

MEDI-CAL  
NOVEMBER 2020  
LOCAL ASSISTANCE ESTIMATE  
*for*  
FISCAL YEARS  
2020-21 *and* 2021-22



The Great Seal

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH CARE SERVICES

**MEDI-CAL**  
**NOVEMBER 2020**  
**LOCAL ASSISTANCE ESTIMATE**  
for  
**FISCAL YEARS**  
**2020-21 and 2021-22**

Fiscal Forecasting Division  
State Department of Health Care Services  
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# NOVEMBER 2020 MEDI-CAL ESTIMATE

## TABLE OF CONTENTS

*The November 2020 Medi-Cal Local Assistance Estimate is organized into several sections, listed below.*

### **REFERENCE DOCUMENTS**

*The following resources are included immediately following this table of contents, before the Management Summary section:*

- Alphabetical List of Policy Changes
- Guide to Key Features of Regular Policy Changes

### **MANAGEMENT SUMMARY**

*The management summary section of the Medi-Cal Local Assistance Estimate provides an overview of projected expenditures by fund and caseload counts for both current and budget years.*

### **CURRENT YEAR**

*The Current Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the current fiscal year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.*

### **BUDGET YEAR**

*The Budget Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the budget year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.*

### **CASELOAD**

*The Caseload section provides the estimated average monthly certified eligible counts for prior, current, and budget years.*

### **FEE-FOR-SERVICE BASE**

*The Fee-For-Service (FFS) Base section provides a detailed overview of projected FFS benefits expenditures by service category and base aid category.*

### **BASE POLICY CHANGES**

*The Base Policy Change section provides detailed information on baseline benefits expenditures beyond those reflected in the Fee-for-Service (FFS) base.*

### **REGULAR POLICY CHANGES**

*The Regular Policy Changes section provides detailed benefits expenditures information by policy according to program area. This section includes new program policies and other estimated expenditures that are not captured in the base expenditures. See the Guide to Key Features of Regular Policy Changes in the pages that follow for more information on how to interpret the information in Regular Policy Changes.*

**COUNTY ADMINISTRATION**

*The County Administration section provides a detailed overview of estimated expenditures for counties to determine Medi-Cal eligibility for both current and budget years.*

**OTHER ADMINISTRATION**

*The Other Administration section provides a detailed overview of estimated expenditures required to administer the Medi-Cal program for both current and budget years. This section includes both Local Assistance Administrative (other than County Administration) costs and Fiscal Intermediary (FI) costs associated with processing of claims.*

**ADDITIONAL INFORMATION**

*The Additional Information section provides supplemental information in support of the Medi-Cal Local Assistance Estimate.*



**NOVEMBER 2020 MEDI-CAL ESTIMATE  
ALPHABETIC LIST OF POLICY CHANGES**

To aid in locating programmatic Policy Changes (PC) in this document, the following is a complete listing of all PC's by PC Name, PC Number, Estimate Section, and page number.

