF)	\$80,000	\$20,000	\$60,000
Process Drug Rebates (75% FF/25% GF)	\$566,000	\$141,000	\$425,000
Provide Litigation Support (75% FF/25% GF)	\$82,000	\$21,000	\$61,000
Service Delivery Support (75% FF/25% GF)	\$4,693,000	\$1,173,000	\$3,520,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$1,603,000	\$681,000	\$922,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$2,429,000	\$607,000	\$1,822,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$978,000	\$416,000	\$562,000
Perform Proactive Provider Research (75% FF/25% GF)	\$85,000	\$21,000	\$64,000
Total:	\$10,890,000	\$3,174,000	\$7,716,000

Funding:

FI 50% Title XIX / 50% GF (4260-101-001-0890)

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2116

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$8,161,000
STATE FUNDS	\$0	\$2,368,750
FEDERAL FUNDS	\$0	\$5,792,250

DESCRIPTION

Purpose:

This policy change estimates the Telephone Service Center (TSC) costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 16-93438

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract is October 2019. The FI contract term is five years with five one-year optional extensions.

The Telephone Service Center functions and services of the Medical FI contract are paid using a Fixed Price and a Variable Pricing methodology. For Fixed Price categories, the Contractor is paid a fixed rate for certain annual services. Variable Pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable Pricing is also known as "Fixed Plus."

The Telephone Service Center provides telephone and chat services to providers and beneficiaries in three areas. Each TSC service area utilizes telecommunications infrastructure, Customer Relationship Management application(s), and the records repository which are implemented and maintained by the contractor.

- Provider Customer Services (Variable Pricing)
- Member Customer Services (Variable Pricing)
- Financial Services (Fixed Price)

Reason for Change:

This is a new policy change.

MEDICAL FI BO TELEPHONE SERVICE CENTER

OTHER ADMIN. POLICY CHANGE NUMBER: 62

Methodology:

1. TSC costs are paid using Variable price rates based on volumes within a maximum threshold. The contract stipulates an annual fixed price for services up to a specified volume and a per-transaction price for services which exceed that volume.
2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$4,933,000	\$1,432,000	\$3,501,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$2,429,000	\$705,000	\$1,724,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$799,000	\$232,000	\$567,000
Total	\$8,161,000	\$2,369,000	\$5,792,000

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2111

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$7,132,000
STATE FUNDS	\$0	\$1,783,000
FEDERAL FUNDS	\$0	\$5,349,000

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 16-93438

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require an FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract is October 2019. The Business Operations FI contract term is five years with five one-year optional extensions.

The Operations functions and services of the Medical FI contract are paid using a Variable Pricing methodology. The Variable Pricing methodology is based on estimated volume-driven metrics and account for increases in actual volumes. The costs are calculated using a fixed annual rate for transactions up to a State-specified volume and a per-transaction rate for transactions which exceed that volume. Variable Pricing is also known as "Fixed Plus."

Operations constitute contractual responsibilities required for the contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of:

- Process Paper Claims – The Contractor is responsible for the manual entry of claim data into the CA-MMIS Claims system for adjudication, when those claims are received on paper (mail or fax), rather than electronically.
- Process Suspended Claims - The Contractor uses CA-MMIS subsystems and applications to manually adjudicate suspended claims and address suspended claims issues, in accordance with program policy, system validations, established rates, and State and Federal statutes and regulations.
- Manage Records - The Contractor is required to provide a comprehensive Manage Records service that results in preservation, protection and maintenance of all official Medi-Cal records according to State, Federal, Contractual, or program requirements. The Contractor acts as "Custodian of Records" for the Medi-Cal program, including certifying record authenticity, managing

MEDICAL FI BUSINESS OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 63

electronic access to records, performing manual research and record retrieval, and producing “acceptable copies.”

- Process Member Card Request – The Contractor is responsible for the production and distribution of Benefit Identification Cards to Medi-Cal members, and Health Access Program cards to public health providers.
- Process Paper Treatment Authorization Request (TAR) – The Contractor is responsible for the entering of TAR data into the TAR system for review and/or adjudication of TARs and TAR Appeals, including the scanning of paper TARs and attachments so that an official record is stored and made available for further use by TAR adjudicators in the Records Repository.

The FI has provided State-specified volumes for each of the above categories. The Department estimates operations costs by applying the rates established by the contract to the projected volumes for the current and budget year.

Reason for Change:

This is a new policy change.

Methodology:

1. Operation costs are paid using Fixed Plus pricing methodology with a rate for an annual volume threshold and a rate for each transaction which exceeds that threshold.
2. Projected volumes are established by the Department using trends and counts from previous years and the FI rate established by the contract is applied to the respective volume.
3. Takeover costs are not paid with Local Assistance funds.
4. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
5. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Process Paper Claims	\$3,932,000	\$983,000	\$2,949,000
Process Suspended Claims	\$1,563,000	\$391,000	\$1,172,000
Manage Records	\$625,000	\$156,000	\$469,000
Process Member Card Requests	\$836,000	\$209,000	\$627,000
Process Paper TAR	\$176,000	\$44,000	\$132,000
Total:	\$7,132,000	\$1,783,000	\$5,349,000

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2113

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$0	\$6,681,000
STATE FUNDS	\$0	\$1,670,250
FEDERAL FUNDS	\$0	\$5,010,750

DESCRIPTION

Purpose:

This policy change estimates the hourly reimbursement costs of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 16-93438

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract is October 2019. The FI contract term is five years with five one-year optional extensions.

Under the Medi-Cal FI contract, certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed items under the contract consist of Medical Review Services and Service Changes.

- Medical Review Services - The Contractor provides drug utilization review, Formulary File analysis, medical review consultation, and Treatment Authorization Request (TAR) adjudication. An outcome of the Contractor's Medical Review Services is a reduction in excessive treatment and expense while remaining fully compliant with State and Federal requirements and Medi-Cal policy.
- Service Changes - The collection of activities performed by the Contractor's Business Services staff to ensure any changes to the California Medicaid Management Information System (CA-MMIS) Business Services either improve the efficiency of, and/or minimize the disruption to, related services.

Reason for Change:

This is a new policy change.

Methodology:

1. Hourly costs are paid using hourly rates which vary depending on the service being performed and the expertise required.

MEDICAL FI BO HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 64

2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Perform Medical Review Services	\$4,933,000	\$1,233,000	\$3,700,000
Service Changes (formerly Systems Group)	\$1,748,000	\$437,000	\$1,311,000
Total:	\$6,681,000	\$1,670,000	\$5,011,000

Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 11/2019
 ANALYST: Erica Smith
 FISCAL REFERENCE NUMBER: 2114

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$5,100,000
STATE FUNDS	\$0	\$1,352,250
FEDERAL FUNDS	\$0	\$3,747,750

DESCRIPTION

Purpose:

This policy change estimates the cost of miscellaneous expenses of the Medical Fiscal Intermediary (FI) contract.

Authority:

Contract # 16-93438

Interagency Agreement (IA) # 18-95321, 18-85091, 16-93264, and 18-95090

Interdependent Policy Changes:

Not Applicable

Background:

The FI contracts require the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal beneficiaries. The Assumption of Operations for the Business Operations FI contract is October 2019. The FI contract term is five years with five one-year optional extensions.

Under the Medi-Cal FI contract, services classified as Miscellaneous Expenses are paid using a Fixed pricing methodology and include Interagency Agreements, Optional Contract Services (OCS), and Facilities provisioning.

Pursuant to an interagency agreement with the Department, the California State Controller's Office (SCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption. SCO also provides the Department various administrative and project activities as they relate to the electronic claims process for the Health Enterprise (HE) system.

Pursuant to an interagency agreement with the California Department of Consumer Affairs (CDCA), Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

OCS are contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the California Medicaid Management Information System (CA-MMIS) performance. Unlike regular operations activities, OCS are not always part of the FI budget. Costs in this category are due to the contractor proposing an OCS and the Department approving the OCS.

MEDICAL FI BO MISCELLANEOUS EXPENSES

OTHER ADMIN. POLICY CHANGE NUMBER: 65

The FI is required to provide and manage the Medi-Cal Operations Center (MOC) where the Department and Contractors supporting the Medi-Cal program can be co-located with adequate security to ensure protection of the sensitive information and data consumed and produced by the program.

Reason for Change:

This is a new policy change.

Methodology:

1. Miscellaneous costs are paid using Fixed pricing methodology. The contract stipulates an annual rate for each of the services defined above.
2. Takeover costs are not paid with Local Assistance funds.
3. The costs for FY 2019-20 are for six months of FI services which accounts for the contract effective date, payments beginning November 2019, and the shifting of costs incurred at the end of FY 2019-20 to FY 2020-21.
4. Costs are shared between Federal Funds (FF) and General Funds (GF).

FY 2019-20	TF	GF	FF
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$1,700,000	\$502,000	\$1,198,000
Facilities Services (75% FF/25% GF)	\$3,400,000	\$850,000	\$2,550,000
Total:	\$5,100,000	\$1,352,000	\$3,748,000

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 11/2018
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 2051

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$27,935,000	\$40,873,000
STATE FUNDS	\$13,436,640	\$19,836,340
FEDERAL FUNDS	\$14,498,360	\$21,036,660

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Health Care Options (HCO) program for the #17-94437 contract with Maximus.

Authority:

HCO Contract #17-94437

Interdependent Policy Changes:

Not Applicable

Background:

The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries with two Dental Managed Care plan models; one in Sacramento County where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Operations for the contractor are based on a fixed price bid.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase because FY 2019-20 is for a full year of costs.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract. These are based on agreed-upon contracted bid rates in the new contract.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$6,574	\$3,123	\$3,122	\$39	\$290
Packet Mailings	\$4,441	\$2,109	\$2,110	\$27	\$195
BDA/Call Center	\$16,920	\$8,037	\$8,037	\$102	\$744
Total	\$27,935	\$13,269	\$13,269	\$168	\$1,229

HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 66

(Dollars in Thousands)

FY 2019-20	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Transactions	\$8,744	\$4,153	\$4,153	\$90	\$348
Packet Mailings	\$6,879	\$3,268	\$3,268	\$71	\$272
BDA/Call Center	\$25,250	\$11,994	\$11,994	\$260	\$1,002
Total	\$40,873	\$19,415	\$19,415	\$421	\$1,622

Funding:

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

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

FI 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 11/2018
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 2052

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$27,040,000	\$40,619,000
STATE FUNDS	\$13,006,240	\$19,712,860
FEDERAL FUNDS	\$14,033,760	\$20,906,140

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:

HCO Contract #17-94437

Background:

The enrollment broker contract for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contractor assumed operations on October 1, 2018. Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase because FY 2019-20 is for a full year of costs.

Methodology:

- Contract costs are shared between federal funds (FF) and General Fund (GF).

(Dollars in Thousands)

	TF	GF	FF	GF	FF
(FY 2018-19)		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$13,734	\$6,524	\$6,523	\$82	\$605
Printing	\$4,041	\$1,919	\$1,920	\$24	\$178
Materials Maintenance and Development	\$3,357	\$1,595	\$1,594	\$20	\$148
Mass Mailings	\$1,064	\$505	\$506	\$6	\$47
Other Cost. Reimb.	\$1,342	\$638	\$638	\$9	\$57
Additional Systems Group Staff	\$2,891	\$1,373	\$1,373	\$17	\$128
Miscellaneous	\$611	\$290	\$290	\$4	\$27
Total	\$27,040	\$12,844	\$12,844	\$162	\$1,190

HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 67

(Dollars in Thousands)

	TF	GF	FF	GF	FF
(FY 2019-20)		Title XIX	Title XIX	Enhanced Title XXI	Enhanced Title XXI
Postage	\$20,630	\$9,799	\$9,799	\$213	\$819
Printing	\$6,070	\$2,883	\$2,883	\$63	\$241
Materials Maintenance and Development	\$5,043	\$2,395	\$2,395	\$52	\$201
Mass Mailings	\$1,599	\$759	\$759	\$17	\$64
Other Cost. Reimb.	\$2,016	\$958	\$958	\$21	\$79
Additional Systems Group Staff	\$4,343	\$2,063	\$2,063	\$45	\$172
Miscellaneous	\$918	\$437	\$437	\$9	\$35
Total	\$40,619	\$19,294	\$19,294	\$420	\$1,611

Funding:

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

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

FY 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 68
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1858

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$13,582,000	\$0
STATE FUNDS	\$6,532,220	\$0
FEDERAL FUNDS	\$7,049,780	\$0

DESCRIPTION

Purpose:

This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program.

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with MAXIMUS, Inc. ended on September 30, 2018, and a new contractor assumed operations October 1, 2018.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with MAXIMUS, Inc. ended September 30, 2018.

Methodology:

1. Contract costs are shared between federal funds (FF) and General Fund (GF).
2. Printing and postage reflect net savings resulting from Personalized Provider Directories (PPD) in the PPD counties of Sacramento and Los Angeles, in lieu of costs for mailing full county-wide provider directories.

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 68

(Dollars in Thousands)

	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
FY 2018-19		(50%)	(50%)	(12%)	(88%)
Postage	\$6,867	\$3,262	\$3,262	\$41	\$302
Printing	\$2,021	\$960	\$960	\$12	\$89
Other HCO Informing Materials	\$1,678	\$797	\$797	\$10	\$74
Customer Assistance Telephone	\$532	\$252	\$253	\$3	\$24
Miscellaneous	\$306	\$145	\$146	\$2	\$13
Additional Systems Group Staff	\$1,446	\$687	\$687	\$9	\$63
Other Cost Reimb.	\$518	\$246	\$245	\$2	\$25
Temporary Staff	\$214	\$101	\$101	\$1	\$11
Total	\$13,582	\$6,450	\$6,451	\$80	\$601

Funding:

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

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69
 IMPLEMENTATION DATE: 11/2018
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 2053

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$9,304,000	\$13,259,000
STATE FUNDS	\$4,475,300	\$6,434,720
FEDERAL FUNDS	\$4,828,700	\$6,824,280

DESCRIPTION

Purpose:

This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program under the #17-94437 contract with Maximus.

Authority:

HCO contract # 17-94437

Interdependent Policy Changes:

Not Applicable

Background:

The enrollment broker contractor for the HCO program is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. The broker also enrolls beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. Assumption of operations for the new contractor began October 1, 2018. An important goal of the HCO program is to provide every Medi-Cal applicant/beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase because FY 2019-20 is for a full year of costs.

Methodology:

1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.
2. The estimated costs for FY 2018-19 and FY 2019-20 are based on 200 ESRs per year.

HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 69

(Dollars in thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$8,839	\$4,419	\$4,420
Title XXI (88% FF / 12% GF)	\$465	\$56	\$409
Total	\$9,304	\$4,475	\$4,829

(Dollars in thousands)

FY 2019-20	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$12,596	\$6,298	\$6,298
Title XXI (88% FF / 12% GF)	\$166	\$20	\$146
Title XXI (76.5% FF / 23.5% GF)	\$497	\$117	\$380
Total	\$13,259	\$6,435	\$6,824

Funding:

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

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

FI 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1856

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$9,103,000	\$0
STATE FUNDS	\$4,379,360	\$0
FEDERAL FUNDS	\$4,723,640	\$0

DESCRIPTION

Purpose:

This policy change estimates the operational costs of the Health Care Options (HCO) program.

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with MAXIMUS, Inc. ended on September 30, 2018, and a new contractor assumed operations October 1, 2018.

Operations for the HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with operations having ended September 30, 2018, and takeover extending through December 31, 2018, including a 12-month turnover period. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) (50/50 for Administration; and 65/35 or 88/12 for Medicaid Expansion Children's Health Insurance Program).

Operational costs are the routine expenses incurred by HCO's operations such as:

- Transactions – Enrollment or disenrollment processing activities and transactions with the Department.
- Mailings – Mailings include initial informing, re-informing, monthly reconciliation, and annual re-notification mailings.
- Beneficiary Dental Exception (BDE) Mailings – Mailings to dental beneficiaries in Sacramento County for exception to plan enrollment.
- Beneficiary Direct Assistance/Call Center – Telephone Call Center (TCC) agent informing and enrollment assistance to Medi-Cal applicants/beneficiaries and/or their authorized representatives in understanding, selecting, and using managed care medical and dental plans. In addition, the TCC assists providers, health plans, and counties or other interested parties who request information regarding the HCO program and/or Medi-Cal managed care.
- Personalized Provider Directory (PPD) Project– Fixed price costs for the PPD Project.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 70

- Seniors and Persons with Disabilities (SPD) County Inserts – Incremental Costs – Special inserts for SPD informing packets.
- Medi-Cal Publications Management Services – Publication management services for the development, revision, reproduction, and distribution of Medi-Cal publications that do not pertain to HCO informing materials.
- Initial Health Screen Questionnaire - Health Information Form (HIF) - The purpose of the HIF is to ensure applicants/beneficiaries with existing disabilities or with chronic conditions identify themselves to assure timely access to care. The HIFs are distributed and processed to be mailed with the HCO informing packet and are also available at Enrollment Service Representatives presentation sites.
- Base Volume Increase Projection - The estimated cost for the entire infrastructure necessary for HCO Operations for occurrences when current base contract volumes are exceeded from additional and new projects.
- Prior Year Unpaid Invoices - Prior year unpaid invoices will be accrued and paid in the following fiscal year.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with MAXIMUS, Inc. ended September 30, 2018.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract.

(Dollars in Thousands)

FY 2018-19	TF	GF	FF	GF	FF
		Title XIX	Title XIX	Enhanced XXI	Enhanced XXI
		50%	50%	12%	88%
Transactions	\$3,750	\$1,781	\$1,782	\$22	\$165
Packet Mailings	\$2,998	\$1,424	\$1,424	\$18	\$132
BDE Packet Mailings	\$61	\$29	\$29	\$0	\$3
BDA/Call Center	\$1,789	\$850	\$850	\$11	\$78
PPD	\$283	\$135	\$134	\$2	\$12
SPD Inserts	\$22	\$11	\$11	\$0	\$0
Medi-Cal Publications	\$139	\$66	\$66	\$1	\$6
HIF	\$61	\$29	\$29	\$0	\$3
Total	\$9,103	\$4,325	\$4,325	\$54	\$399

Funding:

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

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2015
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1864

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$5,638,000	\$0
STATE FUNDS	\$2,711,840	\$0
FEDERAL FUNDS	\$2,926,160	\$0

DESCRIPTION

Purpose:

This policy change estimates the costs for additional resources for the Health Care Options (HCO) program to provide informing and enrollment assistance to beneficiaries eligible for Medi-Cal.

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries in two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with MAXIMUS, Inc. ended on September 30, 2018, and a new contractor assumed operations October 1, 2018.

The enrollment contractor required additional resources in its telephone call center to adequately and effectively provide informing and enrollment assistance functions to the increasing numbers of Medi-Cal beneficiaries for the following changes:

- Effective January 1, 2014, the ACA established a new income eligibility standard for Medi-Cal, based upon a Modified Adjusted Gross Income of 133% of the federal poverty level for adults.
- Senate Bill 75 (Statutes of 2015) established eligibility for full scope Medi-Cal benefits for undocumented children under 19 years of age (immigration reform project).

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with MAXIMUS, Inc. ended September 30, 2018.

Methodology:

1. Costs are negotiated per agent/person costs through a contract amendment.
2. Contract costs are shared between federal funds (FF) and General Fund (GF).

HCO - ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 71

	FY 2018-19
Telephone Call Center (TCC) Enrollment Operations	\$486,000
System Group Staff	\$5,152,000
Total	\$5,638,000

(Dollars in Thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$5,356	\$2,678	\$2,678
Enhanced Title XXI (88% FF / 12% GF)	\$282	\$34	\$248
Total	\$5,638	\$2,712	\$2,926

Funding:

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

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO TAKEOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 10/2017
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1994

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$5,231,000	\$0
STATE FUNDS	\$2,615,500	\$0
FEDERAL FUNDS	\$2,615,500	\$0

DESCRIPTION

Purpose:

This policy change estimates the takeover costs of the Health Care Options (HCO) program.

Authority:

HCO Contract #17-94437

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary.

Operations for the HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with operations having ended September 30, 2018, and takeover extending through December 31, 2018, including a 12-month turnover period. Funds paid on the contract use a mixture of Federal Funds (FF) and General Funds (GF) 50/50 for Administration.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to all takeover payments completing in FY 2018-19.

Methodology:

1. Costs are based on a fixed price bid.
2. Contract costs are shared between Federal Funds and General Funds.
3. Costs for FY 2018-19 are \$5,231,000 TF (\$2,616,000 GF)

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 7/2014
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1857

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$4,824,000	\$0
STATE FUNDS	\$2,320,420	\$0
FEDERAL FUNDS	\$2,503,580	\$0

DESCRIPTION

Purpose:

This policy change estimates the Enrollment Services Representative's (ESRs) hourly reimbursement for the Health Care Options (HCO) program.

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for HCO since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with MAXIMUS, Inc. ended on September 30, 2018, and a new contractor assumed operations October 1, 2018.

An important goal of the HCO program is to provide every Medi-Cal applicant/ beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with MAXIMUS, Inc. ended September 30, 2018.

Methodology:

1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at county offices statewide.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 73

2. The estimated costs for FY 2018-19 are based on 155 ESRs per year.

(Dollars in thousands)

FY 2018-19	TF	GF	FF
Title XIX (50% FF / 50% GF)	\$4,583	\$2,291	\$2,292
Title XXI (88% FF / 12% GF)	\$241	\$29	\$212
Total	\$4,824	\$2,320	\$2,504

Funding:

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

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 7/2014
ANALYST: Shannon Hoerner
FISCAL REFERENCE NUMBER: 1860

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$4,816,000	\$0
STATE FUNDS	\$2,408,000	\$0
FEDERAL FUNDS	\$2,408,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the costs for the specialized call center and informing materials to transition dually eligible and Medi-Cal only beneficiaries into managed care health plans under the Coordinated Care Initiative (CCI).