<u>PC</u>		<u>Estimate</u>	
<u>Number</u>	<u>PC Name</u>	<u>Section</u>	<u>Page #</u>
27	1% FMAP INCREASE FOR PREVENTIVE SERVICES	Regular PC	61
132	10% PROVIDER PAYMENT REDUCTION	Regular PC	313
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	Regular PC	242
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	Regular PC	245
89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	Regular PC	215
120	AB 1629 ANNUAL RATE ADJUSTMENTS	Regular PC	273
29	ACA DSH REDUCTION	Regular PC	66
237	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	Regular PC	573
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	Other Admin	68
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	Regular PC	75
113	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	Regular PC	255
103	AIDS HEALTHCARE CENTERS (OTHER M/C)	Base PC	72
201	ARRA HITECH - PROVIDER PAYMENTS	Regular PC	489
9	ARRA HITECH INCENTIVE PROGRAM	Other Admin	45
222	ASSISTED LIVING WAIVER EXPANSION	Regular PC	542
209	AUDIT SETTLEMENTS	Regular PC	506
224	BASE RECOVERIES	Base PC	104
49	BCCTP DRUG REBATES	Regular PC	123
249	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	Regular PC	606
30	BEHAVIORAL HEALTH TREATMENT	Regular PC	70
231	BH QUALITY IMPROVEMENT PROGRAM	Regular PC	558
53	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	Regular PC	134
4	BREAST AND CERVICAL CANCER TREATMENT	Regular PC	15
84	BTR - LIHP - MCE	Regular PC	211
227	CALAIM - DENTAL CARIES RISK ASSESSMENT	Regular PC	551
230	CALAIM - DENTAL CONTINUITY OF CARE	Regular PC	556
226	CALAIM - DENTAL PREVENTIVE SERVICES	Regular PC	549
229	CALAIM - DENTAL SILVER DIAMINE FLUORIDE	Regular PC	554
228	CALAIM - MANAGED CARE SMHS CARVE-OUT	Regular PC	552
234	CALAIM - MSSP CARVE-OUT OF CCI	Regular PC	566
238	CALAIM - ORGAN TRANSPLANT	Regular PC	575
235	CALAIM - TRANSITIONING POPULATIONS	Regular PC	568
225	CALAIM ECM-ILOS-PLAN INCENTIVES	Regular PC	546
66	CALHEERS DEVELOPMENT	Other Admin	184
38	CALIFORNIA COMMUNITY TRANSITIONS COSTS	Regular PC	94
39	CALIFORNIA HEALTH INTERVIEW SURVEY	Other Admin	118
74	CALIFORNIA SMOKERS' HELPLINE	Other Admin	203
3	CALWORKS APPLICATIONS	County Admin	12
148	CAPITAL PROJECT DEBT REIMBURSEMENT	Regular PC	375
105	CAPITATED RATE ADJUSTMENT FOR FY 2021-22	Regular PC	240

**NOVEMBER 2020 MEDI-CAL ESTIMATE  
ALPHABETIC LIST OF POLICY CHANGES**

<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
25	CAPMAN	Other Admin	85
4	CASE MANAGEMENT FOR OTLICP	County Admin	14
20	CCHIP DELIVERY SYSTEM	Regular PC	45
187	CCI IHSS RECONCILIATION	Regular PC	470
21	CCI-ADMINISTRATIVE COSTS	Other Admin	76
90	CCI-MANAGED CARE PAYMENTS	Regular PC	217
102	CCI-QUALITY WITHHOLD REPAYMENTS	Regular PC	238
1	CCS CASE MANAGEMENT	Other Admin	22
37	CCS DEMONSTRATION PROJECT	Regular PC	91
203	CCS SAR EPC	Regular PC	497
44	CCT FUND TRANSFER TO CDSS	Regular PC	110
43	CCT OUTREACH - ADMINISTRATIVE COSTS	Other Admin	125
17	CDCR RETRO REPAYMENT	Regular PC	39
67	CDDS ADMINISTRATIVE COSTS	Other Admin	188
82	CDPH I&E PROGRAM AND EVALUATION	Other Admin	215
76	CHART REVIEW	Regular PC	184
12	CHDP COUNTY ALLOCATION	Other Admin	55
79	CHHS AGENCY HIPAA FUNDING	Other Admin	212
7	CHILDREN'S HEALTH INSURANCE PROGRAM	Base PC	14
21	CHIP PREMIUMS	Regular PC	47
211	CIGARETTE AND TOBACCO SURTAX FUNDS	Regular PC	513
73	CLPP CASE MANAGEMENT SERVICES	Other Admin	201
207	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)	Base PC	99
215	CLPP FUND	Regular PC	524
214	CMS DEFERRED CLAIMS	Regular PC	521
57	CMS DEFERRED CLAIMS - FI	Other Admin	165
46	CMS DEFERRED CLAIMS - OTHER ADMIN	Other Admin	133
23	COMMUNITY FIRST CHOICE OPTION	Regular PC	52
233	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	Regular PC	563
110	COORDINATED CARE INITIATIVE RISK MITIGATION	Regular PC	249
4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	31
1	COUNTY ADMINISTRATION ALLOCATION	County Admin	8
87	COUNTY ORGANIZED HEALTH SYSTEMS	Base PC	47
223	COUNTY SHARE OF OTLICP-CCS COSTS	Regular PC	544
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	Other Admin	26
177	COVID-19 - SICK LEAVE BENEFITS	Regular PC	460
175	COVID-19 BASE RECOVERIES	Regular PC	454
173	COVID-19 BEHAVIORAL HEALTH	Regular PC	447
172	COVID-19 CASELOAD IMPACT	Regular PC	443
176	COVID-19 ELIGIBILITY	Regular PC	457
174	COVID-19 FFS REIMBURSEMENT RATES	Regular PC	451
178	COVID-19 INCREASED FMAP - DHCS	Regular PC	462
45	COVID-19 INCREASED FMAP - OTHER ADMIN	Other Admin	130