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for the Health Care Options (HCO) program since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models including Two Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary. The contract with MAXIMUS, Inc. ended on September 30, 2018, and a new contractor assumed operations October 1, 2018.

The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care institutional services, In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services Program, and other Home and Community-Based Services from fee-for-service into managed care health plans. Notices and packets were mailed to beneficiaries.

In addition, to ensure a seamless enrollment selection process for beneficiaries impacted by the CCI programs, costs have been included for a beneficiary-centric specialized call center and specialized informing materials. The beneficiaries covered under this project have a dedicated toll free number, which directs them to their own specialized team of CCI experts who guide them through the enrollment process and are able to answer all the Medi-Cal and Medicare questions.

The Governor's Budget estimate of the 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 has been removed from capitation rate payments effective January 1, 2018.

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 74

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is because the contract with MAXIMUS, Inc. ended September 30, 2018.

Methodology:

1. Costs include informing materials development and mailing, CCI telephone call center staffing and equipment, and translations of informing materials into Braille and audio formats.
2. The FY 2018-19 costs are below:

	FY 2018-19
Printing/Postage	\$2,033,000
Equipment/Non-Equipment	\$783,000
Staffing	\$2,000,000
Total	\$4,816,000

3. Costs are shared between federal funds (FF) and General Fund (GF).

	TF	GF	FF
FY 2018-19	\$4,816,000	\$2,408,000	\$2,408,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO TURNOVER

OTHER ADMIN. POLICY CHANGE NUMBER: 75
 IMPLEMENTATION DATE: 11/2017
 ANALYST: Shannon Hoerner
 FISCAL REFERENCE NUMBER: 1993

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,436,000	\$0
STATE FUNDS	\$718,000	\$0
FEDERAL FUNDS	\$718,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the turnover costs of the Health Care Options (HCO) program.

Authority:

HCO contract # 07-65829

Interdependent Policy Changes:

Not Applicable

Background:

MAXIMUS, Inc. had been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. was responsible for enrolling Medi-Cal beneficiaries into managed care health plans within three Medi-Cal managed care health plan models, including Two-Plan, Regional, and Geographic Managed Care. MAXIMUS, Inc. also enrolled beneficiaries into two Dental Managed Care plan models; one in Sacramento County, where enrollment is mandatory, and one in Los Angeles County, where enrollment is voluntary.

Operations for the HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months, and six one-year optional extension years, with operations having ended September 30, 2018, with turnover extending through December 31, 2018. Funds paid on this contract use a mixture of Federal Funds (FF) and General Funds (GF) 50/50 for Administration.

Reason for change:

There is no change from the prior estimate for FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to all turnover payments completing in FY 2018-19.

Methodology:

1. Costs are based on a fixed price bid.
2. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
3. Costs for FY 2018-19 are \$1,436,000 TF (\$718,000 GF)

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 76
 IMPLEMENTATION DATE: 3/2018
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2007

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$60,773,000	\$45,742,000
STATE FUNDS	\$21,843,500	\$16,429,000
FEDERAL FUNDS	\$38,929,500	\$29,313,000

DESCRIPTION

Purpose:

This policy change estimates the total cost for reimbursable items and payment for operations for the 2016 Dental Administrative Services Organization (ASO).

Authority:

Contract 16-93287

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental (Delta) was awarded a multi-year contract in 2016. ASO assumption of operations began in February 2018. Delta is responsible for ASO services for the Medi-Cal Dental Program. The administrative costs consist of reimbursement for both operations costs as well as cost reimbursables.

Operations constitute all contractual obligations required for the contractor to administer and operate the ASO. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are to be included in fixed price components. These cost categories consist of:

- Adjudicated Claim Services Lines (ACSL), paid on a per claim line basis and includes claims related to the Dental Transformation Initiative from Federally Qualified Health Centers.
- Treatment Authorization Requests (TAR), paid on a per document basis
- Telephone Service Center (TSC), paid on a per minute basis

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Printing
2. Postage/Parcel Services
3. Data Center Access
4. Toll Free Phone Charges
5. Special Training, Conferences, and Travel
6. Facilities Improvement
7. Audits
8. Independent Contractor Consideration

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 76

- 9. Annual Risk Assessments
- 10. Miscellaneous
- 11. Cost Reimbursement Invoices

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updated projected costs based on actuals and some FY 2017-18 invoices being paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20 in the current estimate is due to updated projected costs based on actuals.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the ASO contract.
2. ACSL and TAR volumes are based on actual invoices with a growth factor. Provider Enrollment activities account for 15% of the total ACSL/TAR costs.
 - a. Provider Enrollment
 - i. 69% of costs are funded at 50% FF and 50% GF
 - ii. 31% of costs are funded at 75% FF and 25% GF
 - b. Remaining costs are funded at 75% FF and 25% GF
3. TSC minutes are based on actual invoices with a growth factor and funded at 50% FF and 50% GF.

FY 2018-19	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$31,746,000	\$7,937,000	\$23,809,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$5,603,000	\$2,367,000	\$3,236,000
Total ACSL/TAR	\$37,349,000	\$10,304,000	\$27,045,000
TSC – Provider (50% FF / 50% GF)	\$7,144,000	\$3,572,000	\$3,572,000
TSC – Beneficiary (50% FF / 50% GF)	\$14,170,000	\$7,085,000	\$7,085,000
Total TSC	\$21,314,000	\$10,657,000	\$10,657,000
Total Operations Costs	\$58,663,000	\$20,961,000	\$37,702,000

FY 2019-20	TF	GF	FF
Administration/Operations (75% FF / 25% GF)	\$23,820,000	\$5,955,000	\$17,865,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,203,000	\$1,776,000	\$2,427,000
Total ACSL/TAR	\$28,023,000	\$7,731,000	\$20,292,000
TSC – Provider (50% FF / 50% GF)	\$5,976,000	\$2,988,000	\$2,988,000
TSC – Beneficiary (50% FF / 50% GF)	\$9,948,000	\$4,974,000	\$4,974,000
Total TSC	\$15,924,000	\$7,962,000	\$7,962,000
Total Operations Costs	\$43,947,000	\$15,693,000	\$28,254,000

*Totals may not add due to rounding

DENTAL ASO ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 76

4. Cost reimbursements are based on actual invoices with a growth factor.

FY 2018-19	TF	GF	FF
Total Cost Reimbursable	\$2,110,000	\$883,000	\$1,227,000

FY 2019-20	TF	GF	FF
Total Cost Reimbursable	\$1,795,000	\$736,000	\$1,059,000

5. Total Administration Cost

	TF	GF	FF
FY 2018-19*	\$60,773,000	\$21,844,000	\$38,929,000
FY 2019-20*	\$45,742,000	\$16,429,000	\$29,313,000

*Note: some slight variations due to rounding

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 77
 IMPLEMENTATION DATE: 11/2017
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2006

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$24,066,000	\$21,358,000
STATE FUNDS	\$6,579,500	\$5,910,250
FEDERAL FUNDS	\$17,486,500	\$15,447,750

DESCRIPTION

Purpose:

This policy change estimates the total cost for operations, cost reimbursable items, and hourly reimbursables for the 2016 Dental Fiscal Intermediary (FI).

Authority:

Contract 16-93286

Interdependent Policy Changes:

Not Applicable

Background:

DXC Technology Services (DXC) was awarded a multi-year contract in 2016. The 2004 Delta Dental FI contract ended operations at the end of January 2018 and DXC assumed operational responsibility immediately thereafter. DXC is responsible for the FI services of the Medi-Cal Dental Program. The administrative costs consist of reimbursement for operations, cost reimbursables, and hourly reimbursable costs.

Operations constitute all contractual responsibilities required for the contractor to administer and operate the FI. Only direct costs of certain operations are eligible for cost reimbursement. All other costs are included in fixed price components. These cost categories consist of a combined document count of claims, including Federally Qualified Health Center (FQHC) claims for the Dental Transformation Initiative program, and Treatment Authorization Requests (TAR), paid on a per document basis.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs. Various costs incurred by the contractor while performing responsibilities under the contract will be reimbursed by the Department. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1. Printing
2. Postage/Parcel Services
3. Data Center Access
4. Special Training, Conferences, Travel
5. Facilities Improvement
6. Audits
7. Independent Contractor Consideration
8. Annual Risk Assessments
9. Miscellaneous

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

10. Cost Reimbursement Invoice

Certain activities are reimbursed on an hourly basis by the Department. The rate paid to the contractor consists of all direct and indirect costs required to support these activities. The hourly reimbursed area consists of the Systems Group (SG).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updated projected costs based on actuals and some FY 2017-18 invoices paid in FY 2018-19. The change from FY 2018-19 to FY 2019-20 in the current estimate is due to updated projected costs based on actuals.

Methodology:

1. Operations costs are fixed price rates based on scanned claim and TAR document volumes within minimum and maximum ranges under the FI contract.
2. Claim and TAR scanned document volumes are based on FY 2017-18 actual document counts and increased by a growth factor.
3. Check write expenditures are associated with the cost of sending payment to providers, based on adjudicated claims from the Dental Administrative Services Organization contractor.

FY 2018-19	TF	GF	FF
Scanned Claims/TAR	\$14,232,000	\$3,558,000	\$10,674,000
Check Write	\$265,000	\$66,000	\$199,000
Total	\$14,497,000	\$3,624,000	\$10,873,000

FY 2019-20	TF	GF	FF
Scanned Claims/TAR	\$11,674,000	\$2,919,000	\$8,755,000
Check Write	\$244,000	\$61,000	\$183,000
Total	\$11,918,000	\$2,980,000	\$8,938,000

4. Cost reimbursements are based on actual invoices with a growth factor.

FY 2018-19	TF	GF	FF
Total	\$2,890,000	\$1,285,000	\$1,605,000

FY 2019-20	TF	GF	FF
Total	\$2,431,000	\$1,178,000	\$1,253,000

5. Hourly Reimbursables:

System Group	TF	GF	FF
FY 2018-19	\$6,679,000	\$1,670,000	\$5,009,000
FY 2019-20	\$7,009,000	\$1,752,000	\$5,257,000

DENTAL FI ADMINISTRATION 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 77

6. Total Administration Cost:

Fiscal Year	TF	GF	FF
FY 2018-19*	\$24,066,000	\$6,579,000	\$17,487,000
FY 2019-20*	\$21,358,000	\$5,910,000	\$15,448,000

*Note: some slight variations due to rounding

Funding:

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL FI TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 78
 IMPLEMENTATION DATE: 8/2017
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2004

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$9,760,000	\$0
STATE FUNDS	\$2,440,000	\$0
FEDERAL FUNDS	\$7,320,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the total cost of Takeover from the previous Fiscal Intermediary (FI), Delta Dental of California (Delta), to the current FI contractor, DXC Technology Services, LLC (DXC).

Authority:

Contract 16-93286

Interdependent Policy Changes:

Not Applicable

Background:

DXC was awarded the multi-year FI contract in 2016. The FI contractor is responsible for all the FI services of the Medi-Cal Dental Program including: operations of the California Dental Medicaid Management Information System (CD-MMIS), claims processing, quality management operations, System Group (SG), and system enhancements. Takeover started from the Contract Effective Date (CED), January 10, 2017, and ended at the end of January 2018.

Takeover constitutes all contractual obligations required for the FI contractor to assume responsibility for the operations of the CD-MMIS. Payment for takeover is on a fixed price basis with the exception of those specific work items paid under Cost Reimbursement and Hourly Reimbursed Systems Group. The Treatment Authorization Request (TAR) documents processed during takeover will be paid at the bid rate for phase one of operations and will be counted in the phase one combined claim and TAR document volume. Takeover payment also includes costs for related expansion items and other work that may occur during takeover, as outlined in the contract.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to invoices budgeted for payment in FY 2017-18 now paying in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to all remaining takeover payments getting paid in FY 2018-19.

Methodology:

1. The price of takeover is \$29,280,000 TF.
2. A total of \$19,520,000 TF was paid in FY 2017-18. The remaining balance of \$9,760,000 will be paid in FY 2018-19.

DENTAL FI TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 78

Fiscal Year	TF	GF	FF
FY 2018-19	\$9,760,000	\$2,440,000	\$7,320,000
FY 2019-20	\$0	\$0	\$0

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 11/2015
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 1890

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$7,152,000	\$0
STATE FUNDS	\$1,788,000	\$0
FEDERAL FUNDS	\$5,364,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of the base California Dental Medicaid Management Information System's (CD-MMIS) turnover services from the previous Dental Fiscal Intermediary (FI), Delta Dental of California (Delta) to the current FI contractor, DXC Technology Services, LLC (DXC) including the cost of the CD-MMIS runout services for the previous Dental FI contractor, Delta.

Authority:

Contract # 04-35745

Interdependent Policy Changes:

Not Applicable

Background:

Delta was awarded a multi-year dental FI contract in 2004. The 2004 FI contract with Delta ended in January 2018, with the new Administrative Services Organization (ASO) and FI contractors assuming operational responsibility beginning February 1, 2018. The dental FI is responsible for FI services related to the Medi-Cal Dental Program.

The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers.

In February 2012, there was an unsuccessful attempt to procure a new dental FI with Delta and they began takeover activities. However, the Centers for Medicare and Medicaid Services (CMS) determined the 2012 FI contract with Delta failed to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the 2004 FI contract for the period of July 1, 2013, through June 30, 2015. The Department instructed the 2004 FI contractor to stop all turnover activities. The 2004 FI contractor filed a Notification of Claim to recoup costs already expended for turnover activities. The Department determined that the 2004 FI contractor should be reimbursed and five (5) out of the nine (9) installments were paid at that time.

The Department has instructed the 2004 FI contractor to resume turnover support services and all activities in accordance with the contract requirements. The turnover period ensures the orderly transfer of the dental FI contract from the 2004 FI contractor, Delta, to the successor contractor, DXC, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation are included in the Office of Medi-Cal Procurement's data library. As a result, the turnover bid price has been renegotiated. The amendment to implement this change was approved by CMS on June 29, 2015.

DENTAL FI CD-MMIS COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 79

The schedule of payments for turnover services to the 2004 FI contractor, Delta, is contractually agreed upon. The turnover bid price is paid in nine installments, four (4) of which still remain to be paid, and one final installment of 50% of the turnover bid price. The final payment is made upon completion of all turnover requirements.

Following the turnover phase of the 2004 FI contract is the runout phase. The runout period ensures the orderly decommissioning of systems and closeout of the 2004 FI contract.

The schedule of payments for runout services to the 2004 FI contractor, Delta, is contractually agreed upon. The runout bid price is paid in seven equal installments, and one final installment of 50% of the runout bid price. The final payment is made upon completion of all runout requirements.

Reason for change:

The change from the prior estimate, for FY 2018-19, is an increase due to the addition of the separate runout bid for the 2004 FI contract. In addition, there is an increase due to a shift of FY 2017-18 payments going into FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to turnover and runout activities concluding and billing expected to be completed by the end of FY 2018-19.

Methodology:

- Costs are based on fixed turnover contract and runout bid prices, adjusted for CCPI as appropriate.
- The total Turnover Bid is \$2,556,600, of which, \$623,300 was paid in the previous year. In FY 2018-19, installment payments totaling \$655,300, as well as, a final payment of \$1,278,300 are expected to be made.
- Costs for runout activities are \$5,218,300.
- On a cash basis, Turnover and Runout Costs will be:

FY 2018-19 Remaining Turnover Installments	\$655,300
FY 2018-19 Final Turnover Payment	\$1,278,300
Turnover Total	\$1,933,600
Runout	\$5,218,300
FY 2018-19 Turnover and Runout Activities Total	\$7,151,900

- Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2018-19	\$7,152,000	\$1,788,000	\$5,364,000
FY 2019-20	\$0	\$0	\$0

*Numbers slightly different due to rounding

Funding:

FI 75% Title XIX FF / 25% GF (4260-101-0001/0890)

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

DENTAL ASO TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 9/2017
 ANALYST: Matt Wong
 FISCAL REFERENCE NUMBER: 2003

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$2,192,000	\$0
STATE FUNDS	\$548,000	\$0
FEDERAL FUNDS	\$1,644,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the total cost of Takeover from the 2004 Fiscal Intermediary, Delta Dental of California (Delta), to the current Administrative Services Organization (ASO) contractor Delta.

Authority:

Contract 16-93287

Interdependent Policy Changes:

Not Applicable

Background:

Delta was awarded the multi-year ASO contract in 2016. The ASO contractor is responsible for duties including claims processing, provider enrollment, and outreach of the Medi-Cal Dental Program. Takeover started from the Contract Effective Date (CED), January 10, 2017, and ended January 2018.

Takeover constitutes all contractual obligations required for the ASO contractor to assume administrative responsibilities. Payment for takeover is on a fixed price basis with the exception of those specific work items paid under fixed price per Treatment Authorization Request (TAR) and Cost Reimbursement. Takeover payment also includes costs for related expansion items and other work that may occur during takeover, as outlined in the contract.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to delayed invoice submission by the ASO contractor which caused invoice payments expected to be paid in FY 2017-18 to be completed in FY 2018-19. The change from FY 2018-19 to FY 2019-20, in the current estimate, is due to completion of Takeover and final payment being issued in FY 2018-19.

Methodology:

1. The price of Takeover is \$4,695,000 based on the revised takeover cost plan.
2. The remaining balance of \$2,192,000 TF is expected to be paid in FY 2018-19.

Fiscal Year	TF	GF	FF
FY 2018-19	\$2,192,000	\$548,000	\$1,644,000
FY 2019-20	\$0	\$0	\$0

DENTAL ASO TAKEOVER 2016 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 80

Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

DENTAL BENEFICIARY OUTREACH & ED PROGRAM - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 4/2016
ANALYST: Matt Wong
FISCAL REFERENCE NUMBER: 1949

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,656,000	\$1,206,000
STATE FUNDS	\$828,000	\$603,000
FEDERAL FUNDS	\$828,000	\$603,000

DESCRIPTION

Purpose:

The policy change estimates the administrative cost of implementing strategies to increase utilization for Medi-Cal dental services for the current Administrative Services Organization (ASO) contractor.

Authority:

Welfare & Institutions Code (WIC) Section 14132.91
 Contract 16-93287

Interdependent Policy Changes:

PC 37 Dental Beneficiary Outreach Efforts

Background:

The Department has identified effective strategies to increase utilization of services as a result of an audit of the Medi-Cal Dental Program. The outreach plan seeks to increase utilization of these services, particularly in counties where utilization levels are lowest.

Under the 2016 contract, the ASO (Delta) has expanded its outreach efforts by securing a subcontractor (RSE) who specializes in marketing and education. RSE began with a beneficiary survey at end of 2017 followed by focused groups in early 2018. This enabled them to identify any gaps or barriers and create marketing strategies that best captured this population's needs, develop innovative marketing approaches, and improve the content of outreach and education materials while containing costs.

The outreach efforts are as follows:

- ▮ Beneficiary websites optimized for access by mobile phone and other devices
- ▮ Care coordination and case management
- ▮ Brochures provided in print and electronic media to a variety of stakeholders
- ▮ Updates to the beneficiary handbook and a beneficiary bulletin
- ▮ Fee-For-Service communications with managed care plans regarding outreach
- ▮ Trainings to local agencies and community organizations
- ▮ Social media campaigns – Smile, California; First Tooth, First Birthday; Year-End Utilization
- ▮ Quarterly mailings with brochures
- ▮ Newly enrolled mailer campaign

Outreach and education will help increase beneficiary awareness about dental benefits and provide assistance in locating a dentist to schedule an appointment.

**DENTAL BENEFICIARY OUTREACH & ED PROGRAM -
ADMIN**
OTHER ADMIN. POLICY CHANGE NUMBER: 81

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to less billable outreach activities outside of the contract with the ASO. The change from FY 2018-19 to FY 2019-20 in the current estimate is a decrease due to invoice timing from services from FY 2017-18 being paid in FY 2018-19.

Methodology:

1. In 2018, the ASO contractor began the new outreach efforts, which involves various individual beneficiary promotions.
2. Only costs above and beyond the contractual outreach obligations included in the contract bid price are budgeted. The cost for the newly enrolled mailer campaign is an estimated \$300,000 per quarter in FY 2018-19. This will continue into FY 2019-20 and a growth factor will be applied to the costs as beneficiary count is expected to increase.
3. The administrative costs for FY 2018-19 and FY 2019-20 will be:

Fiscal Year	TF	GF	FF
FY 2018-19	\$1,656,000	\$828,000	\$828,000
FY 2019-20	\$1,206,000	\$603,000	\$603,000

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 4/1993
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 236

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$361,790,000	\$366,060,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$361,790,000	\$366,060,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP), and IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:

Interagency Agreement (IA) 03-75676
 IA 14-90483
 IA 15-92139
 IA 09-86307 IPO

Interdependent Policy Changes:

Not Applicable

Background:

The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

Reason for Change:

Updated expenditure data was provided by CDSS.

Methodology:

The estimates, on a cash basis, were provided by CDSS.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 82

(Dollars in Thousands)

FY 201819	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$650,420	\$325,210	\$325,210
CMIPS II	\$73,160	\$36,580	\$36,580
Total	\$723,580	\$361,790	\$361,790

FY 201920	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	\$611,360	\$305,680	\$305,680
CMIPS II	\$120,760	\$60,380	\$60,380
Total	\$732,120	\$366,060	\$366,060

Totals may differ due to rounding.

Funding:

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 83
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 233

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$391,657,000	\$291,859,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$391,657,000	\$291,859,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

This policy change reflects the 100% FFP provided to CDSS.

Authority:

Interagency Agreements:

CWS 01-15931
 CWS/CMS 06-55834
 CSBG/APS 01-15931

Interdependent Policy Changes:

Not Applicable

Background:

The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); 4) Adult Protective Services (APS) and; 5) Psychotropic Medications Medical Review.

Reason for Change:

Updated expenditure data received from CDSS.

Methodology:

The estimates, on a cash basis, were provided by CDSS.

(Dollars in Thousands)

FY 2018-19	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$409,500	\$204,750	\$204,750
CWS/CMS	\$8,092	\$4,046	\$4,046
CSBG/APS	\$365,242	\$182,621	\$182,621
Psychotropic	\$480	\$240	\$240
TOTAL	\$783,314	\$391,657	\$391,657

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 83

FY 2019-20	TF	DHCS FFP	CDSS GF/ County Match
CWS	\$315,942	\$157,971	\$157,971
CWS/CMS	\$8,696	\$4,348	\$4,348
CSBG/APS	\$258,600	\$129,300	\$129,300
Psychotropic	\$480	\$240	\$240
TOTAL	\$583,718	\$291,859	\$291,859

*Totals may differ due to rounding.

Funding:

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

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 6/2012
ANALYST: Erica Smith
FISCAL REFERENCE NUMBER: 1679

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$126,756,000	\$148,090,000
STATE FUNDS	\$26,252,330	\$33,042,380
FEDERAL FUNDS	\$100,503,670	\$115,047,620

DESCRIPTION

Purpose:

This policy change estimates the cost for the development, implementation, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This policy change also includes the cost for contractors on the Health Exchange and Medi-Cal Interface (HEMI) project to maintain the electronic interface between the Medi-Cal Eligibility Data System (MEDS) and CalHEERS.

Authority:

Affordable Care Act (ACA) of 2010
 AB 1602 (Chapter 655, Statutes of 2010)
 SB 900 (Chapter 659, Statutes of 2010)
 Interagency Agreement #12-89551
 Contract # 73031236

Interdependent Policy Changes:

Not Applicable

Background:

California established Covered California to provide competitive health care coverage for individuals and small employers. CalHEERS determines an applicant's eligibility for subsidized coverage. In creating this one-stop shop experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person at a county social services agency, by mail, or by telephone. To meet this requirement, the Department and Covered California formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that allows the required one-stop shopping, making health insurance eligibility purchasing easier and more understandable.

The Department is responsible for the coordination, clarification, and implementation of Medi-Cal regulations, policies, and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. The Department also works with the county welfare department consortiums to develop the business rules necessary to implement eligibility policy and maintain the records of beneficiaries in the county eligibility systems and MEDS.

CalHEERS was programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. In order to provide seamless integration with the CalHEERS system, the Department designed and implemented technology solutions for the ongoing maintenance of MEDS.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 84

The ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department also receives enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS. Medi-Cal's associated cost for the one-time development and implementation (D&I) of CalHEERS is 90/10 Federal Financial Participation (FFP) for Title XIX. CalHEERS ongoing maintenance and operations (M&O) cost is 75/25 FFP for Title XIX. The FFP for Title XXI for both D&I and M&O is 88/12 until September 30, 2019 and 76.5/23.5 beginning October 1, 2019 through September 30, 2020. CalHEERS' costs are shared between Covered California and Medi-Cal.

The Department requests its own enhanced federal funding from the Centers for Medicare and Medicaid Services (CMS) for the HEMI project. In November 2017, CMS approved funding through federal fiscal year (FFY) 2019. The Department will submit an IAPDU in October 2018, seeking approval for funding through subsequent fiscal years.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a decrease due to a lower shared cost allocation rate for the Department as it relates to CalHEERS. There is no change to the HEMI portion of the policy change.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to increases in employee compensation and benefits in FY 2019-20 as well as anticipated costs of transition activities to a new system integrator for CalHEERS. There is no change to the HEMI portion of the policy change.

Methodology:

1. Contractors began D&I work in July 2012 with payments beginning in August 2012. M&O started in January 2015.
2. Until September 30, 2018, FY 2018-19 costs were based on the estimated enrollment for shared costs at a rate of 12.14% Covered California and 87.86% to the Department. Costs directly attributable to the Department will be 100% the responsibility of the Department.
3. Effective October 1, 2018, FY 2018-19 and FY 2019-20 costs are based on the estimated enrollment for shared costs at a proposed rate of 12.38% Covered California and 87.62% to the Department. Costs directly attributable to the Department will be 100% the responsibility of the Department.
4. In FY 2018-19 and FY 2019-20, costs incurred are for CalHEERS' D&I and M&O.
The D&I period is eligible for:
 - 86.27% at 90% federal reimbursement
 - 13.73% at 88% federal reimbursement through September 30, 2019, and 76.5% federal reimbursement from October 1, 2019 to September 30, 2020.The M&O period is eligible for:
 - 86.27% at 75% federal reimbursement
 - 13.73% at 88% federal reimbursement through September 30, 2019, and 76.5% federal reimbursement from October 1, 2019 to September 30, 2020.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 84

FY 2018-19			
75% Title XIX FF / 25% GF	\$85,215,000	\$21,304,000	\$63,911,000
88% Title XXI FF / 12% GF	\$16,930,000	\$2,031,000	\$14,899,000
90% Title XIX FF / 10% GF	\$21,161,000	\$2,116,000	\$19,045,000
CalHEERS Subtotal	\$123,306,000	\$25,451,000	\$97,855,000
75% Title XIX FF / 25% GF	\$2,976,000	\$744,000	\$2,232,000
88% Title XXI FF / 12% GF	\$474,000	\$57,000	\$417,000
DHCS EITS Subtotal	\$3,450,000	\$801,000	\$2,649,000
Total	\$126,756,000	\$26,252,000	\$100,504,000

FY 2019-20			
75% Title XIX FF / 25% GF	\$103,629,000	\$25,907,000	\$77,722,000
76.5% Title XXI FF / 23.5% GF	\$15,610,000	\$3,669,000	\$11,941,000
88% Title XXI FF / 12% GF	\$4,249,000	\$510,000	\$3,739,000
90% Title XIX FF / 10% GF	\$21,152,000	\$2,115,000	\$19,037,000
CalHEERS Subtotal	\$144,640,000	\$32,201,000	\$112,439,000
75% Title XIX FF / 25% GF	\$2,976,000	\$744,000	\$2,232,000
76.5% Title XXI FF / 23.5% GF	\$355,000	\$83,000	\$272,000
88% Title XXI FF / 12% GF	\$119,000	\$14,000	\$105,000
DHCS EITS Subtotal	\$3,450,000	\$841,000	\$2,609,000
Total	\$148,090,000	\$33,042,000	\$115,048,000

Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)
88% Title XXI / 12% GF (4260-113-0001/0890)
76.5% Title XXI / 23.5% GF (4260-113-001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/1997
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 243

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$54,998,000	\$58,670,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$54,998,000	\$58,670,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

CDDS administrative costs are comprised of Developmental Centers (DC)/State Operated Community Facility (SOCF) Medi-Cal Administration, Developmental Centers Medi-Cal Eligibility Contract, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

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

Reason for Change:

The change for FY 2018-19, from the prior estimate, is a net increase due to updated expenditure data. Increases are estimated for TCM RC Admin and DC/SOCF Medi-Cal Admin expenditures. Decreases are estimated for HCBS Waiver Admin and NHR Admin expenditures.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a net increase due to a increases in HCBS Waiver Admin and NHR Admin expenditures; and decreases in TCM RC Admin and RC Medicaid Admin expenditures are estimated in FY 2019-20.

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 85

Methodology:

1. CDDS provides the following cash estimates of its administrative cost components:

FY 2018-19		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$5,553,000	\$5,553,000	03-75282/83
	DC/SOCF HIPAA*	\$163,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$525,000	\$525,000	01-15378
3	HCBS Waiver Admin.	\$21,528,000	\$21,528,000	01-15834
4	RC Medicaid Admin.	\$16,132,000	\$5,377,000	03-75734
5	NHR Admin.	\$420,000	\$420,000	03-75285
6	TCM Headquarters Admin.	\$392,000	\$392,000	03-75284
	TCM RC Admin.	\$9,647,000	\$9,647,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$54,998,000	\$43,442,000	

FY 2019-20		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$5,553,000	\$5,553,000	03-75282/83
	DC/SOCF HIPAA*	\$163,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$525,000	\$525,000	01-15378
3	HCBS Waiver Admin.	\$27,219,000	\$27,219,000	01-15834
4	RC Medicaid Admin.	\$15,436,000	\$5,145,000	03-75734
5	NHR Admin.	\$606,000	\$606,000	03-75285
6	TCM Headquarters Admin.	\$393,000	\$393,000	03-75284
	TCM RC Admin.	\$8,137,000	\$8,137,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	Total	\$58,670,000	\$47,578,000	

Funding:

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)*

HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 86
IMPLEMENTATION DATE: 7/1999
ANALYST: Melinda Yegge
FISCAL REFERENCE NUMBER: 246

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$41,379,000	\$41,379,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$41,379,000	\$41,379,000

DESCRIPTION

This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

Authority:

Welfare & Institutions Code, Section 16501.3
 AB 1111 (Chapter 147, Statutes of 1999)
 SB 1013 (Chapter 35, Statutes of 2012)
 SB 238 (Chapter 534, Statutes of 2015)
 SB 319 (Chapter 535, Statutes of 2015)
 AB 97 (Chapter 14, Statutes of 2017)
 Interagency Agreement (IA) 18-95316

Interdependent Policy Change:

Not Applicable

Background:

On January 1, 2010, the Department, in collaboration with CDSS, implemented the following requirements of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access,
- Improve incentives for adoption, and
- Require Title IV-B state and county agencies to develop a plan for ongoing oversight and coordination of health care services for children in foster care.

CDSS and the Department implemented the HCPCFC through the existing Child Health and Disability Prevention (CHDP) program so counties can employ public health nurses to help foster care children access health-related services including the review and monitoring of foster children under treatment with psychotropic medications.

The responsibility for HCPCFC was realigned to the counties in 2011 as part of 2011 Public Safety Realignment. Pursuant to Proposition 30, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or levels of

**HEALTH OVERSIGHT & COORD. FOR FOSTER CARE
CHILDREN**
OTHER ADMIN. POLICY CHANGE NUMBER: 86

service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

1. CDSS provides the annual Local Revenue Fund of \$13,793,000 for FY 2018-19 and FY 2019-20.

(Dollars in Thousands)

Fiscal Year	TF	CDSS GF	DHCS FFP
FY 2018-19	\$55,172	\$13,793	\$41,379
FY 2019-20	\$55,172	\$13,793	\$41,379

Funding:

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

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 87
IMPLEMENTATION DATE: 7/1992
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 234

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$37,556,000	\$37,558,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$37,556,000	\$37,558,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child and Adolescent Health (MCAH) programs.

Authority:

Interagency Agreement 07-65592
 SB 852 (Chapter 25, Statutes of 2014)

Interdependent Policy Changes:

Not Applicable

Background:

The MCAH program administers the following services:

- Conducts outreach to pregnant and parenting adolescents who are potentially eligible for Medi-Cal;
- Assists Medi-Cal eligibles in accessing services;
- Recruits providers for Medi-Cal's Comprehensive Perinatal Services Program (CPSP) and provides technical assistance regarding CPSP enhanced services to Medi-Cal beneficiaries;
- Administers programs that offer prenatal care guidance for a target population, provides case management services, and conducts follow-up to improve access to early obstetrical care services for Medi-Cal eligible pregnant women;
- Administers programs for preventive and primary care services for children and youth; and
- Administers programs for family-centered, community-based, comprehensive health services to children with special health care needs.

The MCAH program includes the following services:

- ▮ Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African-American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants as well as decrease health and social inequities for African-American women and infants. Effective July 1, 2014, SB 852 restored the General Fund for the Black Infant Health Program.
- ▮ Comprehensive Perinatal Services Program (CPSP): Provides a wide range of services to Medi-Cal pregnant women, from conception through 60 days postpartum, and provide case management services and conduct follow-up to improve access to early obstetrical and postpartum care (60-days following the delivery) for Medi-Cal eligible pregnant women.
- ▮ Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant adolescents to address the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 87

parenting adolescents and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon the adolescents' strengths and resources to work toward:

- 1) Improving the health of the pregnant and parenting adolescent;
- 2) Improving graduation rates;
- 3) Reducing repeat pregnancies; and
- 4) Improving linkages and creating networks for pregnant and parenting adolescents.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updated claims data. The change in the current estimate, from FY 2018-19 to FY 2019-20, is a net increase primarily due to a higher estimate for CPSP and PCG in FY 2019-20 based on actual claims data.

Methodology:

1. The Department claims Title XIX federal funds with Certified Public Expenditures (CPE) from local agencies.
2. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2018-19	DHCS FFP	CDPH GF	County Match
BIH	\$4,010	\$2,104	\$1,349
CPSP & PCG	\$32,289	\$0	\$23,705
AFLP	\$1,257	\$0	\$1,015
Total for FY 2018-19	\$37,556	\$2,104	\$26,069

FY 2019-20	DHCS FFP	CDPH GF	County Match
BIH	\$3,680	\$2,011	\$1,199
CPSP & PCG	\$32,713	\$0	\$23,800
AFLP	\$1,165	\$0	\$961
Total for FY 2019-20	\$37,558	\$2,011	\$25,960

Funding:

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 7/2002
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 256

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$28,747,000	\$21,842,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$28,747,000	\$21,842,000

DESCRIPTION**Purpose:**

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:

Interagency Agreements (IA):

IHSS PCSP	03-75676
IHSS Health Related	01-15931
CWS/CMS for Medi-Cal	06-55834
IHSS Plus Option Sec. 1915(j)	09-86307
SAWS	04-35639
Medi-Cal State Hearings	16-93214
Public Inquiry and Response	16-93215
Medicaid Disability Evaluation Services	16-93213

Interdependent Policy Changes:

Not Applicable

Background:

These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Coordinated Care Initiative (CCI) Inter-agency Agreement (IA), and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change:

The change from the prior estimate, FY 2018-19, is a decrease due to updated expenditure data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease due to revised expenditure data provided by CDSS and the shift of costs for Medicaid Disability Evaluation Services from FY 2017-18 to FY 2018-19.

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 88

Methodology:

The following estimates on a cash basis were provided by CDSS.

FY 2018-19	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$14,336,000	\$7,168,000	\$7,168,000
IHSS Health Related	\$50,000	\$25,000	\$25,000
CWS/CMS for Medi-Cal	\$278,000	\$139,000	\$139,000
IHSS Plus Option Sec. 1915(j)	\$3,454,000	\$1,727,000	\$1,727,000
SAWS	\$736,000	\$368,000	\$368,000
Medi-Cal State Hearings	\$21,374,000	\$10,687,000	\$10,687,000
Public Inquiry and Response	\$416,000	\$208,000	\$208,000
Medicaid Disability Evaluation Services	\$16,848,000	\$8,424,000	\$8,424,000
TOTAL	\$57,494,000	\$28,747,000	\$28,747,000
FY 2019-20	TF	DHCS FFP	CDSS GF
IHSS PCSP	\$14,500,000	\$7,250,000	\$7,250,000
IHSS Health Related	\$60,000	\$30,000	\$30,000
CWS/CMS for Medi-Cal	\$284,000	\$142,000	\$142,000
IHSS Plus Option Sec. 1915(j)	\$3,510,000	\$1,755,000	\$1,755,000
SAWS	\$750,000	\$375,000	\$375,000
Medi-Cal State Hearings	\$18,200,000	\$9,100,000	\$9,100,000
Public Inquiry and Response	\$504,000	\$252,000	\$252,000
Medicaid Disability Evaluation Services	\$5,876,000	\$2,938,000	\$2,938,000
TOTAL	\$43,684,000	\$21,842,000	\$21,842,000

*Totals may differ due to rounding.

Funding:

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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 7/2007
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1192

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$14,891,000	\$13,881,000
STATE FUNDS	\$3,395,000	\$3,250,000
FEDERAL FUNDS	\$11,496,000	\$10,631,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for State Operations administrative costs related to services provided to Medi-Cal beneficiaries.

Authority:

Interagency Agreement (IA) 07-65592
 IA 07-65642
 IA 07-65689
 IA 15-92271
 IA 07-65503 A01
 IA 10-10494 A02
 IA 13-20463 A02
 AB 1559 (Chapter 565, Statutes of 2014)
 SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:

PC 149 Quality and Accountability Supplemental Payments

Background:

The Department has existing IAs with CDPH to allow for the provision of Title XIX federal funds as a reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following program support costs:

- Maternal, Child and Adolescent Health (MCAH)
- Office of AIDS
- Childhood Lead Poisoning Prevention Program (CLPP)
- Center for Health Care Quality (CHCQ)
- Skilled Nursing Facilities (SNF)

The MCAH program ensures the provision of statutorily required programs by developing systems to protect and improve the health of women of reproductive age, infants, children, adolescents, and their families through the following programs: Information & Education program, Adolescent Family Life program, and Black Infant Health program.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) waiver. The HIV/AIDS waiver program provides services designed to allow people with HIV or AIDS to remain in their homes, stabilize their health, improve their quality of life, and avoid costly institutional care.

The CLPP program provides public health nurse case management and environmental investigation services with associated administrative activities to lead burdened children who are Medi-Cal beneficiaries and meet the case definition of lead poisoning.

The CHCQ program has the responsibility for regulatory oversight of health facilities, certified nurse assistants (CNAs), home health aides (HHAs), certified hemodialysis technicians (CHTs) and licensed nursing home administrators. The CHCQ contract estimate includes reimbursements for the following programs:

- Provider Certification Unit,
- Registered Nurse Unit,
- Nurse Aide Training and Competency Evaluation Program (NAR/NATCEP),
- Centralized Application Unit, and
- Intermediate Care Facility for the Developmentally Disabled Continuous Nursing Pilot Project Waiver.

Skilled Nursing Facility: SB 853 implemented a quality and accountability supplemental payment program (QASP) for nursing facilities (NF-Bs). The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to more FY 2017-18 claims for CLPP, previously budgeted in FY 2017-18, being paid in FY 2018-19. In addition, SNF administrative costs have decreased.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is a decrease due to more previous year claims budgeted in FY 2018-19 for CLPP, and decreased SNF administrative costs in FY 2019-20.

Methodology:

1. CDPH provides the General Fund match.
2. For Maternal, Child and Adolescent Health, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs. The estimate also includes funding for the Black Infant Health Program.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 89

3. CDPH provided the following estimates.

FY 2018-19 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	\$1,900,000	\$0	\$1,900,000	\$0
Office of AIDS	\$737,000	\$0	\$737,000	\$0
CLPP	\$3,077,000	\$0	\$0	\$3,077,000
CHCQ	\$2,387,000	\$0	\$0	\$2,387,000
Skilled Nursing Facilities	\$3,395,000	\$3,395,000	\$0	\$0
Total	\$11,496,000	\$3,395,000	\$2,637,000	\$5,464,000

FY 2019-20 (Cash Basis)	DHCS FFP*	DHCS SF**	CDPH GF	Other Match
MCAH	\$1,900,000	\$0	\$1,900,000	\$0
Office of AIDS	\$737,000	\$0	\$737,000	\$0
CLPP	\$2,357,000	\$0	\$0	\$2,357,000
CHCQ	\$2,387,000	\$0	\$0	\$2,387,000
Skilled Nursing Facilities	\$3,250,000	\$3,250,000	\$0	\$0
Total	\$10,631,000	\$3,250,000	\$2,637,000	\$4,744,000

Funding:

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

SNF Quality & Accountability (non-GF) (4260-605-3167)**

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 90
IMPLEMENTATION DATE: 7/1997
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 239

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$6,536,000	\$4,200,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$6,536,000	\$4,200,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:

Interagency Agreement 07-65689

Interdependent Policy Changes:

Not Applicable

Background:

The CLPP Program provides services to the community for the purpose of increasing awareness regarding the hazards of lead exposure, reducing lead exposure, and increasing the number of children assessed and appropriately blood tested for lead poisoning as defined by the Medi-Cal State Plan and CDPH. Specifically, the program services include the following:

- Offers home visitation, environmental home inspections, and nutritional assessments to families of children found to be severely lead-poisoned.
- Provides telephone contacts and educational materials to families of lead-poisoned and lead exposed children.
- Provides information and education to the general public, medical providers, and community-based organizations.
- Provides targeted case management and environmental investigation services with associated administrative activities to lead burdened children who are Medi-Cal beneficiaries and meet the case definition of lead poisoning.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to delayed invoices for FY 2017-18 costs, previously budgeted in FY 2017-18, shifting to FY 2018-19.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to fewer prior year invoices in FY 2019-20.

Methodology:

1. Annual expenditures on an accrual basis are \$4,200,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 90

2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

FY 2018-19	DHCS FFP	CDPH CLPP Fee Funds
FY 2017-18 Claims	\$3,386	\$3,386
FY 2018-19 Claims	\$3,150	\$3,150
Total for FY 2018-19	\$6,536	\$6,536

FY 2019-20	DHCS FFP	CDPH CLPP Fee Funds
FY 2018-19 Claims	\$1,050	\$1,050
FY 2019-20 Claims	\$3,150	\$3,150
Total for FY 2019-20	\$4,200	\$4,200

Funding:

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 7/1984
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 253

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$4,533,000	\$6,494,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,533,000	\$6,494,000

DESCRIPTION**Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). Enhanced federal funding is also provided to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).