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
246	COVID-19 INCREASED FMAP EXTENSION - DHCS	Regular PC	600
86	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	Other Admin	221
179	COVID-19 UTILIZATION CHANGE	Regular PC	466
247	COVID-19 VACCINE ADMINISTRATION	Regular PC	602
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	Regular PC	386
18	CS3 PROXY ADJUSTMENT	Regular PC	41
61	DENTAL ASO ADMINISTRATION 2016 CONTRACT	Other Admin	173
62	DENTAL FI ADMINISTRATION 2016 CONTRACT	Other Admin	177
99	DENTAL MANAGED CARE (OTHER M/C)	Base PC	67
185	DENTAL SERVICES	Base PC	87
72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	Other Admin	199
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	Other Admin	194
195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	Base PC	97
45	DIABETES PREVENTION PROGRAM	Regular PC	114
8	DISABLED ADULT CHILDREN PROGRAM CLEANUP	Regular PC	21
118	DPH INTERIM & FINAL RECONS	Regular PC	269
128	DPH INTERIM RATE	Regular PC	302
119	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	Regular PC	271
115	DPH INTERIM RATE GROWTH	Regular PC	260
145	DPH PHYSICIAN & NON-PHYS. COST	Regular PC	364
63	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	Regular PC	159
17	DRUG MEDI-CAL COUNTY ADMINISTRATION	Other Admin	66
16	DRUG MEDI-CAL COUNTY UR & QA ADMIN	Other Admin	64
64	DRUG MEDI-CAL MAT BENEFIT	Regular PC	164
59	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	Regular PC	154
44	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	Other Admin	128
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	Regular PC	167
143	DSH PAYMENT	Regular PC	357
130	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	Regular PC	307
31	ELECTRONIC ASSET VERIFICATION PROGRAM	Other Admin	100
180	ELECTRONIC VISIT VERIFICATION FED PENALTIES	Regular PC	468
124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	Regular PC	290
40	ENCRYPTION OF PHI DATA	Other Admin	120
6	ENHANCED FEDERAL FUNDING	County Admin	18
42	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	Regular PC	106
97	EXTENDED FILE CORRECTION	Regular PC	230
104	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)	Base PC	75
51	FAMILY PACT DRUG REBATES	Regular PC	128
32	FAMILY PACT PROGRAM	Regular PC	77
37	FAMILY PACT PROGRAM ADMIN.	Other Admin	113
58	FEDERAL DRUG REBATES	Regular PC	151
80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	Other Admin	213
71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	Other Admin	196