Authority:

Interagency Agreements:

 CBAS 03-76137

 MSSP 01-15976

Interdependent Policy Changes:

Not Applicable

Background:

The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to updated invoicing and accounting data. The change from FY 2018-19 to FY 2019-20, in the current estimate, is an increase due to updated invoicing and accounting data and the approval of a Budget Change Proposal.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 92

Methodology:

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

(Dollars in Thousands)

CBAS Support	FY 2018-19: CDA GF	FY 2018-19: FFP	FY 2018-19: CDA GF	FY 2018-19: FFP
FY 2017-18 DOS	\$272	\$371	\$0	\$0
FY 2018-19 DOS	\$1,862	\$2,115	\$252	\$348
FY 2019-20 DOS	\$0	\$0	\$2,690	\$3,238
Total CBAS	\$2,134	\$2,486	\$2,942	\$3,586
MSSP Support				
FY 2017-18 DOS	\$363	\$487	\$0	\$0
FY 2018-19 DOS	\$1,276	\$1,158	\$137	\$467
FY 2019-20 DOS	\$0	\$0	\$1,550	\$2,101
Total MSSP	\$1,639	\$1,645	\$1,687	\$2,568
ADRC Support*				
FY 2017-18 DOS		\$86		
FY 2018-19 DOS		\$316		\$24
FY 2019-20 DOS				\$316
Total ADRC		\$402		\$340
Grand Total	\$3,773	\$4,533	\$4,629	\$6,494

Funding:

100% Title XIX (4260-101-0890)

100% MFP Federal Grant (4260-106-0890)*

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 1/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1680

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$2,562,000	\$2,400,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,562,000	\$2,400,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to California Smoker's Helpline (Helpline) services provided to Medi-Cal beneficiaries.

Authority:

Affordable Care Act Section 4107
 Interagency Agreement (IA) 13-90417

Interdependent Policy Change:

Not Applicable

Background:

CDPH funds statewide smoker quitline services and counseling to Medi-Cal beneficiaries through the University of California, San Diego. The Helpline services follow the Centers for Medicare and Medicaid Services (CMS) guidelines and the Department policies for providing services to Medi-Cal beneficiaries. CDPH ensures the Helpline services includes specially trained counselors to provide free telephone-based counseling, education, and support to Medi-Cal beneficiaries who currently smoke or have recently quit smoking.

The Department has an existing IA with CDPH to enable the State to receive 50% FFP for Helpline services administrative costs beginning July 1, 2013.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is a net increase due to delayed invoices for FY 2017-18 costs, previously budgeted in FY 2017-18, shifting to FY 2018-19, and shifting some FY 2018-19 costs to be paid in FY 2019-20.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to more previous year claims budgeted in FY 2018-19.

Methodology:

1. The Helpline services administrative costs are based on expenditure data for services provided to Medi-Cal beneficiaries. CDPH submits invoices for 50% reimbursement of actual and allowable administrative costs.
2. Annual expenditure on an accrual basis are \$2,400,000 TF. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

CALIFORNIA SMOKERS' HELPLINE

OTHER ADMIN. POLICY CHANGE NUMBER: 93

3. The estimated administrative cost reimbursements, for FY 2018-19 and FY 2019-20, on a cash basis are:

FY 2018-19	TF	FF
FY 2017-18 Claims	\$562,000	\$562,000
FY 2018-19 Claims	\$2,000,000	\$2,000,000
Total for FY 2018-19	\$2,562,000	\$2,562,000

FY 2019-20	TF	FF
FY 2018-19 Claims	\$400,000	\$400,000
FY 2019-20 Claims	\$2,000,000	\$2,000,000
Total for FY 2019-20	\$2,400,000	\$2,400,000

Funding:

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 94
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 249

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,197,000	\$1,223,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,197,000	\$1,223,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing the "Kit for New Parents" to parents of Medi-Cal eligible newborns.

Authority:

Interagency Agreement (IA) #03-76097

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into an IA with the CCFC to allow the Department to claim Title XIX federal funds (FF) for the "Kit for New Parents" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change:

The change from the prior estimate for FY 2018-19, and the change in the current estimate, from FY 2018-19 to FY 2019-20, is due to:

- Decreased number of kits needed in FY 2018-19 and FY 2019-20;
- Increased cost of kits provided by a new vendor; and
- Increased estimated percentage of Medi-Cal eligible newborns in FY 2018-19 and FY 2019-20.

Methodology:

1. CCFC will distribute an estimated 313,000 kits in FY 2018-19 and FY 2019-20, of these kits, 50% are expected to be distributed to Medi-Cal eligible newborns.

$$313,000 \text{ kits} \times 50\% = 156,500 \text{ Medi-Cal kits}$$

2. Each kit, basic or custom, costs \$15.63.

$$156,500 \text{ Medi-Cal kits} \times \$15.63 = \$2,446,000 \text{ TF}$$

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 94

3. Assume 75% of expenditures will be paid in the year the kits are distributed and the remaining 25% of expenditures will be paid in the following year.

Fiscal Year	Accrual	FY 2018-19	FY 2019-20
FY 2017-18	\$2,237,000	\$559,000	\$0
FY 2018-19	\$2,446,000	\$1,835,000	\$611,000
FY 2019-20	\$2,446,000	\$0	\$1,835,000
Total		\$2,394,000	\$2,446,000
Total FF (50%)		\$1,197,000	\$1,223,000

Funding:

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 95
 IMPLEMENTATION DATE: 12/1988
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 232

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$1,100,000	\$1,100,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,100,000	\$1,100,000

DESCRIPTION

Purpose:

This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:

AB 1807 (Chapter 1424, Statutes of 1987)
 California Military & Veterans Code 972.5
 Interagency Agreement 18-95220

Interdependent Policy Changes:

Not Applicable

Background:

AB 1807 permits the Department to make available federal Medicaid funds in order to obtain additional VA benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement (IA) exists with the CDVA. CVSOs help identify additional VA benefits and refer the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program. The previous IA expired on June 30, 2018, and was renewed effective July 1, 2018.

Reason for Change:

There is no change from the prior estimate for FY 2018-19.
 There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

- The contract amount is estimated to be \$1,100,000 for FY 2018-19 and FY 2019-20. The non-federal match is budgeted by CDVA.

FY	FY 2018-19			FY 2019-20		
Cash Basis	TF	CDVA GF	DHCS FF	TF	CDVA GF	DHCS FF
Administrative	\$724,000	\$362,000	\$362,000	\$724,000	\$362,000	\$362,000
Workload Units	\$1,476,000	\$738,000	\$738,000	\$1,476,000	\$738,000	\$738,000
Total	\$2,200,000	\$1,100,000	\$1,100,000	\$2,200,000	\$1,100,000	\$1,100,000

Funding:

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 96
 IMPLEMENTATION DATE: 3/2011
 ANALYST: Melinda Yegge
 FISCAL REFERENCE NUMBER: 1665

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$950,000	\$983,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$950,000	\$983,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR)/California Correctional Health Care Services (CCHCS) for administrative costs related to the Inmate Eligibility Program.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)

SB 1399 (Chapter 405, Statutes of 2010)

AB 396 (Chapter 394, Statutes of 2011)

Interagency Agreement #15-92398

Interdependent Policy Changes:

Not Applicable

Background:

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

- Claim federal reimbursement for inpatient hospital services to Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. As part of these provisions, the CCHCS is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program. The federal funds provided to the CCHCS are included in the Medi-Cal inpatient hospital costs policy changes.

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

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

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

- Claim FFP for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously, these services were paid 100 percent by the CDCR or the county. Policy Change CA 1 County Administration Allocation covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 96

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to an increase in salary and health benefit costs. The change from FY 2018-19 to FY 2019-20 in the current estimate is due to an additional increase in FY 2019-20 for health benefits costs.

Methodology:

1. Implementation of the Inmate Eligibility Program began April 1, 2011.
2. Reimbursements for administrative costs began in March 2011.
3. The federal share of ongoing administrative costs is \$950,000 in FY 2018-19 and \$983,000 in FY 2019-20.

Funding:

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

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 97
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Sharisse DeLeon
 FISCAL REFERENCE NUMBER: 257

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$849,000	\$849,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$849,000	\$849,000

DESCRIPTION

Purpose:

This policy change estimates and reimburses the California Health and Human Services (CHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:

Interagency Agreement (IA) 17-94031

Interdependent Policy Changes:

Not Applicable

Background:

A HIPAA office has been established at the CHHS Agency to coordinate HIPAA implementation and set policy requirements for state departments impacted by HIPAA that utilize Title XIX funding. This funding supports state Agency positions and contracted staff to assist in the implementation of HIPAA. These staff provide oversight and subject matter expertise on HIPAA rules.

Payments began in December 2017 for IA 17-94031, a three-year IA that became effective July 1, 2017.

Reason for Change:

There is no change from the prior estimate for FY 2018-19. There is no change from FY 2018-19 to FY 2019-20 in the current estimate.

Methodology:

- The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
FY 2018-19	\$849,000	\$849,000
FY 2019-20	\$849,000	\$849,000

Funding:

100% HIPAA (4260-117-0890)

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 5/2016
ANALYST: Katy Clay
FISCAL REFERENCE NUMBER: 1774

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$736,000	\$673,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$736,000	\$673,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) for the California Department of Public Health (CDPH) to improve delivery of Vital Records data and to provide certified copies of birth and death records, as needed, to the Department.

Authority:

Contract 15-92272
Contract 18-95019

Interdependent Policy Changes:

Not Applicable

Background:

California birth, death, fetal death, still birth, marriage, and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA—a Centers for Medicare and Medicaid Services (CMS) initiative—fosters an integrated business and information technology (IT) transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department has received CMS approval for enhanced FFP to establish automated and timely processes to receive Vital Record data from CDPH. CMS approved the contract in June 2016.

The Department has entered into a contract with CDPH to provide certified copies of vital records as required for business needs, beginning July 2018.

Reason for Change:

The change in FY 2018-19, from the prior estimate, is due to revised estimated costs based on FY 2017-18 fourth quarter actual invoice amounts. The change from FY 2018-19 to FY 2019-20, in the current estimate, results from higher data claims costs in FY 2018-19.

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 98

Methodology:

1. The Department and CDPH will receive 75% FFP for ongoing costs to deliver vital records data.
2. CDPH will provide the match for FFP from the Health Statistics Special Fund (HSSF).
3. On an accrual basis, the maximum reimbursable amount for the cost associated with preparing the records for transfer to the Department is \$874,000 per year, and \$16,632 per year for the cost of certified copies.
4. On a cash basis, for both contracts, assume three quarters will be paid in the current fiscal year and the remaining quarter will be paid in the subsequent fiscal year.
5. The estimated reimbursements for FY 2018-19 and FY 2019-20 on a cash basis are:

(Dollars in thousands)

FY 2018-19	TF	HSSF	FF
FY 2017-18 Data Claims	\$ 308	\$ 77	\$ 231
FY 2018-19 Data Claims	\$ 656	\$ 164	\$ 492
FY 2018-19 Certified Copies	\$ 13	\$ -	\$ 13
Total	\$ 977	\$ 241	\$ 736

FY 2019-20	TF	HSSF	FF
FY 2018-19 Data Claims	\$ 219	\$ 55	\$ 164
FY 2018-19 Certified Copies	\$ 4	\$ -	\$ 4
FY 2019-20 Data Claims	\$ 656	\$ 164	\$ 492
FY 2019-20 Certified Copies	\$ 13	\$ -	\$ 13
Total	\$ 892	\$ 219	\$ 673

Funding:

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 99
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 261

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$711,000	\$558,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$711,000	\$558,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for providing Information and Education (I&E) Adolescent Sexual Health and Pregnancy Prevention Program services to Medi-Cal beneficiaries.

Authority:

Interagency Agreement (IA) 07-65592
 AB 1762 (Chapter 230, Statutes of 2003)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1762 authorized the Department to require contractors and grantees, under the Office of Family Planning and the I&E program, to establish and implement clinical linkages to the Family PACT program. This linkage includes planning and development of a referral process for program participants to ensure access to family planning and other reproductive health care services, including technical assistance, training, and an evaluation component for grantees.

CDPH budgets the I&E program under the Maternal, Child and Adolescent Health (MCAH) Division. I&E projects have been a major component of MCAH programs. The local projects provide services to youth and adults throughout the state in a variety of settings and utilize various strategies appropriate to meeting the growing and diverse needs of Californians today. The program provides funding for educational programs that emphasize primary prevention to enhance knowledge, attitudes and skills of adolescents and young men and women of childbearing age to make responsible decisions relevant to sexual and reproductive behavior.

The Department has an existing IA with CDPH to receive 50% FFP for the I&E programs administrative costs.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to more FY 2017-18 claims, previously budgeted in FY 2017-18, being paid in FY 2018-19.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due to more previous year claims budgeted in FY 2018-19.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 99

Methodology:

1. CDPH budgets the non-federal matching funds.
2. Annual expenditures on an accrual basis are \$1,116,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
3. The estimates are provided by CDPH on a cash basis.

FY 2018-19	TF	CDPH GF	DHCS FF
FY 2017-18 Claims	\$926,000	\$463,000	\$463,000
FY 2018-19 Claims	\$496,000	\$248,000	\$248,000
Total for FY 2018-19	\$1,422,000	\$711,000	\$711,000

FY 2019-20	TF	CDPH GF	DHCS FF
FY 2018-19 Claims	\$620,000	\$310,000	\$310,000
FY 2019-20 Claims	\$496,000	\$248,000	\$248,000
Total for FY 2019-20	\$1,116,000	\$558,000	\$558,000

Funding:

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Jedidiah Warren
 FISCAL REFERENCE NUMBER: 263

	<u>FY 2018-19</u>	<u>FY 2019-20</u>
TOTAL FUNDS	\$236,000	\$190,000
STATE FUNDS	\$118,000	\$95,000
FEDERAL FUNDS	\$118,000	\$95,000

DESCRIPTION

Purpose:

This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:

IA #12-89476

Interdependent Policy Changes:

Not Applicable

Background:

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meets current state regulations. The Merit System Services (MSS) Program was established under the State Personnel Board and is now administered by CalHR to administer personnel services for the counties that do not have a civil service system. In addition, CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is an increase due to CalHR transitioning the MSS program operations. Previously, the day-to-day operation of the MSS program was handled by a contractor, but will now be operated internally.

The change from FY 2018-19 to FY 2019-20, in the current estimate, is a decrease as CalHR transitions services away from their contractor.

Methodology:

1. CalHR provided the estimates on a cash basis.
2. The estimated reimbursement is \$236,000 TF (\$118,000 GF) in FY 2018-19 and \$190,000 TF (\$95,000 GF) in FY 2019-20.

Funding:

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

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 101
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1114

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$382,000	\$394,000
STATE FUNDS	\$191,000	\$197,000
FEDERAL FUNDS	\$191,000	\$197,000

DESCRIPTION

Purpose:

This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

Authority:

Interagency Agreement (IA) #13-90175

Interdependent Policy Changes:

Not Applicable

Background:

The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services.

Reason for Change:

The change from the prior estimate, for FY 2018-19, is due to the increased rate per package, from \$3.50 to \$4.25, beginning September 1, 2018.

The change in the current estimate, from FY 2018-19 to FY 2019-20, is due the increased rate per package for the full fiscal year.

Methodology:

1. The rate was \$3.50 per package for the PIA contract that was effective through August 31, 2018. PIA renegotiated a contract, with a new rate of \$4.25 per package, effective September 1, 2018. The Department is responsible for one-half of the delivery cost.
2. The contract with United Courier Service costs the Department \$1.75 per package with no fuel surcharge for the pick-up and delivery of orders to optical providers. The contract ended on August 31, 2018. Effective September 1, 2018, the rate for the Department is \$2.13 per package.
3. The number of estimated packages to be paid is 185,000 in FY 2018-19.

$$\begin{aligned}
 & \$1.75 \times 30,833 = \$54,000 \text{ TF (rounded)} \\
 & \$2.13 \times 154,167 = \$328,000 \text{ TF (rounded)}
 \end{aligned}$$

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 101

4. The number of estimated packages to be paid FY 2019-20 payments are estimated to remain stable at 185,000 packages.

$$\$2.13 \times 185,000 = \$394,000 \text{ TF (rounded)}$$

Fiscal Year	TF	GF	FF
FY 2018-19	\$382,000	\$191,000	\$191,000
FY 2019-20	\$394,000	\$197,000	\$197,000

Funding:

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

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 8/2018
 ANALYST: Joy Oda
 FISCAL REFERENCE NUMBER: 2123

	FY 2018-19	FY 2019-20
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$83,092,000	\$0
FEDERAL FUNDS	-\$83,092,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the repayment of Fiscal Intermediary (FI) and administrative deferred claims to the Centers for Medicare and Medicaid Services (CMS).

Authority:

California Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020)
 Title 42, Code of Federal Regulations (CFR), 430.40

Interdependent Policy Changes:

Not Applicable

Background:

CMS reviews claims submitted by state Medicaid agencies to ensure federal financial participation (FFP) eligibility. Claims for which CMS questions the FFP eligibility are deferred and the state Medicaid agency is issued a deferral notice. Upon receipt of the deferral notice, the state Medicaid agency has 120 days to resolve the deferred claim.

When CMS issues a deferral to the state Medicaid agency, in accordance with the timelines set forth in 42 CFR 430.40, the state Medicaid agency must immediately return the deferred FFP to the applicable Payment Management System (PMS) subaccount while the deferral is being resolved. As part of the resolution process, the state Medicaid agency submits documentation in support of the deferred claim to CMS for review. If CMS determines the deferred claim is allowed, then the deferral is released, the funds are returned to the appropriate PMS subaccount, and the state Medicaid agency is notified that the funds are available to be redrawn.

Pursuant to Special Terms and Conditions paragraph 164 of the California Medi-Cal 2020 Demonstration Waiver, Medi-Cal is required to bring all deferrals current. The Department is working with CMS to resolve specific items. All deferred claims and negative PMS subaccount balances must be repaid by the end of the demonstration waiver, December 31, 2020, or within three years from CMS' approval of California's repayment schedule, whichever is longer.

The FI and administrative deferred claims are included in this policy change and are separate from the CMS Deferred Claims policy change. See the CMS Deferred Claims policy change for more information.

Reason for Change:

This is a new policy change.

CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 103

Methodology:

1. The Department estimates to repay the following deferred claims:

(Dollars in Thousands)

FY 2018-19	Total Estimated Repayment
FFY 2016 Quarter 4 (Jul-Sep 2016)	\$16,960
FFY 2017 Quarter 1 (Oct-Dec 2016)	\$19,498
FFY 2017 Quarter 2 (Jan-Mar 2017)	\$46,634
Total FY 2018-19	\$83,092

Funding:

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

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

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

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

MEDI-CAL INFORMATION ONLY
November 2018
FISCAL YEARS 2018-19 & 2019-20

INTRODUCTION

The Medi-Cal Benefit Estimate can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction and is derived from a 36 month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Benefit Estimate.

FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, units/user and dollars/unit for each of 18 aid categories within 11 different service categories. The general functional form of the regression equations is as follows:

	USERS	= f(TND, S.QV, O.QV, Eligibles)
	CLAIMS/USER	= f(TND, S.QV, O.QV)
	\$/CLAIM	= f(TND, S.QV, O.QV)
WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\$/CLAIM	= Total monthly dollars divided by total monthly claims or units by service and aid category.
	TND	= Linear trend variable.
	S.QV	= Seasonally adjusting qualitative variable.
	O.QV	= Other qualitative variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)
	Eligibles	= Actual and projected monthly eligibles for each respective aid category incorporating various lag calculations for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, units/user and dollars/unit are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

FEE-FOR-SERVICE SERVICE CATEGORIES

Medi-Cal categorizes providers into Provider Types. For estimating purposes, the Medi-Cal Estimate groups these provider types into 11 Service Categories. This information is provided below.

Note: The Fee-For-Service delivery system includes the cost of care for those eligibles in the FFS delivery system, it also includes costs for items excluded in the Managed Care delivery model capitation.

Physicians

- Physicians
- Physician Group

Other Medical

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

County and Community Outpatient

- County Hospital Outpatient
- Community Hospital Outpatient

Pharmacy

- Pharmacies or Pharmacists

County Inpatient

- County Hospital Inpatient
- Consists of Designated Public Hospitals. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Community Inpatient

- Community Hospital Inpatient
- Consists of Non-Designated Public Hospitals, Private Hospitals, and some Designated Public Hospitals. The Non-Designated Public Hospitals and Private Hospitals are paid using a Diagnosis Related Group payment methodology. The Designated Public Hospitals are paid based on an interim per diem rate utilizing Certified Public Expenditures. DPH payments are 100% federal funds and the DPH pays the State's match. More information is available at the Department's website (www.dhcs.ca.gov).

Nursing Facilities

- | | |
|--|--|
| <ul style="list-style-type: none">• Long Term Care Nursing Facility• Long Term Care Intermediate Care Facility (NF-A)• Pediatric Subacute Care – Long Term Care• These three provider types include Nursing Facility - Level A (NF-A), Nursing Facility – Level B (NF-B), Distinct Part Skilled Nursing | Facilities of General Acute Care Hospitals (DP/NF-Bs), Distinct Part Adult Subacute Units for General Acute Care Hospitals (DP/SA), Rural Swing Beds, Institution for Mental Diseases, Acute and Transitional Inpatient Care Administrative Days (Administrative Days Level 1) |
|--|--|

ICF-DD

- Long Term Care Intermediate Care Facility/Developmentally Disabled

Medical Transportation

- Ground Medical Transportation
- Air Ambulance Transportation

Other Services

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

Home Health

- Home Health Agency (except Home & Community Based Services)

Effective January 1, 2014, the ACA establishes a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplifies the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The new standard allows current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility under MAGI standards to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

AFFORDABLE CARE ACT

The ACA also imposes a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled in Medi-Cal to enroll in the program. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA. The tax upon those without health coverage expires January 1, 2019.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA increased the Children's Health Insurance Program (CHIP) FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows the Department to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows the Department to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports (LTSS) that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

**In-Home Supportive Services (IHSS) **

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of a chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and be unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

HOME AND COMMUNITY BASED SERVICES

**Targeted Case Management (TCM) **

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment
- Development of an individualized service plan
- Linkage and consultation
- Assistance with accessing services
- Crisis assistance planning
- Periodic review

1915(i) HCBS State Plan Services

The 1915(i) State Plan Services program provides home and community-based services (HCBS) to persons with developmental disabilities (DD) who are Regional Center consumers but do not meet nursing facility level of care criteria required for enrollment in the HCBS Waiver of Persons with DD. As of February 1, 2016, Behavioral Health Treatment (BHT) services for 1915(i) participants under the age of 21 is a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care. The 1915(i) State Plan Amendment (SPA) is approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by submitting a SPA renewal to CMS in May 2016, which became effective on October 1, 2016.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and CDDS submitted a SPA reflecting the rate changes. CMS approved the SPA on September 29, 2016 with a July 1, 2016 effective date. Rate increases includes several different increase models including a 5% rate increase on services and survey based increases on wages.

Waivers

Medi-Cal operates and administers various HCBS waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary State Plan services are less than the total cost incurred at the otherwise appropriate facility plus State Plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS), Assisted Living Waiver (ALW), In-Home Operations (IHO), Home and Community Based Alternatives (HCBA), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with DD, and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

HOME AND COMMUNITY BASED SERVICES

**Assisted Living Waiver (ALW) **

The ALW pays for assisted services and supports, care coordination, and community transition in 15 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, San Francisco, Santa Clara and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF) or through a home health agency while residing in publicly subsidized housing. Approved capacity for this waiver is 3,744. CMS approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019. On May 26, 2017, CMS approved an amendment to expand the ALW into San Francisco County, effective March 1, 2017. This expansion of ALW into San Francisco County allows all San Francisco Community Living Support Benefit (SF CLSB) Waiver participants the option of transitioning into the ALW. The Governor's budget ~~*released on January 10, 2018 includes*~~ ****amended the ALW and authorized**** funding to add an additional 2,000 slots ~~*to the ALW starting*~~ ****effective July**** ~~*June* 1, 2018. *This funding is contingent upon legislative approval and will also require the Department to submit an amendment to the ALW to CMS for approval.*~~ ****The ALW ends February 28, 2019 and is currently going through the stakeholder process to submit a renewal application to CMS.****

****The Department will be assessing the ALW for integration in the HCBS Waiver. ****

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) a Medi-Cal optional benefit. A lawsuit was filed challenging elimination of ADHC (*Darling et al. v. Douglas et al.*), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to approved program participants. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became a managed care benefit effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver. Under the Bridge to Reform Waiver, CBAS was authorized for a temporary extension through December 31, 2015. The Department submitted a new waiver called the California Medi-Cal 2020 Demonstration which was approved on December 30, 2015 for five years. CBAS continues to be a waiver benefit under this new waiver until December 31, 2020. There is no cap on enrollment into this service.

**Home and Community-Based Alternatives (HCBA) Waiver **

The HCBA Waiver will provide Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in his or her home or home-like setting in the community in lieu of institutionalization. The Department will contract with Waiver Agencies for the purpose of performing waiver administration functions and directing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, LOC evaluations, person-centered care/service plan review

HOME AND COMMUNITY BASED SERVICES

and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities and reporting to the Department*, ~~billing the Fiscal Intermediary (FI), and provider claims adjudication*~~.

The Department will maintain an active role in the waiver administration by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. The Department received approval of the HCBA Waiver on May 16, 2017 with a January 1, 2017 effective date. The Department will implement the Waiver Agency model on July 1, 2018. The waiver renewal will serve up to 8,964 participants by the end of the 5-year waiver term. ****Additionally, the Department will be assessing integration of the ALW into the HCBA Waiver towards the end of the HCBA Waiver term.****

In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the HCBA Waiver, for the participant's assessed LOC. CMS approved the IHO waiver renewal from January 1, 2015 through December 31, 2019. The Department will not renew the IHO Waiver at the expiration of the current waiver term. At the point of annual reassessment for each participant, the Department will offer the option of transitioning to the HCBA Waiver. All IHO Waiver participants will be given sufficient notice of the waiver expiration and provided options to transition prior to the expiration of the IHO Waiver.

**Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver **

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

- Administrative Expenses
- Attendant care
- Case management
- Financial supplements for foster care
- Home-delivered meals
- Homemaker services
- In-home skilled nursing care
- Minor physical adaptations to the home
- Non-emergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Psychotherapy

HOME AND COMMUNITY BASED SERVICES

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an aid code with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Waiver participants must also have a written diagnosis of HIV disease or AIDS, certified by the nurse case manager to be at the nursing facility level of care, and score 60 or less using the Cognitive and Functional Ability Scale assessment tool. Children under 13 years of age are eligible if they have been certified by the nurse case manager as HIV/AIDS symptomatic. All waiver participants must have a home setting that is safe for both the client and service providers. The Department received approval for the renewal of the HIV/AIDS Waiver on March 27, 2017.

In 2016, Californians approved Proposition 56, which will generate additional revenue for health care programs. AB 120 (Chapter 22, Statutes of 2017) provides an increase to the AIDS Waiver program of up to \$8,000,000 Total Fund (\$4,000,000 SF). The Department posted the information to its website in July 2017. The Department received approval of a waiver amendment to incorporate the allocation from AB 120 and increase specific AIDS waiver rates on September 22, 2017, retroactive to July 1, 2017.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are at risk of placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care / support center, housing assistance, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Under the approved waiver, beginning July 1, 2014 through June 30, 2019, capacity of unduplicated recipients is as follows:

- Waiver Year 1: 12,000
- Waiver Year 2: 11,684
- Waiver Year 3: 11,684
- Waiver Year 4: 11,684
- Waiver Year 5: 11,684

The decrease in Waiver capacity is a result of the implementation of the Coordinated Care Initiative (CCI), demonstration program. With the implementation of the CCI program, the total number of MSSP members will be reduced based on the integration of this population into managed care no sooner than January 1, 2020 in six of the seven CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara. The initial reduction for the unduplicated recipients in Waiver Year 2 was a result of the completed MSSP transition to managed care in San Mateo County.

HOME AND COMMUNITY BASED SERVICES

A technical amendment was submitted to CMS on February 2, 2017, to restore the total number of slots for the MSSP sites in the remaining six counties. This amendment restored the slots to ensure that services continue to be provided to waiver participants due to the delay of the MSSP transition into managed care to no sooner than January 1, 2020. CMS approved the amendment on April 27, 2017, with an effective date of July 1, 2016. ****The MSSP Waiver is ending June 30, 2019, and is currently going through stakeholder processes with the intention to submit a renewal application to CMS by March 1, 2019.****

****The Department has submitted a request to CMS to extend the CCI demonstration through December 31, 2020, in order to align the timing of decisions on next steps regarding the demonstration with the ending of the Section 1115 Medicaid Waiver. If CMS approves this request, the transition of MSSP into managed care will be pushed back to align with the new end-date for the CCI demonstration.****

****Home and Community-Based Waiver for Persons with Developmental Disabilities (DD) ****

The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the ~~*mentally retarded*~~ ****developmentally disabled**** in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. ~~As of *March 29, 2017*~~ ****February 1, 2016**** Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 is a state plan benefit ~~*paid through fee-for-service and will implement as a managed care—benefit effective July 1, 2018*~~ ****paid through fee-for-service or the managed care delivery system.****

The Department submitted a renewal application to CMS on December 22, 2016 and received approval on December 7, 2017. Approved capacity of unduplicated recipients for this waiver is 130,000 in 2018, 135,000 in 2019, and 140,000 in 2020, ****145,000 in 2021, and 150,000 in 2022.**** The waiver is approved from January 1, 2018 through December 31, 2022.

The DD rate increase, as outlined in ABx2 1, was chaptered in October 2015. The Department and CDDS submitted a SPA reflecting the rate changes, retroactive to July 1, 2016.

****Home and Community-Based Self Determination Program Waiver for Persons with Developmental Disabilities ****

The SDP waiver provides home and community-based services to persons with developmental disabilities that are able to self-direct and are Regional Center consumers. The SDP waiver is an alternative to care provided in a facility that meets the federal requirement of an Intermediate Care Facility/Developmentally Disabled-type facility, or a State Developmental Center. The estimated capacity of unduplicated recipients for the SDP is 1,000 for waiver year 1, and 2,500 for waiver years 2 and 3. The SDP will transition DD waiver participants, ~~who can self-direct their care, at no additional cost to the General Fund.~~ *This waiver is pending CMS approval.* ****CMS approved this waiver on June 6, 2018, with an effective date of July 1, 2018. This waiver is for a three-year period, ending June 30, 2021. The State may renew the waiver at the end of the initial three-year period by providing evidence and documentation of satisfactory performance and oversight.****

HOME AND COMMUNITY BASED SERVICES

*As of March 29, 2017, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 is a state plan benefit paid through fee-for-service and will implement as a managed care benefit effective July 1, 2018. *

****As of February 1, 2016, Behavioral Health Treatment (BHT) services for Waiver participants under the age of 21 is a state plan benefit and paid through fee-for-service, or the managed care delivery system. ****

*The SDP was expected to be effective July 1, 2016, as a five year waiver, ending June 30, 2021. The SDP Waiver is currently under the CMS Request for Additional Information (RAI) process as CDDS and the Department work to resolve issues with the application. The SDP RAI stops the clock on the application indefinitely until all issues are resolved, and the Department submits the application for final approval. The proposed effective date is yet to be determined. *

****Pediatric Palliative Care (PPC) Waiver ****

The PPC provides children hospice-like services, in addition to State Plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009, through March 31, 2012. CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective April 1, 2012, through December 26, 2017. The Department submitted a waiver renewal application on September 29, 2017 to request a new five year waiver term. *CMS approved a temporary extension of the PPC Waiver to May 15, 2018 and the waiver is expected to be renewed prior to the expiration.* ****After discussions with CMS, the Department determined there were service delivery issues with the waiver and to end the PPC Waiver and transition current waiver participants to other systems of care. CMS is expected to approve an extension of the current waiver term through December 31, 2018. Transition is expected to begin by January 1, 2019. ****

Managed Care Programs

****Program of All Inclusive Care for the Elderly (PACE) ****

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical long-term services and supports, dental, vision and other specialty services, allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place.

HOME AND COMMUNITY BASED SERVICES

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease.

Special Grant

**California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant **

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a grant for the Money Follows the Person Rebalancing Demonstration Grant, called California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. Grant funds may be requested from January 1, 2007, through September 30, 2020. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal members who have resided continuously in health care facilities for 90 days or longer back to a federally-qualified residence. The Department will discontinue processing new transitions effective January 1, 2019 to ensure sufficient time to bill post transition period claims and perform grant close-out functions.

1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) ended on December 31, 2015. The Medi-Cal 2020 Section 1115(a) Medicaid Demonstration (Medi-Cal 2020) was approved effective January 1, 2016, for five years.

Medi-Cal 2020 builds on the successes of the state's Bridge to Reform waiver in 2010, a critical piece of the state's implementation of the Affordable Care Act. The Medi-Cal 2020 waiver opens the door to innovative changes in the way Medi-Cal provides services to its members, all with the goals of improving efficiency, access, and quality of care.

This final Medi-Cal 2020 renewal reflects the overall construct announced at the end of October. It includes initial federal funding over the five years of \$6.2 billion, with the potential for additional federal funding in the Global Payment Program (GPP) after the initial year of the waiver.

Some of the key programmatic elements of Medi-Cal 2020 are:

- **Public Hospital Redesign and Incentives in Medi-Cal (PRIME)** – This program builds on the success of the state's Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five years, federal funding for PRIME for DPHs is \$3.27 billion, and for DMPHs is \$466.5 million.
- **Global Payment Program (GPP)** – A new program aimed at improving the way care is delivered to California's remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new and innovative approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change – focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization. The federal funding for GPP will be a combination of the DSH funding for participating DPHs and \$236 million in federal funding for the first year from the prior SNCP. The non-DSH funding for years two through five will continue to be \$236 million in federal funding.
- **Dental Transformation Initiative (DTI)** – For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI

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provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to \$750 million in total funding is available under DTI. The non-federal share for DTI will be funded through State General Fund savings achieved through limited continuation of Designated State Health Program (DSHP) funding.

- Whole Person Care (WPC) Pilots – Another innovative component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC Pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to \$1.5 billion in federal funding over the five years; WPC Pilot lead entities will provide the non-federal share.
- In addition to these programs, Medi-Cal 2020 continues authorities for the Medi-Cal managed care program, Community-Based Adult Services, the Coordinated Care Initiative (including CalMediConnect), and the Drug Medi-Cal Organized Delivery System.

MANAGED CARE

Medi-Cal Managed Care Rates

Base rates are developed utilizing plan reported costs and utilization data by category of services (i.e. Inpatient, Emergency Room, Pharmacy, Primary Care Provider, Specialist, etc.) for each category of aid (COA). Actuaries review the base data for reasonableness and make adjustments to remove costs for services or populations that are not included in the capitation rates for the future rating period.

Trends and programmatic changes, as well as administrative and underwriting loads, are then applied to arrive at reasonable, appropriate, and attainable plan-specific rates.

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates are risk adjusted in the Child, Adult/Family, Seniors and Persons with Disabilities (SPD), and ACA Optional Expansion (ACA OE) COAs.

Risk adjustment and county averaging is prepared with plan-specific pharmacy data (with National Drug Codes) gathered for managed care and Fee-For-Service (FFS) enrollment data for the most recent 12-month period.

Risk adjustment is performed using the Medicaid RX risk adjustment software from UC San Diego. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Child, Adult/Family, SPED, and ACA OE rate categories in a specific plan who meets certain eligibility criteria, is assigned a risk score. Member scores are aggregated for each plan operating in a county and a county-specific rate is then developed for each COA based on the sum of the plan-specific rates weighted for each plan's enrollment. For the FY 2017-18 rates, each plan's final rate is a blend consisting of 70% of the county-specific rate and 30% of the plan's plan-specific rate. County Organized Health Systems (COHS) rates are not risk adjusted due to the presence of only one plan in each county. The risk adjustment policy is examined on an ongoing basis and adjusted if necessary.

Occasionally, when deemed necessary, the State will implement supplemental payments to help mitigate risk for unpredictable utilization trends. The State has also implemented supplemental payments for the costs of providing Hepatitis C drug treatment and Behavioral Health Treatment for children diagnosed with Autism Spectrum Disorder.

SBX2-2 (Chapter 2, Statutes of 2016) was signed by the Governor on March 1, 2016, and provides for a statewide tax on managed care plans based on enrollment into these plans. The tax is tiered based on whether the enrollee is a Medi-Cal enrollee, alternate health care service plan enrollee, or other enrollee. The MCO Enrollment tax is effective July 1, 2016 through June 30, 2019.

****Coordinated Care Initiative (CCI) Program****

The 2017 Budget Act discontinued the CCI program, effective January 1, 2018. Based on the lessons learned from the CCI demonstration project, the 2017 Budget extended the Cal MediConnect (CMC) program and the mandatory enrollment of dual eligible beneficiaries and the integration of long-term services and supports, except In-Home Supportive Services (IHSS),

MANAGED CARE

into managed care. IHSS was removed from capitation rate payments effective January 1, 2018.

Capitation payments for Medi-Cal enrollees participating in CCI are subject to risk corridor calculations that may result in additional payments to or recoups from participating health plans for historical contract periods. Corridors are in place for CMC and non-CMC full dual members and for non-full dual members enrolled in managed care in CCI counties. Specifically, for CMC, there are limited up-side and down-side risk corridors from April 1, 2014, through December 31, 2017. For non-CMC members, there is a 24-month symmetrical down-side and up-side risk corridor, as specified in W&I Code section 14182.18 and in the existing Medi-Cal MCP contracts. ****The Department anticipates risk corridor calculations to occur no sooner than FY 2019-20.****

****Capitation payments for CMC and non-CMC full dual members are subject to an additional, ongoing risk mitigation requirement. For time periods when capitation payments are based on a projected mix of full dual members of varying levels of acuity, and if there is a difference between the projected member mix and the actual member mix that results in a greater than 2.5 percent impact to the capitation rates, the Department and MCPs will equally share any cost increases or decreases beyond the 2.5 percent threshold (independent of the MCPs' actual gains or losses). The Department anticipates these calculations to occur for retroactive periods no sooner than FY 2018-19, and ongoing thereafter; however, an estimate of the total dollar impact is not available at this time.****

****Specific Federal Requirements:****

****Full-risk Medi-Cal managed care health plans (MCP) contracts establish a risk corridor pertaining to Medical Loss Ratio (MLR) for ACA Optional Expansion (ACA OE) members, for the incurred periods of January 1, 2014, through June 30, 2015, and July 1, 2015, through June 30, 2016. For this period, MCPs who do not expend at least 85% of net capitation payments received for ACA OE members on allowed medical expenses for ACA OE members, for each county or region. An MCP which does not meet the minimum 85% threshold for a given county or region must return the difference between 85% of total net capitation payments and actual allowed medical expenses to DHCS. If an MCP's MLR exceeds 95% of total net capitation payments, then DHCS must make additional payment to the MCP equal to the difference between the MCP's allowed medical expenses and 95% of net capitation payments.****

****CMS would not approve the state's ACA OE FY 2016-17 rates without the extension of the ACA OE MLR risk corridor through the FY 2016-17 rating period. The ACA OE MLR risk corridor for FY 2016-17 is currently in the process of being contractually established between the Department and MCPs. The timeframe and dollars associated with this MLR period cannot be estimated at this time. CMS indicated they are considering extending the ACA OE MLR requirements for future ACA OE rating periods. The Department is working through process and timing in the event CMS extends this requirement past FY 2016-17.****

MANAGED CARE

Fee-for-Service (FFS) Expenditures for Managed Care Beneficiaries

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to Federally Qualified Health Center/Rural Health Clinic providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 (Chapter 875, Statutes of 2004) requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), including Freestanding Subacute Nursing Facility, Level Bs (FSSA/NF-Bs). Rates are updated annually and are established based on the most recent audited cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for FS/NF-Bs and FSSA/NF-Bs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personal activities. Costs are limited to the 90th percentile of each facility's peer group.
- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

PROVIDER RATES

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for FS/NF-Bs and FSSA/NF-B facilities by August 1, 2010. The QASP Program will enable the reimbursement for these facilities to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped. Reimbursements are equal to the median of each peer group.

PROVIDER RATES

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective June 2014, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65th percentile.

Effective August 1, 2016, ABX2 1 (Chapter 3, Statutes of 2016) requires the Department to reimburse ICF/DD, ICF/DD-H, and ICF/DD-N providers the rate in effect in the 2008-09 rate year, increased by 3.7%.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) revenue provided a funding source for supplemental payments to ICF/DD facilities. AB 120 (Chapter 22, Statutes of 2017) appropriated said funds for supplemental payments to ICF/DDs in the 2017-18 Rate Year. ****The Budget Act of 2018 allows for the continuation of the Proposition 56 funding, which will extend the ICF/DD supplemental payments by one year.****

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers (Distinct Part Pediatric Subacute (DP/PSA) facilities) and Freestanding Pediatric Subacute (FS/PSA) facilities. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

INFORMATION ONLY
REVENUES1. **Revenues**

The State is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2018-19:	*\$ 26,890,000* **	ICF-DD Quality Assurance Fee
<u>\$25,606,000**</u>	*\$ 521,982,000* **	<u>\$508,437,000**</u> Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 9,977,000 **	<u>\$9,951,000**</u> ICF-DD Transportation/Day Care Quality Assurance Fee
	\$ 933,000	<u>\$1,227,000**</u> Freestanding Pediatric Subacute Quality Assurance Fee
	\$ 2,563,988,000	<u>\$2,562,919,000**</u> MCO Enrollment Tax
	\$ 5,062,836,000 **	<u>\$5,062,342,000**</u> Hospital Quality Assurance Revenue Fund (EMATA) Fund (Item 4260-611-3158)
	\$ 1,899,000 **	<u>\$1,889,000**</u> Medi-Cal Emergency Medical Air Transportation (MEMTF) (Item 4260-601-3323)
	\$ 8,262,803,000 **	<u>\$8,249,024,000**</u> Total

<u>**FY 2019-20:**</u>	<u>** 25,379,000**</u>	<u>**ICF-DD Quality Assurance Fee **</u>
	<u>**\$ 526,842,000**</u>	<u>**Skilled Nursing Facility Quality Assurance Fee (AB 1629) **</u>
	<u>**\$ 9,951,000**</u>	<u>**ICF-DD Transportation/Day Care Quality Assurance Fee**</u>
	<u>**\$ 1,227,000**</u>	<u>**Freestanding Pediatric Subacute Quality Assurance Fee **</u>
	<u>**\$ 4,078,000,000**</u>	<u>**Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)**</u>
	<u>**\$ 4,267,000**</u>	<u>**Emergency Medical Air Transportation (EMATA) Fund **</u>
	<u>**\$ 70,009,000**</u>	<u>**Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)**</u>
	<u>**\$ 1,440,526,000**</u>	<u>**Medi-Cal Drug Rebates Fund (Item 4260-601-3331)**</u>
	<u>**\$ 6,156,201,000**</u>	<u>**Total**</u>

INFORMATION ONLY

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee for AB 1629 facilities is assessed, to include Medicare.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

SBx2-2 (Chapter 2, Statutes of 2016) provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing sufficient funding to restore the 7% reduction in the In-Home Supportive Services Program.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to the enactment of a new hospital QAF that results in revenue for FY 2011-12 children's services of at least \$320 million.

SB 335 (Chapter 286, Statutes of 2011) authorized the implementation of a new Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This extension authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1607 (Chapter 27, Statutes of 2016) extended the inoperative date of the Hospital QAF program to January 1, 2018, creating a one-year extension of the program.