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
146	FFP FOR LOCAL TRAUMA CENTERS	Regular PC	367
1	FPL INCREASE FOR AGED AND DISABLED PERSONS	Regular PC	8
122	FQHC/RHC/CBRC RECONCILIATION PROCESS	Regular PC	282
219	FUND 3156 TRANSFER TO THE GENERAL FUND	Regular PC	534
220	FUND 3311 TRANSFER TO THE GENERAL FUND	Regular PC	535
212	FUNDING ADJUST.—ACA OPT. EXPANSION	Regular PC	515
213	FUNDING ADJUST.—OTLICP	Regular PC	518
127	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	Regular PC	300
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM	Regular PC	389
88	GEOGRAPHIC MANAGED CARE	Base PC	53
78	GLOBAL PAYMENT PROGRAM	Regular PC	188
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	Regular PC	332
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	Regular PC	262
20	HCBA WAIVER ADMINISTRATIVE COST	Other Admin	74
59	HCO COST REIMBURSEMENT 2017 CONTRACT	Other Admin	169
60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	Other Admin	171
58	HCO OPERATIONS 2017 CONTRACT	Other Admin	167
14	HEALTH ENROLLMENT NAVIGATORS	Other Admin	60
98	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	Regular PC	232
6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	Other Admin	36
24	HEALTH INSURER FEE	Regular PC	54
69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	Other Admin	192
65	HEALTH-RELATED ACTIVITIES - CDSS	Other Admin	182
46	HEARING AID COVERAGE	Regular PC	117
208	HIPP PREMIUM PAYOUTS (MISC. SVCS.)	Base PC	101
204	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	Regular PC	499
182	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)	Base PC	80
243	HOME HEALTH & PDHC RECOUPMENTS	Regular PC	587
125	HOSPICE RATE INCREASES	Regular PC	293
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	Regular PC	361
25	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	Regular PC	56
26	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	Regular PC	59
216	HOSPITAL QAF - CHILDREN'S HEALTH CARE	Regular PC	526
134	HOSPITAL QAF - FFS PAYMENTS	Regular PC	322
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	Regular PC	326
197	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	Regular PC	483
188	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	Regular PC	472
169	IGT ADMIN. & PROCESSING FEE	Regular PC	438
168	IGT PAYMENTS FOR HOSPITAL SERVICES	Regular PC	436
210	IMD ANCILLARY SERVICES	Regular PC	509
248	INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SRVS.	Regular PC	604
200	INDIAN HEALTH SERVICES	Regular PC	487
218	INDIAN HEALTH SERVICES FUNDING SHIFT	Regular PC	532

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
193	INFANT DEVELOPMENT PROGRAM	Regular PC	476
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	Base PC	26
77	INTERIM AND FINAL COST SETTLEMENTS - SMHS	Regular PC	186
10	INTERIM AND FINAL COST SETTLEMENTS-SMHS	Other Admin	49
77	KIT FOR NEW PARENTS	Other Admin	208
133	LABORATORY RATE METHODOLOGY CHANGE	Regular PC	318
72	LATE CLAIMS FOR SMHS	Regular PC	179
192	LAWSUITS/CLAIMS	Base PC	94
34	LEA EXPANSION	Regular PC	83
24	LITIGATION RELATED SERVICES	Other Admin	83
50	LITIGATION SETTLEMENTS	Regular PC	126
33	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	Regular PC	80
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	Regular PC	304
5	LOS ANGELES COUNTY HOSPITAL INTAKES	County Admin	16
123	LTC RATE ADJUSTMENT	Regular PC	285
42	LTSS ACTUARIAL STUDY	Other Admin	124
114	MANAGED CARE DRUG REBATES	Regular PC	257
112	MANAGED CARE EFFICIENCIES	Regular PC	253
92	MANAGED CARE HEALTH CARE FINANCING PROGRAM	Regular PC	223
136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	Regular PC	329
91	MANAGED CARE PUBLIC HOSPITAL EPP	Regular PC	220
38	MANAGED CARE REGULATIONS - MENTAL HEALTH	Other Admin	115
19	MANAGED CARE REGULATIONS - MH PARITY	Other Admin	70
108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	Regular PC	247
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	Regular PC	370
68	MATERNAL AND CHILD HEALTH	Other Admin	190
33	MEDCOMPASS SOLUTION	Other Admin	104
81	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	Regular PC	199
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	Regular PC	208
80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	Regular PC	195
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	Base PC	17
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	Base PC	11
12	MEDI-CAL COUNTY INMATE PROGRAMS	Regular PC	27
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	Regular PC	30
48	MEDI-CAL DRUG REBATE FUND	Regular PC	119
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	Other Admin	93
50	MEDICAL FI BO & IT CHANGE ORDERS	Other Admin	143
49	MEDICAL FI BO & IT COST REIMBURSEMENT	Other Admin	139
55	MEDICAL FI BO HOURLY REIMBURSEMENT	Other Admin	160
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	Other Admin	162
52	MEDICAL FI BO OTHER ESTIMATED COSTS	Other Admin	150
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	Other Admin	154
54	MEDICAL FI BUSINESS OPERATIONS	Other Admin	157

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	Other Admin	137
51	MEDICAL FI IT INFRASTRUCTURE SERVICES	Other Admin	147
78	MEDI-CAL INPATIENT SERVICES FOR INMATES	Other Admin	210
43	MEDICAL INTERPRETERS PILOT PROJECT	Regular PC	108
84	MEDI-CAL NONMEDICAL TRANSPORTATION	Other Admin	219
26	MEDI-CAL RECOVERY CONTRACTS	Other Admin	88
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	Regular PC	408
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	Regular PC	410
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	Regular PC	139
8	MEDI-CAL RX - ADMINISTRATIVE COSTS	Other Admin	42
57	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	Regular PC	146
236	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	Regular PC	570
2	MEDI-CAL STATE INMATE PROGRAMS	Regular PC	10
54	MEDICAL SUPPLY REBATES	Regular PC	137
191	MEDI-CAL TCM PROGRAM	Base PC	91
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	Regular PC	104
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	Regular PC	18
10	MEDICARE PART B DISREGARD	Regular PC	23
183	MEDICARE PAYMENTS - PART D PHASED-DOWN	Base PC	82
181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	Base PC	77
81	MERIT SYSTEM SERVICES FOR COUNTIES	Other Admin	214
93	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	Regular PC	225
47	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	Other Admin	135
85	MH/UCD—SAFETY NET CARE POOL	Regular PC	213
69	MHP COSTS FOR CONTINUUM OF CARE REFORM	Regular PC	169
241	MHP COSTS FOR FFPSA - AFTERCARE SERVICES	Regular PC	582
240	MHP COSTS FOR FFPSA - QUAILIFIED INDIVIDUAL	Regular PC	579
22	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	Regular PC	50
194	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	Regular PC	478
7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	Other Admin	38
22	MITA	Other Admin	78
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	Other Admin	122
39	MSSP SUPPLEMENTAL PAYMENTS	Regular PC	99
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	Regular PC	89
60	NARCOTIC TREATMENT PROGRAM	Base PC	20
149	NDPH IGT SUPPLEMENTAL PAYMENTS	Regular PC	379
163	NDPH SUPPLEMENTAL PAYMENT	Regular PC	421
29	NEWBORN HEARING SCREENING PROGRAM	Other Admin	95
15	NON-EMERGENCY FUNDING ADJUSTMENT	Regular PC	35
153	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	Regular PC	392
14	NON-OTLICP CHIP	Regular PC	32
40	OPTIONAL BENEFITS RESTORATION	Regular PC	101
52	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	Regular PC	131

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
11	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	Other Admin	51
61	OUTPATIENT DRUG FREE TREATMENT SERVICES	Base PC	23
95	PACE (OTHER M/C)	Base PC	62
32	PACES	Other Admin	102
27	PASRR	Other Admin	91
71	PATHWAYS TO WELL-BEING	Regular PC	176
23	PAVE SYSTEM	Other Admin	81
28	PAYMENTS TO PRIMARY CARE PHYSICIANS	Regular PC	64
30	PERFORMANCE OUTCOMES SYSTEM	Other Admin	97
64	PERSONAL CARE SERVICES	Other Admin	180
184	PERSONAL CARE SERVICES (MISC. SVCS.)	Base PC	85
232	PHARMACY RETROACTIVE ADJUSTMENTS	Regular PC	560
83	PIA EYEWEAR COURIER SERVICE	Other Admin	217
15	POSTAGE & PRINTING	Other Admin	61
139	PRIVATE HOSPITAL DSH REPLACEMENT	Regular PC	341
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	Regular PC	350
156	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	Regular PC	401
155	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	Regular PC	399
154	PROP 56 - DEVELOPMENTAL SCREENINGS	Regular PC	395
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	Regular PC	427
121	PROP 56 - HOME HEALTH RATE INCREASE	Regular PC	279
164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	Regular PC	425
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	Regular PC	412
161	PROP 56 - MEDI-CAL FAMILY PLANNING	Regular PC	417
167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	Regular PC	433
126	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	Regular PC	296
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	Regular PC	336
190	PROP 56 - PROVIDER ACES TRAININGS	Regular PC	474
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM	Regular PC	347
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	Regular PC	485
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	Regular PC	440
242	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	Regular PC	584
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	Regular PC	344
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	Regular PC	419
166	PROPOSITION 56 FUNDS TRANSFER	Regular PC	430
11	PROVISIONAL POSTPARTUM CARE EXTENSION	Regular PC	25
79	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	Regular PC	192
202	QAF WITHHOLD TRANSFER	Regular PC	493
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	Regular PC	383
117	RATE INCREASE FOR FQHCS/RHCS/CBRCS	Regular PC	266
111	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	Regular PC	251
131	REDUCTION TO RADIOLOGY RATES	Regular PC	310
19	REFUGEE MEDICAL ASSISTANCE	Regular PC	43

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<u>PC Number</u>	<u>PC Name</u>	<u>Estimate Section</u>	<u>Page #</u>
94	REGIONAL MODEL	Base PC	57
239	REMOTE PATIENT MONITORING	Regular PC	577
217	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	Regular PC	530
65	RESIDENTIAL TREATMENT SERVICES	Base PC	29
35	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	Regular PC	86
96	RETRO MC RATE ADJUSTMENTS	Regular PC	228
101	SAN MATEO HEALTH PLAN REIMBURSEMENT	Regular PC	236
7	SAVE	County Admin	20
2	SAWS	County Admin	10
16	SCHIP FUNDING FOR PRENATAL CARE	Regular PC	37
3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	Other Admin	28
34	SDMC SYSTEM M&O SUPPORT	Other Admin	106
196	SELF-DETERMINATION PROGRAM - CDDS	Regular PC	481
100	SENIOR CARE ACTION NETWORK (OTHER M/C)	Base PC	70
75	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	Regular PC	182
73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	Regular PC	180
5	SMH MAA	Other Admin	34
13	SMHS COUNTY UR & QA ADMIN	Other Admin	57
67	SMHS FOR ADULTS	Base PC	32
68	SMHS FOR CHILDREN	Base PC	37
70	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	Regular PC	174
35	SSA COSTS FOR HEALTH COVERAGE INFO.	Other Admin	108
221	STATE ONLY CLAIMING ADJUSTMENTS	Regular PC	536
244	STATE ONLY CLAIMING ADJUSTMENTS - SMHS AND DMC	Regular PC	589
245	STATE ONLY CLAIMING ADJUSTMENTS - TCM	Regular PC	595
56	STATE SUPPLEMENTAL DRUG REBATES	Regular PC	143
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	Regular PC	405
186	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)	Base PC	89
36	T-MSIS	Other Admin	110
206	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	Regular PC	504
86	TWO PLAN MODEL	Base PC	42
82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	Regular PC	204
3	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	Regular PC	13
76	VETERANS BENEFITS	Other Admin	207
75	VITAL RECORDS	Other Admin	205
205	WPCS WORKERS' COMPENSATION	Regular PC	502



# NOVEMBER 2020 MEDI-CAL ESTIMATE GUIDE TO KEY FEATURES OF REGULAR POLICY CHANGES

This document is intended to aid in interpreting the information included in Regular Policy Changes.

## PROP 56 - DEVELOPMENTAL SCREENINGS

Typically, this represents an accrual amount, before application of cash lags. (In some cases, complex policy changes require lags to be applied at this stage. In these cases, cash amounts are displayed.)

PC numbers are updated each November Estimate as items are re-sorted by category and dollar value.

**REGULAR POLICY CHANGE NUMBER:** 154

**IMPLEMENTATION DATE:** 1/2020

**ANALYST:** Joel Singh

**FISCAL REFERENCE NUMBER:** 2171

Date of first fiscal impact, not the policy effective date.

Permanent reference number, does not change each November.

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST</b> - TOTAL FUNDS	\$53,308,000	\$61,960,000
- STATE FUNDS	\$20,954,890	\$25,877,550
<b>PAYMENT LAG</b>	0.9984	1.0000
<b>% REFLECTED IN BASE</b>	6.73 %	7.68 %
<b>APPLIED TO BASE</b>		
TOTAL FUNDS	\$49,640