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

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The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

SB 523 (Chapter 773, Statutes of 2017) implements a Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) on all ground emergency medical transports, effective July 1, 2018. The QAF will be assessed on each GEMT transport for base ground emergency medical services. The revenue generated by the QAF collections will be deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

ELIGIBILITY

****County Health Initiative Matching (CHIM) – Santa Clara****

This section has been deleted as this will be included in the County Health Initiative Matching (CHIM) policy change.**

1. ****Impact of SB 708 on Long-Term Care for Aliens****

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected due to the spending limit.

INFORMATION ONLY**2. **Refugee Resettlement Program****

The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, a majority of refugees are expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

3. **FFP Claiming Methodology Update for Lawfully Present Pregnant Women and Children**

Under an approved State Plan Amendment, the Department may claim Federal Financial Participation (FFP) for full scope Medi-Cal services provided to eligible documented immigrants who are lawfully present in the United States if they are under 21 years of age or pregnant. This includes New Qualified Immigrants and other lawfully present immigrants as defined by the federal government. The Department has determined that some of these immigrants who are currently claimed at a 50/50 federal/state matching rate are eligible for a higher FFP matching rate (currently 88/12). The Department is reviewing current claiming methodology for this population. When that analysis is completed, the Department will take the steps necessary to claim any additional FFP available.

AFFORDABLE CARE ACT****Disproportionate Share Hospital Reduction********This item has been deleted as this is now a new policy change.******1. **Realignment****

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care

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plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be ~~*\$1.006 billion for FY 2014-15,*~~ **** \$980.7 million for FY 2015-16,** ~~** \$585.9*~~ **** \$885.1**** million for FY 2016-17, \$688.8 million for FY 2017-18, *and \$665.26* **** \$773.2 **** million for FY 2018-19, **** and \$617.7 million for FY 2019-20.****

BENEFITS

1. ****Pompe Disease and Hurler's Syndrome Identified through Newborn Screening Program (NBS)****

SB 1095 (Chapter 393, Statute of 2016) requires that statewide newborn screening be expanded to include any disease that is detectable in blood samples as soon as practicable, but no later than 2 years after the disease is adopted by the federal Recommended Uniform Screening Panel (RUSP). Hurler's Syndrome (also known as MPS I) and Pompe Disease are two conditions previously adopted by the RUSP when SB 1095 was enrolled. The Genetic Disease Screening Program (GDSP) is now required to add these two conditions to the NBS Program and anticipates initiation of universal screening of all newborns for Hurler's Syndrome and Pompe Disease beginning in August 2018.

Children identified through the NBS Program as having, or at risk of having, Hurler's Syndrome or Pompe Disease will require confirmatory testing/diagnostic studies, clinical/medical management, monitoring, and treatment. There could be a potential indeterminate cost impact to the program due to earlier detection and implementation of services.

2. ****Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)****

****The Child Health and Disability Prevention (CHDP) administered by the state and counties provide preventive health screening examinations (i.e., well child health assessments) and immunizations to children under 21 years of age (EPSDT) and non-Medi-Cal eligible children at or under 18 years of age whose family income was at or below 200% of the Federal Poverty Level (FPL).****

****In May 2016, the passage of SB 75 expanded Medi-Cal for all children, including the CHDP non-Medi-Cal population. All persons under 21 years of age who were eligible for CHDP services were shifted to full-scope Medi-Cal. For FY 2019-20, the few remaining CHDP screens are included in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy change.****

3. ****Palliative Care Services Implementation****

****SB 1004 requires the Department to:****

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- ****Establish standards and provide technical assistance for Medi-Cal managed care plans to ensure delivery of palliative care services.****
- ****Establish guidance on the medical conditions and prognoses that render a beneficiary eligible for the palliative care services.****
- ****Develop a palliative care policy that, to the extent practicable, is cost neutral to the General Fund on an ongoing basis.****
- ****Define palliative care services. and****
- ****Provide access to curative care for beneficiaries eligible for palliative care.****

****Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.****

HOME & COMMUNITY BASED-SERVICES**BREAST AND CERVICAL CANCER TREATMENT****PHARMACY**

****Pharmacist-Delivered Medi-Cal Services****

****This item has been deleted as this is now a new policy change.****

1. ****State Supplemental Drug Rebates – Managed Care****

State supplemental rebates for drugs are negotiated by the Department with drug manufacturers to provide rebates in addition to the mandatory federal rebates already collected. SB 870 (Chapter 40, Statute of 2014) authorizes the Department to include utilization data from MCOs to determine and collect state supplemental rebates for prescription drugs added to the Medi-Cal Statewide Contract Drug List pursuant to Welfare & Institutions Code section 14105.33. Examples of prescription drugs subject to MCO state supplemental rebates may include drugs to treat diseases such as, but not limited to, cancer, HIV/AIDS, hemophilia and hepatitis C. The Department is not actively pursuing contracts for these rebates. Subsequent to SB 870, the Department is in the process of developing a Regulation Package. ~~*The tentative release date for public comments is no sooner than the first quarter of 2018.*~~ The Department does not anticipate entering into contracts with manufacturers prior to completion of the regulations. The fiscal impact has not been determined.

2. ****Outpatient Prescription Drug Rule – Blood Factor****

On February 1, 2016, CMS published the Final Rule for Covered Outpatient Drugs, effective April 1, 2016. In December 2016, CMS required the Department to change its reimbursement methodology for blood factor products and services. The changes require federal approval via a State Plan Amendment (SPA). Appropriate billing codes and a rate methodology must be determined prior to submission of the SPA and initiation of system changes are necessary to process blood factor claims to meet the directives of CMS. Therefore, implementation of this new reimbursement methodology is expected in

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FY ~~2018-19~~ **2019-20**.** The fiscal impact of the change to blood factor reimbursement has yet to be determined.

3. **Non-Blood Factor Rebates****

****Blood factor CCS and GHPP rebate invoices have been generated and collected quarterly since FY 2009. Non-blood factor CCS and GHPP rebate invoices have never been included in the rebate program. The first non-blood factor invoices will be generated in August 2019. Non-blood factor invoices will include all pharmacy and physician dispensed medication. These invoices will reflect Quarter 3 FY 2006 volume through the current year and quarter in August 2019. Currently there are no volume estimates.****

4. **New High Cost Treatments for Specific Conditions****

There are additional treatments approved and ready to be phased into use.

~~*L-Glutamine oral powder (Endari) is a lifetime treatment to reduce complications of sickle cell disease in patients 5 years of age and older. The Federal Food and Drug Administration (FDA) approved L-Glutamine oral powder on July 7, 2017, for ages five years and older to reduce complications of this disease.*~~

~~*Emicizumab-kxwh (Hemlibra) is a lifetime treatment of Hemophilia A (Factor VIII deficiency) with inhibitors. The FDA approved the treatment on November 16, 2017, for children and adult hemophilia patients to bridge the gap between Factor IX and Factor X in the clotting cascade, to bypass the function of Factor VIII.*~~

****Pegvaliase-pqpz (Palynzio) is a lifetime treatment, approved by the FDA on May 24, 2018 to treat PKU adults who are unable to maintain phenylalanine (Phe) levels (below 600 µmol/L) with current therapy.****

****Cannabidiol (Epidiolex) is a lifetime treatment, approved by the FDA on June 25, 2018 to treat two rare forms of epilepsy, Lennox-Gastaut Syndrome and Dravet Syndrome, in patients older than 2 years of age.****

Axicabtagene ciloleucel (Yescarta) is a one-time treatment for youth and adults, aged 18 and over with refractory or relapsing large B-cell lymphoma. The FDA approved the drug for treatment of individuals with types of refractory or relapsing large B-cell lymphoma (DLBCL), a type of non-Hodgkin lymphoma (NHL) whose cancer has either not responded to or returned after two or more attempts at standard systemic therapy.

Voretigene neparvovec-rzyl (Luxturna) is a proposed one-time treatment for “biallelic RPE65 mutation-associated retinal dystrophy.” The FDA approved this drug on December 19, 2017, as a new gene therapy to treat children and adults with confirmed “biallelic RPE65 mutation-associated retinal dystrophy,” an inherited form of impaired vision that may progress to complete blindness. There is no age restriction; however, there must be “viable retinal cells” remaining to treat.

INFORMATION ONLY**DRUG MEDI-CAL**1. ****FQHCs and RHCs: DMC and SMHS****

Effective January 1, 2018, SB 323 (Chapter 540, Statute of 2017) allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or the Department for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries. SB 323 clarifies the process for FQHCs and RHCs to become billable providers for SMHS and DMC services. Per SB 323, costs associated with providing SMHS and DMC services shall not be included in the FQHC's or RHC's per-visit PPS rate.

2. ****Residential Treatment Services (RTS) EPSDT Rates****

****Effective July 1, 2018, the Department added RTS rate for EPSDT clients under the Drug Medi-Cal State Plan services. RTS provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-medical residential setting. Due to the limited number of licensed residential facilities that are certified to provide services to EPSDT beneficiaries, it is unknown if there will be utilization for these services.****

MENTAL HEALTH1. ****Specialty Mental Health Services (SMHS) Claim Adjudication Errors****

The Department discovered claim adjudication errors resulting from Short-Doyle/Medi-Cal (SDMC) Phase II system coding that prevented SMHS claims from being adjudicated correctly and/or completely. System issues include claims with multiple aid codes. Beneficiaries can have up to four approved aid codes. Payments were denied because the SDMC II system adjudicates claims based on the aid code with the highest percentage of FFP. If that aid code was denied, the system did not select another aid code listed on the claim and the claim was denied.

The Department will need General Fund to reimburse County Mental Health Plans (MHPs) for SMHS claims that identified as unpaid and are past the two-year FFP claiming limit. The Department is working to identify the total amount.

2. ****FQHCs and RHCs: DMC and SMHS****

Effective January 1, 2018, SB 323 (Chapter 540, Statute of 2017) allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed directly from a county or the Department for providing Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services to Medi-Cal beneficiaries. SB 323 clarifies the process for FQHCs and RHCs to become billable providers for SMHS and DMC services.

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Per SB 323, costs associated with providing SMHS and DMC services shall not be included in the FQHC's or RHC's per-visit PPS rate. The Department initially estimated the number of clinics that may participate in the provision of SMHS to be 15 percent of FQHCs and RHCs in the State.

1115 WAIVER—MH/UCD & BTR/WAIVER 2020**1. **Waiver 2020 Negative Balance and Deferral Repayment****

The Special Terms and Conditions (STC) of the California Medi-Cal 2020 Demonstration Waiver (Medi-Cal 2020) requires California's resolution of all existing negative Payment Management System (PMS) subaccount (federal funding) balances and deferred claims.

- **Negative PMS subaccount balances:** Pursuant to STC 164 of the Medi-Cal 2020 waiver, negative PMS subaccount balances for federal fiscal year (FFY) 2013 and prior must be resolved by the end of the Medi-Cal 2020 waiver period (December 31, 2020). California and CMS continue to actively work toward the resolution of these negative PMS subaccount balances. In June of 2017, due to the progress made to date, the CMS waiver team verbally declared that the STC 164 requirements had been met and that they would be sending written confirmation. Written confirmation from CMS is still pending. STC 164 requires that, for any negative PMS subaccount balances remaining after June 30, 2017, CMS will issue a demand letter and require California to return sufficient funding to bring the PMS subaccount balances to \$0. California has submitted adjustments to resolve a significant portion of the negative PMS subaccount balances via Quarters 1 and 2 of the 2016 grant year. If CMS disallows adjustments or claims, California will have the right to appeal them. STC 164 further requires that, for negative PMS subaccount balances identified in CMS' demand letter, California will need to repay CMS, in regular quarterly installments, with interest, by the end of the Medi-Cal 2020 waiver (December 31, 2020) or in three years from CMS' approval of California's repayment schedule, whichever is longer. Interest begins on the date of CMS' demand letter.
- **Repayment of deferred claims:** Claims for which California has drawn down federal funding but CMS has deferred on or before June 30, 2017, CMS will issue a disallowance, triggering the appeal process. However, if the appeal is unsuccessful, California will be required to reimburse the federal funding. The deferred claims reimbursement will not be subject to interest. Some deferred claims contribute to the negative PMS subaccount balances, mentioned above, and may be liquidated through the negative PMS subaccount balance resolution. California is actively working to resolve these deferrals and the total federal funding reimbursement is unknown at this time. California will begin the federal fiscal year quarterly payments when the amounts are finalized.

Ongoing deferred claims repayment: In the past, California has not returned federal funding on CMS deferred claims until after the deferred claim was officially disallowed. Pursuant to the Special Terms and Conditions of the Medi-Cal 2020 waiver, California must begin complying with 42 Code of Federal Regulations 430.40, which requires the immediate repayment of federal funding for deferred claims while the deferral is being resolved. Upon

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its determination that the claim is allowable, CMS will release the funding and allow California to utilize the federal funding. CMS disallowances fluctuate quarter to quarter, resulting in an unpredictable federal fund repayment amount.

2. **BTR Designated State Health Program Reconciliation**

The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the Certified Public Expenditures (CPEs) of approved Designated State Health Programs (DSHP). The annual limit the State-Only programs may claim for DSHP is \$400 million each Demonstration Year (DY) for a five-year total of \$2 billion. This claiming has first priority on the Safety Net Care Pool funds. In addition to the State-Only programs, the Designated Public Hospitals (DPHs) are allowed to voluntarily provide excess CPEs as necessary for the State to claim the full \$400 million.

The DSHP program undergoes a reconciliation to determine expenditures for each DY. Currently DY 8, DY 9, and DY 10 are still undergoing reconciliations. Until the entire Demonstration Period is fully reconciled across all DSHP programs, the State will not be able to estimate the final reconciliation amounts; however, it is anticipated to have a fiscal impact.

MANAGED CARE

Managed Care Public and Private Directed

~~This assumption has been deleted as these are now new policy changes.~~

PROVIDER RATES**1. **Newborn Screening Program Fee Increase****

**SB 1095 (Chapter 393, Statutes of 2016) requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide newborn screenings to include any disease that is detectable in blood samples as soon as practicable, but no later than two years after the disease is adopted by the Federal Recommended Uniform Screening Panel (RUSP).

Spinal Muscular Atrophy (SMA) is a condition adopted by the RUSP on July 2, 2018. Pursuant to SB 1095, GDSP is required to add SMA to the Newborn Screening panel and begin screening for the disorder by July 2020. It is assumed the screening will cost an additional estimated \$15 per patient.

SUPPLEMENTAL PAYMENTS

Freestanding Clinics Supplemental Payments

This item has been deleted as this has been withdrawn.

INFORMATION ONLY1. ****Capital Project Debt Reimbursement****

In February 2014, Los Angeles County requested reimbursement of a \$322 million bond project for the Construction, Renovation and Reimbursement Program (CRRP). The project was completed in April 2014. The Department is currently working with Los Angeles County to determine eligibility for this project under the CRRP program.

2. ****Local Educational Agency Medi-Cal Billing Option Program (LEA BOP) Expansion****

SPA 15-021: The Medi-Cal LEA BOP provides federal financial participation (FFP) reimbursement to school districts, county offices of education, community colleges, and university campuses for certain health-related services provided by qualified medical practitioners to students receiving special education services and who are Medi-Cal eligible.

In September 2015, the Medi-Cal LEA BOP submitted State Plan Amendment (SPA) 15-021 to the Centers for Medicare and Medicaid Services (CMS) for approval to add new assessment/treatment services, and new practitioner types, and to lift the claiming limitation of 24 services in a 12 month period for beneficiaries without an Individualized Education Plan or Individualized Family Service Plan (IEP/IFSP), effective July 1, 2015. Once approved, the Department assumes that LEAs would choose to bill retroactively for new services and practitioners, provided they meet specific documentation requirements. In order for the SPA to be implemented, the new services and practitioners must be administered into the program and published in the LEA Provider Manual, and Xerox must develop and apply an updated rate table and utilization controls. At this time, the Department does not have an estimate of when SPA 15-021 will be approved and implemented. SPA 15-021 is estimated to increase LEA BOP FFP payments. There will be no GF impact.

SPA 16-001: SB 276 (Chapter 653, Statutes of 2015) amended Welfare and Institutions Code 14132.06 requiring that Targeted Case Management (TCM) Services be available to all Medicaid eligibles regardless of whether they have an IEP/IFSP. On March 29, 2016, SPA 16-001 was submitted to CMS which proposes to amend the population receiving TCM services in the LEA Program to include all Medicaid eligibles, regardless of whether they have an IEP/IFSP under the Individuals with Disabilities Education Act. Approval of SPA 16-001 will align California with the provisions in Welfare and Institutions Code 14132.06.

The reimbursement methodology for the TCM services described in SPA 16-001 is under review by CMS, pending approval of SPA 15-021, due to the overlapping nature of these two SPAs. Once SPA 15-021 is approved, the Department will submit reimbursement pages under SPA 16-001, from SPA 15-021, which will reflect the expanded TCM-eligible population to include all Medi-Cal eligible children, regardless of whether they have an IEP/IFSP.

The expected impact of SPA 16-001 to the LEA Program includes expanded access of care for individuals on school sites receiving TCM services and an increase of FFP for Medi-Cal covered TCM services.

INFORMATION ONLY**OTHER: AUDITS AND LAWSUITS**1. **SB 1103 Litigation**• **OAHA Administrative Appeals and Superior and Appellate Court Actions**

In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103. During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA). All challenge SB 1103's validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103's alleged invalidity.

OAHA has been holding these administrative appeals in abeyance during the *Mission Hospital Regional Medical Center v. Douglas* litigation, which finally terminated in early 2014. OAHA dismissed at least 24 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission* litigation's challenge to SB 1103. In approximately 16 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petitions and the hospitals appealed.

(*Dignity Health v. Douglas*; *Hi-Desert Med. Center v. Douglas & Modoc Med. Center v. Douglas*). In four other cases, the superior court granted the writ petitions and the Department appealed one (*George L. Mee Mem'l Hosp. v. Douglas*). The appellate court heard these four cases together and, in August 2015, found that each hospital's case was barred by its participation in the *Mission* litigation. The hospitals sought rehearing before the appellate court and filed a petition for review with the Supreme Court, both of which were denied. Since the California Supreme Court denied the petition for review, all remaining superior court petitions were dismissed.

The Department also appealed two other cases in which the superior court had granted the hospital's writ petition. (*Desert Valley Hosp. v. Douglas & Ridgecrest Regional Hosp. v. Douglas*.) Because Desert Valley Hospital did not participate in the *Mission* litigation and actively tried to pursue its administrative appeal while *Mission* was pending, the Department settled this case for \$500,000. The Department did, however, pursue the *Ridgecrest* appeal. In an unpublished opinion, the Second District Court of Appeal affirmed the lower court's decision granting Ridgecrest's writ petition. The Department subsequently negotiated a \$315,000 settlement with Ridgecrest resolving all outstanding issues, including attorney's fees, related to the administrative appeal, petition for writ of mandate, and subsequent appeal.

In mid-October 2016, four administrative appeals were still pending before OAHA, all of which involve hospitals that did not participate in the *Mission* litigation. Given the Court of Appeal's opinion in *Ridgecrest*, the Department began negotiating settlements with these providers. A settlement of \$220,000 was reached in the

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Children's Hospital at Mission consolidated appeal, a \$77,895 settlement was obtained in the Community Hospital of Monterey Peninsula matter, and a \$1,775,977 settlement was negotiated in Enloe Medical Center. OAHA issued final decisions incorporating the Children's Hospital at Mission, Community Hospital of Monterey Peninsula, and Enloe Medical Center settlement agreements on November 3, 2016, November 7, 2016, and March 21, 2017, respectively. OAHA discovered a fifth administrative appeal involving Community Hospital of Long Beach, a non-Mission litigant, which was previously unknown to the Department. ~~*The Department continues to negotiate settlements in the two administrative appeals that remain before OAHA.*~~ ****The Department settled with Northern Inyo on October 20, 2017 for \$301,000 and with Community Hospital of Long Beach for \$380,797 on August 22, 2017.****

To date, no court has ruled on SB 1103's substantive validity. ****Based on the above, these matters are closed and will no longer be reported in these Informational Assumptions.****

2. ****Santa Rosa Memorial Hospital, et al. v. Department of Health Care Services and Northbay Healthcare Group, et al. v. Department of Health Care Services (State Court Litigation)****

The Plaintiffs in these two state court lawsuits are over 30 hospitals, including the 17 that are Plaintiffs in the federal court *Santa Rosa Memorial Hospital* case. The two lawsuits have been consolidated for litigation purposes. The Plaintiffs contend that the 10% Medi-Cal payment reduction and larger reduction for some hospitals that the Department implemented for non-contract hospital inpatient services, pursuant to ABX 4 5 (Chapter 3, Statutes of 2008) and AB 1183 (Chapter 758, Statutes of 2008) violate various federal Medicaid laws, including 42 U.S.C. sections 1396(a)(8), 1396a(a)(13), and 1396a(a)(30). The Plaintiffs seek retroactive damages of almost \$100 million, including interest based on the Department's implementation of the AB 5 and AB 1183 reduced payments.

Litigation in this case had been stayed (i.e., placed on hold), until the federal court ruling dismissing the federal court *Santa Rosa Memorial Hospital* lawsuit. After the parties completed briefing on the Plaintiffs' legal claims, there was a court hearing on April 18, 2016. The court tentatively ruled in favor of the Department on July 19, 2016, and a further hearing was held on December 13, 2016. On April 12, 2017, the trial court issued a judgment in favor of the Department. On April 24, 2017, the plaintiffs appealed the judgment, ~~*and their opening appellate brief was filed on October 8, 2017. The Department's response brief is due on March 9, 2018.*~~ ****Appellate briefing concluded in April 2018, and oral argument is scheduled for July 25, 2018.****

3. ****AB 97 Rates Litigation****

A few lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

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- ****California Medical Transportation Association v. Douglas, et al.****
Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.
On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services. *The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018.* **** On May 8, 2018, the district court granted the state and federal defendants' motion to stay proceedings for six months to facilitate the Department and CMS review of access monitoring data relevant to the approved SPA at issue.****
- ****California Medical Association et al. v. Douglas,****
Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government, which approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).
On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012, that are not reimbursed at the unreduced rates prior to that date. The Department and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for

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a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the Plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the Plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the Plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments. ~~*The parties have agreed to a briefing schedule in federal district court to occur in the first half of 2018.*~~

****On May 8, 2018, the district court granted the state and federal defendants' motion to stay proceedings for six months to facilitate DHCS/CMS review of access monitoring data relevant to the approved SPA at issue.****

4. ***American Indian Health Services, Inc., et al. v. Toby Douglas, et al***

Petitioners and Plaintiffs, which are Federally Qualified Health Centers (FQHC), filed a Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief in Sacramento Superior Court. Petitioners and Plaintiffs sought an order requiring the Department to process and pay claims for adult dental, podiatry, and chiropractic services that Petitioners provided to eligible Medi-Cal beneficiaries during the period July 1, 2009, to September 26, 2013, pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (2), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007. On December 8, 2015, the court granted the Petition for Writ of Mandate. The court further directed Counsel for Petitioners to prepare a formal judgment and writ, submit it to the Department's counsel for approval as to form, and thereafter submit it to the court for signature and entry of judgment. On January 11, 2016, the Court issued the final formal judgment and writ. ~~*On February 19, 2016, Counsel for Petitioners sent a letter to Counsel for Respondents; this letter set forth an informal settlement proposal. Counsel for Respondents responded in April 2016, via letter, reflecting the Department's disinterest in pursuing the proposal.*~~ The Department appealed the final judgment. Appellate briefing was completed in the fall of 2017 ~~*and the parties await scheduling of oral argument.*~~ **** On June 19, 2018, the appellate court affirmed the final judgment in favor of plaintiffs.****

5. ***Managed Care Potential Legal Damages***

Three health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 2002 through 2005. The cases are referred to as:

- *Health Net of California, Inc. v. DHCS*
- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

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On June 13, 2011, judgment was issued in favor of Plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The amount of payment due is contingent on each plan's profits, and the settlement accounting is scheduled to occur as follows, subject to applicable run-out ****and reconciliation**** periods provided in the settlement terms: *Molina* (January 1, 2018); *Blue Cross* (January 1, 2019); *Health Net* (January 1, 2020).

6. **Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly**

This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The court granted Petitioners' writ on the third cause of action (duty to review rates annually) and ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. On October 24, 2014, the court found the Department's 2011 rate review report and the analyses of the five third-party payer rates data satisfactory, and discharged the Department's ministerial duty under Welfare and Institutions Code section 14079. The court also found that the Department satisfactorily demonstrated its intention of conducting this rate review on an annual basis. On May 22, 2015, Petitioners filed a motion for attorneys' fees and costs in the amount of \$2.5 million. On February 5, 2016, the court denied the plaintiff's motion for attorneys' fees. Plaintiff filed a notice of appeal on February 24, 2016, ~~and filed their opening brief on December 27, 2016. The Department filed its response brief on April 14, 2017. The plaintiffs' reply brief was filed on May 4, 2017. Oral arguments have not been set.~~ **** The Appellate Court found that the judgement on the Writ was not entered timely, and therefore dismissal of petitioner's claim for attorney's fees was not supported. The matter was remanded to the trial court for further proceedings. No hearing dates have been set. ****

7. **Asante, et al. v. Department of Health Care Services, et al.**

Plaintiffs are 19 out-of-state border hospitals that challenge the validity of Medi-Cal reimbursement paid to out-of-state hospitals for hospital inpatient services. They filed this lawsuit in June 2014 in San Francisco Superior Court. The Department removed the case to federal court. Plaintiffs contend that aspects of the diagnosis-related group (DRG) reimbursement policy discriminate against out-of-state hospitals in violation of the Interstate Commerce clause and Equal Protection clause of the United States Constitution. They seek an injunction to eliminate the alleged discriminatory DRG policies with respect to both fee-for-service reimbursement, and in the DRG based rates that managed care plans pay to out-of-

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network hospitals. They further contend that the Department is violating federal Medicaid law and discriminating against out-of-state hospitals in violation of the Commerce Clause and Equal Protection Clause by not making disproportionate share hospital (DSH) payments to qualifying out-of-state hospitals. In addition to injunctive relief, the Plaintiffs seek damages back to July 1, 2013.

On December 21, 2015, the federal court granted the Plaintiffs' motion for partial summary judgment, ruling that certain aspects of the DRG rate methodology and the Department's policy of not making DSH payments to qualifying out-of-state hospitals constituted discrimination against out-of-state hospitals in violation of the Commerce Clause. On March 24, 2016, the district court issued an order requiring the Department to implement changes in the DRG rate policies for plaintiffs and to make DSH payments to any plaintiff hospital that meets the same eligibility standards that apply to California hospitals, with respect to admissions on or after December 21, 2015. On October 12, 2016, the district court issued a final judgment, which incorporated the terms of the court's March 24, 2016 order, as well as an April 2016 ruling denying the plaintiffs' claim for retroactive relief with respect to admissions July 1, 2013-December 20, 2015.

Both parties appealed the final judgment. The plaintiffs appealed the final judgment because it did not grant relief for admissions July 1, 2013-December 20, 2015, and because it requires the plaintiffs to submit the same information that California hospitals are required to submit to establish eligibility to DSH payments under the Medi-Cal program. Appellate briefing concluded in late 2017. In addition, the plaintiffs filed a motion for attorney fees and costs totaling \$890,407. On February 24, 2017, the district court issued an order awarding the plaintiffs \$735,712 for their attorney fees and costs. The Department appealed the attorney fee award and the district court stayed its enforcement pending the Department's appeal. On October 18, 2017, the Ninth Circuit granted the Department's motion to consolidate the merits appeals and the attorney fee appeal. Oral argument in the Ninth Circuit was ~~*scheduled for*~~ ****held on**** March 14, 2018.

****On April 2, 2018, the Ninth Circuit reversed the district court in favor of the Department finding no violation of the Interstate Commerce Clause, and also reversing the award of attorney fees. Plaintiffs filed a petition for rehearing which was denied by the court on May 14, 2018. The case has been remanded to district court and a hearing on the Department's motion for entry of judgement following reversal is scheduled for July 12, 2018.****

8. ****Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.****

On July 22, 2014, Riverside Recovery Resources filed an amended writ of administrative mandamus and complaint in Riverside County Superior Court against the Department and Riverside County Department of Mental Health contesting disallowances of monies for Drug Medi-Cal services provided to minors in Riverside County schools. A Post Service Post Payment audit found that Plaintiff, Riverside Recovery Resources, submitted claims for services provided at uncertified satellite sites, which were not eligible for reimbursement. As a result, Riverside County withheld reimbursement for services during the period of time Riverside Recovery Resources was found to be in non-compliance. Plaintiff disputes the facts

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upon which the non-compliance findings were based, and alleges denial of due process in the administrative appeal process.

Plaintiff filed their opening brief in support of the writ of administrative mandamus on May 1, 2015. Plaintiff argues the Department should be equitably estopped from disallowing the claims because of a lack of clarity in the certification standards. The Department filed its opposition on June 30, 2015. Plaintiff filed its reply brief on July 31, 2015. On August 20, 2015 the court issued a tentative ruling holding the Department violated Welfare & Institutions code section 14171 by failing to provide Plaintiff with an administrative appeal pursuant to the Administrative Procedures Act. The tentative ruling remanded the case back to the Department for a formal evidentiary hearing before an administrative law judge. On November 19, 2015, pursuant to a stipulation, the court remanded the case back to the Department to provide Plaintiff with a formal evidentiary hearing. The Department has filed a return in superior court showing that the Department has complied with the writ of mandate by vacating its decision on the second level appeal and setting the date for a formal hearing on Riverside Recovery's appeal. Although the hearing was originally set for March 15, 2016, at plaintiff's request, it was continued to November 18, 2016, and, at the request of Riverside Recovery Resources, continued again to January 20, 2017. Based on documents that the Riverside Recovery Resources received in discovery and just completed reviewing, it was requested that the Department review a small portion of the recoupment. Review of this contention involves reviewing numerous documents. The hearing on remand occurred on March 9, 2017. A proposed decision in favor of the Department was issued on January 3, 2018, and ~~the parties await the final decision. Post-hearing briefing has commenced and should conclude by August 14, 2017.~~ **** the final decision was issued on January 30, 2018, sustaining the Department's action to recover the money as an overpayment. This matter is now closed and will no longer be reported in these Informational Assumptions.****

9. **Placentia-Linda Hospital, et al. v. California Department of Health Care Services**

The lawsuit was filed in San Francisco County Superior Court on April 9, 2014. Plaintiffs are five hospitals that contend that the Department implemented Medi-Cal payment reductions for non-contract hospital inpatient services from July 1, 2008, through April 12, 2011, as required by Assembly Bill 5 (statutes 2008) and Assembly Bill 1183 (statutes 2008), in violation of 42 United States Code sections 1396a(a)(13) and 1396a(a)(30)(A). Plaintiffs seek a court order requiring the Department to retroactively pay them the additional money they would have received if the Department had not implemented the reductions. This case was stayed pending final resolution of the federal court Santa Rosa Memorial Hospital, et al. v. Douglas, et al. case, which has since ended and thus that stay was lifted. The parties have agreed to another litigation stay, pending resolution of the state court Santa Rosa Memorial Hospital/Northbay v. DHCS case listed above.

10. **Thomas, et al. v. Jennifer Kent, Director of DHCS, et al.**

Plaintiffs are disabled Medi-Cal beneficiaries receiving nursing care and other services in their homes under the Medi-Cal Home and Community Based Alternatives Waiver

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(formally named Nursing Facility/Acute Hospital Waiver, or NF/AH Waiver). Plaintiffs allege that they are unable to obtain needed services to continue living safely in their homes because of the Waiver's individual cost limitations for each level of care, which are below the cost for the individual to live in an equivalent institution. Plaintiffs allege that the individual cost cap places the Plaintiffs and other similarly situated Medi-Cal beneficiaries at risk of institutionalization, and therefore violates the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and California Government Code section 11135. Plaintiffs ask the US District Court to:

- Declare the Waiver's individual cost limitations unlawful;
- Enjoin the Department from reducing services, discriminating against Plaintiffs, and putting them at risk of institutionalization through the cost and eligibility limitations;
- Order the Department to provide Plaintiffs needed services, and amend policies and procedures to meet Plaintiffs' needs and federal cost neutrality requirements. (By, among other things, amending the waiver to an aggregate cap, increasing the total cost of the waiver, and adding additional participant slots to the waiver.)

The court denied Plaintiffs' three Motions for Summary Judgment (MSJs), and failed to rule on the Department's Motion to Dismiss based on the Waiver amendment mooted out the second amended complaint allegations. ~~*The court reopened discovery regarding the renewed Home and Community Based Alternatives Waiver, which replaced the NF/AH Waiver, and is allowing plaintiffs to file a third amended complaint. The parties are currently contemplating a voluntary dismissal of the case, without prejudice. If dismissed in this fashion, plaintiffs intend to continue litigating against the Department to recover associated attorney's fees and costs.*~~ **The Department renewed the waiver as the Home and Community Based Alternatives Waiver, in which services are approved based on medical necessity without any individual cost limits. Plaintiffs dismissed the case without prejudice, and both parties are seeking to recover attorney's fees and costs. The hearing date for the motions on the right to recovery of attorney's fees has not yet been set.****

11. **Rivera v. Douglas, Director of DHCS**

There were a significant number of Medi-Cal applicants whose applications had not been processed within 45 days of the application date ("backlog") and that were still pending when Petitioners filed suit. Petitioners filed a writ seeking an order that this backlog is in violation of state law and that state law requires that all Medi-Cal applicants that appear to be eligible should be granted eligibility for Medi-Cal benefits while any necessary verifications are being completed; and specifically that the Department (1) give notice to all applicants in the backlog that they have a right to hearing on the delay, and (2) grant all pending applicants that appear eligible conditional eligibility for Medi-Cal benefits.

Petitioners' Motion for Preliminary Injunction (PI) Motion was granted on January 20, 2015. The Preliminary Injunction prohibited the Department from failing to comply with its duty to make eligibility determinations within 45 days unless certain specified legal exceptions apply. It further ordered that when an application has not been determined within 45 days, the Department may comply with the injunction by (1) for applicants who appear likely

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eligible for Medi-Cal, granting Medi-Cal benefits, including a notice of action, pending completion of the final eligibility determination, and (2) for each applicant who has not been granted these benefits and to whom none of the exceptions apply, provide with a notice of hearing rights. Petitioners' claim that all applicants that appear to be eligible should be granted conditional eligibility while verification is completed was not determined in the PI ruling. The PI no longer binds the Department because final Judgment has been entered.

The writ was heard on May 18, 2015 and largely granted on August 15, 2015. The court ruled in favor of the Petitioners on all but one claim and issued its Judgment on December 2, 2015. This Judgment ordered the Department to comply with its duty to make eligibility determinations within 45 days unless certain specified legal exceptions apply. It further ordered that the Department may, as an alternative means of complying with this duty, (1) for applicants who appear likely eligible for Medi-Cal, grant provisional Medi-Cal benefits until those applications have received an eligibility determination, and (2) for each applicant who has not been granted these benefits and to whom none of the exceptions apply, provide him/her with a notice of hearing rights that includes a statement of the specific reason or reasons why the application has not been determined within 45 days. The court denied without prejudice Petitioners' request that the Department be required to grant "conditional benefits" as early in the 45 day period as the county finds an applicant for whom income verification is pending is otherwise eligible. The injunction and writ were stayed by 61 days to allow the Department time to file an appeal.

The Department appealed the Judgment/Writ. The Notice of Appeal was filed on February 1, 2016. Petitioners originally cross-appealed but have dismissed that cross-appeal.

Petitioners filed a motion to enforce the Writ claiming that the filing of the appeal did not automatically stay enforcement. This motion was heard by the court March 9, 2016 and was denied on May 9, 2016. The Department's opening brief in the appeal was filed on October 11, 2016, and Petitioners' response brief was filed on December 8, 2016. The Department filed its reply brief on February 1, 2017. The appellate court has notified the parties that the case has been placed on the conference list and of their right to waive hearing; both parties filed a request for a hearing. The appellate court has not yet scheduled a hearing.

Costs attributable to the writ are currently unknown. If the Appeal is not successful, the costs attributable to the writ will likely be one or more of the following: (1) for granting provisional eligibility to applicants whose applications have not been determined within 45 days whenever the Department is unable to timely determine eligibility, and (2) for sending out notices to applicants not granted provisional eligibility and that have not had their eligibility determined within 45 days, with the specific reason(s) for the delay specified in each notice.

12. **MALDEF, et al. Title VI Administrative Complaints; Analina Jimenez Perea, et al., v. Diana Dooley, et al.; *Deuschel v. Dooley et. al.***

On December 15, 2015, the Mexican American Legal Defense and Educational Fund (MALDEF), the National Health Law Program (NHeLP), and several other advocacy

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groups filed an administrative complaint with the U.S. Department of Health & Human Services' Office for Civil Rights (DHHS OCR) pursuant to Title VI of the 1964 Civil Rights Act. The groups allege, on behalf of several Medi-Cal beneficiaries, that inadequate Medi-Cal reimbursement rates, coupled with the Department's failure to ensure timely access to services, constitute discrimination against the Latino population. They seek a finding from DHHS OCR that the Department's reimbursement rates violate Title VI and an order requiring the Department to raise the rates. On December 22, 2015, MALDEF sent a copy of the administrative complaint to the attention of CHHS Secretary Diana Dooley and Department Director Jennifer Kent, along with a cover letter citing the Department's regulations governing Title VI complaint investigations. The letter demands immediate action from the Department to raise reimbursement rates and improve monitoring of access. There has been no DHHS OCR activity known to the Department since the administrative complaint was filed.

On July 12, 2017, five individuals and three organization filed a class action suit (**Perea, et al.**) against CHHS and DHCS in Alameda County Superior Court seeking injunctive relief against the same Medi-Cal reimbursement and access policies identified in the above described Title VI Administrative Complaints. Plaintiffs allege that the Department's failure to provide adequate access to providers disparately impacts Latinos. Plaintiffs allege that Medi-Cal is "disproportionately and majority Latino," and that while all beneficiaries receive poorer treatment than whites covered by other insurance plans (such as Medicare and employer-provided insurance), Latinos are impacted more than other non-Latino Medi-Cal beneficiaries. They also allege that administrative burdens in the Medi-Cal program hinder access to "meaningful" health care. Plaintiffs also contend that the Department fails to monitor Medi-Cal beneficiaries' access to health care services, and fails to ensure managed care plans have adequate networks of providers. Finally, plaintiffs contend that as the percentage of Latino Medi-Cal beneficiaries has increased, the Department has "disinvested" in the Medi-Cal program by reducing Medi-Cal rates relative to Medicare. All of these acts, plaintiffs contend, have disparately impacted Latinos, and constitute purposeful discrimination.

Plaintiffs allege violations of Government Code section 11135 (prohibiting discrimination in state programs), and the California Constitution, Articles I and IV (equal protection, substantive due process). Plaintiffs seek injunctive relief as taxpayers, under California Code of Civil Procedure section 526a, and seek a writ of mandate under Code of Civil Procedure section 1085. Plaintiffs contend that the Department's actions also violate federal Medicaid statutes, including 42 U.S.C. section 1396b(m)(1)(a)(i), and 42 U.S.C. section 1396a(a)(30)(A). Plaintiffs do not seek monetary relief for any of the individual plaintiffs. Rather, they are seeking an order requiring the Department to increase the rates it pays to Medi-Cal providers. ~~*On November 22, 2017, the Department filed a Demurrer, which was scheduled for hearing on February 9, 2018.*~~ ****On April 12, 2018, the court sustains the Department's demurrer but granted Plaintiffs leave to amend their complaint. Plaintiffs filed their first amended complaint on May 18, 2018 and the Department demurred on June 20, 2018. A hearing on the demurrer is scheduled for August 10, 2018.****

On December 11, 2017, another lawsuit *****(Deuschel) was***** filed by an individual plaintiff ~~*made substantially*~~ ****against the Department, CHHS, and the Department of Social**

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Services making** similar **discrimination**** allegations as the class action suit, though the allegations are based on disability status. **Plaintiff seeks injunctive relief and writ of mandate requiring the Department to increase Medi-Cal rates and to monitor and enforce network adequacy and timely access, as well as compensatory damages. The Department filed a demurrer on February 9, 2018, which is scheduled for hearing on July 26, 2018.****

13. **Quest Diagnostics Inc., et al. v. Department of Health Care Services****

Plaintiffs in this case are clinical laboratory testing providers, specifically Quest Diagnostics Inc. and the California Clinical Laboratory Association.

On June 29, 2016, Plaintiffs filed a Complaint in the Sacramento Superior Court for Injunctive and Declaratory Relief, challenging reimbursement paid by DHCS for Medi-Cal laboratory testing services. Plaintiffs contend that the Department violated Assembly Bill (AB) 1494 (codified at Section 14105.22 of the Welfare and Institutions Code) by continuing to apply the AB 97 10% reduction to payments to clinical laboratories under the new market-based rate methodology established pursuant to AB 1494. Plaintiffs contend that AB 1494 required the Department to discontinue the AB 97 10% payment reduction once the new AB 1494 methodology was implemented.

Plaintiffs seek to compel the Department to eliminate the AB 97 10% payment reduction applied to the AB 1494 methodology, to reimburse petitioners for the reductions already applied to applicable laboratory services reimbursement, and to obtain a declaration that the Department has violated AB 1494.

Plaintiffs' petition for writ of mandate was heard on October 28, 2016. The Court denied the writ petition and complaint, ruling in favor of the Department. On November 16, 2016, Plaintiffs filed a notice of appeal. Appellate briefing concluded in late 2017 and ~~the parties await scheduling of~~ oral argument **was scheduled for July 18, 2018.****

14. **Boothby, et al v. DHCS, et al.****

The lawsuit was filed in Los Angeles Superior Court on July 22, 2016. The Plaintiffs, all of whom are licensed Registered Dental Hygienists in Alternative Practice (RDHAP), brought this action to challenge the Department's new policy regarding prior authorization requirements for scaling and root planning for Medi-Cal beneficiaries residing in skilled nursing facilities or intermediate care facilities. The new policy went into effect on July 15, 2016, and it was published via a Medi-Cal Dental provider bulletin. Plaintiffs challenge the substantive validity of the policy, as well as the administrative steps that the Department took prior to implementing the policy. Medi-Cal Dental provider bulletin decreases the periodontal maintenance rate which the lawsuit alleges will put providers out of business as their costs will exceed reimbursement. The Plaintiff's also assert the Department has no authority for imposing prior authorization requirements on RDHAPs aligning them to prior authorization requirements already in place for Dentists.

A trial setting conference (TSC) was held on December 1, 2016. At the TSC, Plaintiffs sought an alternative writ and preliminary injunction (1) staying the provider bulletin and

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the reimbursement changes contained therein until the Department receives CMS SPA approval; (2) directing the Department to pay providers the rates previously approved by CMS for services provided since July 14, 2016; and (3) setting an expedited briefing schedule and preferential hearing date on the petition.

Subsequent to the December 1, 2016 TSC, the parties engaged in settlement discussions; however, those negotiations stalled and have become the subject of a new cause of action filed by Plaintiffs. Based on this new cause of action, Plaintiffs brought an unsuccessful motion for summary adjudication claiming the Department entered into an oral agreement with Plaintiffs to settle the matter and seeking specific performance. The court denied Plaintiffs' motion and set the complaint causes of action for hearing on March 21, 2018. The writ petition ~~*will be*~~ ****was**** heard ~~*in a different courtroom on January 23*~~ ****on**** February 8, 2018, ****and the court found that the Department failed to perform certain administrative protocols prior to implementation of the provider bulletin changes. Final judgement was issued on May 29, 2018, requiring the Department to perform certain ministerial duties including obtaining federal approval for the provider bulletin policies, but denying retroactive monetary relief for Plaintiffs and their substantive challenge under 42 U.S.C. §1396a(a)(30)(A). On June 30, 2018, the Department submitted a State Plan Amendment to effectuate the subject provider bulletin policies, which is pending at CMS. As of August 2018, this lawsuit has been settled.****

15. ****Dental Managed Care Plans Notifications of Dispute with the Department****

The three dental managed care plans (the Plans) filed notifications of dispute (NOD) with the Department alleging the Department breached the managed care contracts. The contracts permitted the Department to withhold 10% of the monthly capitation rate and allowed the Plans to recover some or all of the withheld amount should it satisfy the agreed upon performance measures, plus earn an up to 5% as a bonus for exceptional performance. In the NODs, the Plans disputed the formula used to calculate the recoverable amount of the withhold because it rendered the withheld amounts unattainable, and, due to the Plans' inability to recover any portion of the withheld amounts, the capitation rates paid fell below the actuarially sound range.

On August 1, 2016, the Department issued All Plan Letter 16-009, waiving the Department's contractual right to withhold 10% of the monthly capitation payment from July 1, 2014, through July 31, 2016. For the service periods that remain at issue, the parties are engaged in settlement discussions.

16. ****Blue Cross of California v. DHCS, et. al.; California Physicians' Service DBA Blue Shield of California v. DHCS, et. al.****

Blue Cross of California and Blue Shield of California (Plaintiff) are real parties in interest in a pending California taxpayer action filed in Los Angeles Superior Court captioned Myers v. State Board of Equalization, et al. (Myers), which seeks a writ of mandate directing the appropriate taxing agencies to collect the annual gross premiums tax (GPT) from Plaintiffs as "insurers" under the California Constitution. The Plaintiffs seek reimbursement from the Department for managed care organization (MCO) taxes paid or

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that will be paid pursuant to SBx2 2 (Chapter 2, Statutes of 2016, 2nd Ex. Sess.) in the event that Myers action results in the Plaintiff being subject to the GPT and exempt from assessment of the SBx2 2 version of the MCO tax. ~~*The Blue Cross action has*~~ **Both actions have** been formally stayed after being designated a related case to Myers, and a status conference has been scheduled for ~~*May 29, 2018.~~ The Department awaits the court's ruling on the relatedness of the Blue Shield action to Myers, but it is expected that ~~action will be stayed as well.*~~ **January 15, 2019.**

17. *Ivory N. and James B. v. Kent et al.*

****Plaintiffs, through a class action, seek declaratory and injunctive relief requiring the Department to arrange for in-home skilled nursing care to meet the needs of medically fragile Medi-Cal eligible children in their home. Plaintiffs assert that DHCS has failed to arrange for medically-necessary in-home shift nursing services, resulting in institutionalization and risk of institutionalization, in violation of the Medicaid Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and state non-discrimination laws. Plaintiffs ask the court to order the Department to take all steps necessary to arrange for medically necessary in-home shift nursing for the class members.****

18. *Shield California Health Care Center, Inc. v. Department of Health Care Services*

****The lawsuit was filed in Los Angeles County Superior Court on May 22, 2018. Plaintiff seeks to enjoin the Department from recouping overpayments made to Plaintiff for medical supplies furnished to Medi-Cal patients between June 1, 2011 and October 24, 2013. The overpayments were the result of a since-lifted injunction on the ten percent Medi-Cal payment reductions made pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes 2011; codified at Welf. & Inst. Code § 14015.192). Plaintiff asserts that the Department unreasonably delayed the retroactive recoupment. Plaintiff asserts that the doctrine of laches should be applied to invalidate the Department's continuing recoupment of the AB 97 overpayments. The Department's responsive pleading is due July 31, 2018.****

19. *AIDS Healthcare Foundation Rate Disputes Settlement*

****In January 2018, the Department entered into settlement with AIDS Healthcare Foundation (AHF) to resolve multiple managed care rate disputes dating back to 2007 and past fee-for-service overpayments for certain prescription drugs. The settlement requires AHF to pay the Department \$624,102.99 upon approval of the settlement, amongst other terms. The settlement is currently under review with the federal Centers for Medicare and Medicaid Services (CMS). If not approved by CMS, the Department may be required to return federal financial participation associated with some or all of the past rate years at issue in the underlying litigation.****

20. *California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician Administered Drugs*

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The OIG reviewed \$237,533,773 of California's fee-for-service claims for physician-administered drugs paid for the quarter April through June 2008, July through September 2009, and October through December 2010. Of the amount paid, OIG reviewed \$58,907,969 that was not billed for rebates. Of the remaining \$178,625,804 that was billed for rebates, OIG reviewed \$61,432,295 to verify that the claims were properly billed. OIG recommended that the State refund to the Federal Government \$4,392,568 (Federal Share) for claims for single-source and top-20 multiple-source physician-administered drugs, and \$27,349,486 (Federal Share) for other claims, all of which were ineligible for Federal reimbursement.

The Department has completed a review of 1.4 million claims, and has identified those not eligible for rebates.

21. **California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals**

OIG reviewed and reconciled hospital incentive payments reported for the period of October 1, 2011 through December 31, 2015. Although the State made Medicaid EHR incentive payments to eligible hospitals, it did not always make them in accordance with Federal Requirements. The OIG is requesting the Department refund CMS \$28,361,240 in net overpayments to the 64 hospitals.

Department staff ~~have started~~ **completed audits of** ~~auditing~~ the hospitals reviewed by OIG to determine actual overpayment amounts based on adjudicated claims **versus reliance on hospital-generated reports. Recent CMS clarification on the treatment of administrative, psychological, rehabilitation, and nursery bed days may result in revisions to the department's audit findings.** Subsequently, the Department's initial audit findings suggest the OIG's overpayment findings were significantly overstated.

The Department intends to offset identified overpayments against the hospitals' **pending** future EHR incentive payments. **The Department will request voluntary repayment from hospitals without pending payments, and initiate collection if necessary.**

22. **California Did Not Bill Manufacturers for Rebates for Physician Administered Drugs Dispensed to Enrollees of Some Medicaid Managed Care Organizations**

OIG reviewed drug utilization data or encounter data for physician administered drugs for 20 of CA's 28 MCO's from April 1, 2010 through December 31, 2010. After reviewing records for physician-administered drugs in the encounter data for the 13 MCOs, OIG estimated that the Department paid \$157,157,582 (\$96,793,355 Federal share) for drugs that were eligible or may have been eligible for rebates. On the basis of this amount, OIG estimated that the Department did not bill for and collect from manufacturer rebates of \$69,109,297 (\$42,564,416 Federal share).

The Department is performing an ongoing review of the information received from OIG; the review is estimated to be completed in September 2018.

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The Office of the Inspector General (OIG) worked to verify that State Fiscal Year (SFY) 1998 DSH Payments to the University of California, San Diego Medical Center (UCSDMC) did not exceed the hospital specific limit as mandated by Omnibus Reconciliation Act (OBRA) of 1993.

The Department made DSH payments to UCSDMC that exceeded the limit for SFY 1998. The UCSDMC limit determined by the state did not comply with federal statutes and CMS requirements and implementing guidance. The limit determined by the state, based on projected data, was \$54,218,316. The state made DSH payments to UCSDMC totaling \$50,363,032 (\$3,855,284 less than the state determined limit) for SFY 1998. The limit based on audit results, however, was \$34,437,864. As a result, UCSDMC received a payment of \$15,925,168 (\$7,999,212 federal share) in excess of the limit based on the audit.

State law requires that any DSH payment exceeding the limit as determined by an audit or federal disallowance should be recouped by the state for payments that exceeded the limit. The Department disagreed with this finding and subsequent repayment. The Department submitted the required disallowance package to CMS but is still waiting on final approvals. Should the package be denied, the Department will work with CMS on the appropriate next steps.

24. **Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998**

The OIG worked to verify that State Fiscal SFY 1998 DSH Payments to Kern Medical Center (KMC) did not exceed the hospital specific limit as mandated by OBRA of 1993.

The audit showed that the Department made DSH payments to KMC that exceeded the limit by \$38,714,784 (\$19,446,435 federal share) for SFY 1998. Payment in excess of the limit occurred primarily because the limit for KMC determined by the state did not comply with federal statutes and regulations and CMS implementing guidance.

The overstatement of the KMC limit consisted of the following items:

- Using projected amounts instead of actual incurred expenses and payments
- Not limiting total operating expenses to amounts that would be allowable under Medicare cost principles;
- Including bad debts as an additional operating expense;
- Double counting charges for the Short Doyle program and including charges for services provided to inmates and Kern County employees.

OIG recommended the Department refund to the CMS \$14,165,950 representing the federal share of the KMC overpayment associated with the findings for Medicare cost

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principles, bad debts, Short Doyle program, and services provided to Kern County employees.

The Department disagreed with the findings and submitted a disallowance package to CMS for review and approval. Should the package be denied, the Department will work with CMS on the appropriate next steps.

25. ****California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered or Prescribed by Excluded Providers****

The Department made unallowable Medicaid payments of \$1,900,466 (\$1,170,497 Federal share) for items and services furnished, ordered, or prescribed by excluded providers. The Department made these payments because it did not have policies and procedures to (1) ensure that all agencies within California responsible for enrolling providers or processing Medicaid claims for reimbursement performed monthly review to identify excluded providers and (2) identify whether any furnishing, ordering, or prescribing providers listed on a claim were excluded. Of the \$1,170,497 amount, the Department still owes \$139,778 FFP.

The Department made unallowable Medicaid payments for services claimed by excluded providers the Department paid \$1,134,529 (\$698,756 Federal share) for additional items or services that may have been furnished, ordered, or prescribed by excluded providers and therefore may have been unallowable. The claim data provided by the Department did not always include sufficient detail to verify whether some furnishing or prescribing providers were excluded or to determine the specific roles of some providers listed on the claims (i.e., ordering, prescribing, or referring). Because the exclusion status of some providers could not be verified and some providers may have been acting only as referring physicians and may not have ordered or prescribed the items or services claimed, Medicaid payments are to be non-excluded.

The audit period occurred between July 1, 2009 and June 30, 2010.

OTHER: REIMBURSEMENTS

1. ****Federal Upper Payment Limit****

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

2. ****Accrual Costs Under Generally Accepted Accounting Principles****

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in

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which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis

3. **Refund of Recovery**

CMS requested the Department prepare reconciliations of grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of \$240 million FFP for federal FY 2007 through 2011 and \$34 million FFP ongoing each month.

4. **Payment Deferrals**

The Department issues weekly payments for Fee-For-Service providers. This process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the payments of the Fee-For-Service checkwrite by one week, and (2) the last checkwrite in June of each fiscal year has been delayed until the start of the next fiscal year. Beginning in FY 2012-13, an additional checkwrite and the last month of managed care capitation payments are delayed at the end of each fiscal year until the start of the next fiscal year.

OTHER: RECOVERIES****Additional Personal Injury Recoveries****

****This assumption has been deleted as this has been withdrawn.****

****Refund to Express Scripts****

****This assumption has been deleted as this has been withdrawn.****

1. **The Qualified Achieving a Better Life Experience (ABLE) Program**

SB 218 (Chapter 482, Statutes of 2017) ****added protections that prohibit certain types of recovery against Achieving a Better Life Experience Act (ABLE) accounts.**** ****may**** ****This will have a minimal fiscal**** impact ****on**** the Department's recoveries ~~as related to ABLE accounts~~. ABLE accounts are tax-advantaged savings accounts that allow for individuals with disabilities to save funds for health related expenses while allowing the savings to not disqualify their eligibility for disability benefits. The introduction of ABLE accounts may cause a decrease in the Department's Special Needs Trust (SNT) program recoveries, because monies that may have otherwise funded a SNT may be placed into an ABLE account and become exempt from

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collections. ABLE account asset limits, however, are relatively low, and not all individuals are eligible to open ABLE accounts. Therefore, a minimal fiscal impact is expected for SNT recoveries.

Furthermore, provisions of SB 218 prohibit the Department from seeking direct ABLE account recovery upon a beneficiary's death. The fiscal impact from this barrier to recovery is also expected to be minimal because ABLE account funds are highly transactional and may be used to pay for funeral or other administrative expenses, which is likely to leave little for recovery. Also, according to recent guidance from the Centers for Medicare and Medicaid Services, Estate Recovery (ER) is still required for individuals aged 55 and older on the date of death and against ABLE account funds that enter a beneficiary's probate estate.

OTHER: **MISCELLANEOUS ~~*INFORMATION MANAGEMENT*~~****1. **Certified Vital Records****

The Department is creating a new contract with CDPH to obtain vital records data. The current contract allows the Third Party Liability Recovery Division (TPLRD) to request records from CDPH. The new contract will continue to allow TPLRD to request records, and expand contract scope to include Audits & Investigations Division and Med-Cal Eligibility Division. The Department may amend the new contract to include other divisions as appropriate.

2. **Prop 56 Physicians & Dentists Loan Repayment Program

Senate Bill (SB) 849 (Chapter 47, Statutes of 2018), established the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program and appropriates \$220 million for a loan assistance program for recently graduated physicians and dentists. The selection of physicians and dentists for participation will be based on the Department's eligibility criteria, ensuring quality care in the Medi-Cal program, and requiring minimum years of commitment.

The Department will administer separate payment pools for participating physicians and dentists, and will develop the eligibility criteria to be used to evaluate applicant physicians and dentists, including the minimum number of years a participating physician or dentist shall be a Medi-Cal enrolled provider to be eligible for loan assistance.**

3. **Medi-Cal Program Integrity Data Analytics**

****Senate Bill 840 (Chapter 29, Budget Act of 2018) appropriated funding for the Department for Medi-Cal Program Integrity Data Analytics (MPIDA) subject to meeting the requirements of provisional language below:****

- ****4260-001-0001 - The Department of Finance may augment the amount appropriated in Schedule (1) beginning in the 2019–20 fiscal year by up to**

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\$250,000 for a data analytics contract based upon verified satisfactory progress or completion of predetermined data analytics milestones.**

- **4260-001-0890 - The Department of Finance may augment the amount appropriated in this item beginning in fiscal year 2019–20 by up to \$750,000 for a data analytics contract based upon verified satisfactory progress or completion of predetermined data analytics milestones.**

There is a separate policy change for recoveries of various types, which includes fraud/abuse recoveries. The Department will begin tracking a Return on Investment for MPIDA, which will be separately identified in the Medi-Cal Estimate. Based on the limited information the Department has from the interim pilot, the contract may provide a maximum of \$40 million total funds in savings and cost avoidance over several years.

4. **Health Plan of San Mateo Dental Pilot Project**

A dental integration pilot program in San Mateo County has been authorized. The pilot program is required to be designed to test the impact to oral care access, quality, and utilization, as well as medical cost impacts by the delivery of covered dental care services as a managed care benefit under the operation of the Health Plan of San Mateo. Implementation is assumed to be January 2020.

5. **Electronic Visit Verification**

Electronic Visit Verification (EVV) must be implemented for Medicaid-funded personal care services by January *2019* ****2020****, and *home health care services* ****Home Health Care Services (HHCS)**** by January 2023, pursuant to subsection I, section 1903 of the Social Security Act (42 U.S.C. 1396b) enacted in December 2016. EVV must be developed and implemented, including education and training for all *IHSS* ****Personal Care Services (PCS)**** providers and recipients.

On July 30, 2018, the President approved H.R. 6049 which extended the Federal Medical Assistance Percentage (FMAP) penalty for one year, from the initial EVV implementation deadline for PCS of January 1, 2019, to January 1, 2020. This penalty will reduce the FMAP rate for programs providing PCS by 0.25 percentage points starting in January 2020 and increasing each year by 0.25 percentage points to a maximum of one percent in 2023. There is a similar penalty for HHCS beginning January 2023 if EVV for HHCS is not implemented by January 1, 2023.

~~*While the State intends to comply with the federal law to implement EVV, the process will take time to identify and procure a system that is easy to use for providers and recipients, as well as support more than a million recipients and providers transitioning to an EVV. It is unlikely this will be accomplished by the January 2019 deadline. If the State does not meet the deadline, a federal penalty will be assessed.*~~

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~~*This penalty would reduce the Federal Medical Assistance Percentage rate for the IHSS program by 0.25 percentage points starting in January 2019 and increasing each year by 0.25 percentage points to a maximum of one percent in 2023.*~~

****While the State is currently in the process of developing an infrastructure that will support the implementation of EVV, the process to successfully design and implement the EVV mandates outlined in The CURES Act will require extensive multi-agency planning, collaboration, and coordination. To ensure EVV is implemented in a manner that is consistent with the provisions outlined in The Olmstead decision, is least intrusive for participants, complies with federal law, and minimizes costs to the State as outlined in the MITA provisions, the State will be submitting a Good Faith Extension Request to the Centers for Medicare and Medicaid to extend the penalty period for one year. If approved, the Good Faith Extension Request will extend the FMAP penalty period for PCS until January 1, 2021 and for HHCS until January 1, 2024.****

FISCAL INTERMEDIARY: MEDICAL

****Medical Fiscal Intermediary Contract and Business Operations****

****This item has been deleted as these are now new policy changes.****

1. ****Advance Payment Authority****

The Department proposes to seek legislative authority which authorizes the State Controller's Office to make advance payments pursuant to the California Medicaid Management Information Systems Fiscal Intermediary (FI) contract contingency payment process. This would allow advanced interim payments to providers in the event there are issues with checkwrite production during any of the System Replacement Releases. If approved, this legislation would reduce the State's potential risk of losing Federal Financial Participation due to non-compliance with federal and the California's Prompt Payment Act requirements, and allows up to twenty thousand providers to receive payment for services rendered to ensure California's 12 million Medi-Cal beneficiaries continue to receive health care services.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**FISCAL INTERMEDIARY: DENTAL**

****Allied Dental Professionals Enrollment****

****This assumption is deleted because the enrollment of allied dental professionals did not result in a significant increase to associated costs.****

1. ****Dental Program Utilization Controls Assessment****

In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and administrative requirements to improve and streamline the provider experience while

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maintaining program integrity. The objective of these efforts is to increase provider participation and increase beneficiary utilization.

2. **Pure Premium Fund Reconciliation**

The Department transitioned to a new dental fiscal intermediary starting in 2016 when DXC Technology Services (DXC) was awarded a multi-year contract. The pure premium fund for the previous contractor, Delta Dental, will need to be reconciled and dissolved. The Department is working on a plan to reconcile the fund and is in the process of determining any gain/loss to be shared in accordance with the contract language.

DISCONTINUED POLICY CHANGES **Fully

Incorporated into Base Data/Ongoing**

ELIGIBILITY

CA 2 Implementation of the ACA
PC 13 Paris-Veterans

AFFORDABLE CARE ACT

BENEFITS

PC 33 Annual Contraceptive Coverage
PC 31 Dental Beneficiary Outreach Efforts - Benefits

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

PC 47 New High Cost Treatments for Specific Conditions

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PC 222 Indian Health Services Managed Care Program

PROVIDER RATES

PC 130 Alternative Birthing Center Reimbursement

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OA 117 Health Information Exchange Expansion
PC 202 Medi-Cal Recoveries Settlements and Legal Costs

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED POLICY CHANGES **Fully

SYSTEMS OF CARE Incorporated into Base Data/Ongoing**

DISCONTINUED POLICY CHANGES

****Time Limited/No Longer Available****

ELIGIBILITY

AFFORDABLE CARE ACT

OA 91 ACA Outreach and Enrollment Counselors

BENEFITS

OA 50 Enrollment Assist for BHT Institutionally Deemed

HOME & COMMUNITY-BASED SERVICES

PC 43 SF Community-Living Support Benefit Waiver

PC 201 Integration of the SF CLSB into the ALW

BREAST AND CERVICAL CANCER

PHARMACY

PC 48 Drug Rebates Prior Year Funding Adjustment

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PC 195 CCI-Transfer of IHSS Costs to DHCS

PC 93 Managed Care Public Hospital IGTs

PC 96 HQAF Rate Range Increases

PC 108 MCO Tax Managed Care Plans

PROVIDER RATES

PC 131 DP/NF-B Retroactive Recoupment Forgiveness

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

PC 193 Healthcare Svcs. Plans Fines and Penalties Fund

OTHER

OA 33 MEDS Modernization

FISCAL INTERMEDIARY: MEDICAL

OA 114 Medical FI Turnover

DISCONTINUED POLICY CHANGES

****Time Limited/No Longer Available****

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

OA 47 Dental PAPD Project Manager

OA 73 Dental FI Operations

OA 76 Dental FI Hourly Reimbursement

OA 77 Dental FI Cost Reimbursement

OA 83 Dental FI Federal Rule - Revalidation

OA 84 Dental FI Federal Rule – Database Checks

OA 85 Dental FI Conlan, Schwarzmer, Stevens v. Bonta

OA 86 Dental FI HIPAA Addendum Security Risk Assessment

OA 106 CDDS Dental Services – Admin

PC 190 CDDS Dental Services

DISCONTINUED POLICY CHANGES

****Withdrawn****

ELIGIBILITY

OA 48 CCS Case Management Supplemental Payment

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PC 219 Health Care Services For Reentry Program

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

OTHER: MISCELLANEOUS

OA 49 TAR Postage

PC 228 Prop 56 Physicians & Dentist Loan Repayment Program

OA 43 IRS Reporting for Min. Essential Coverage

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL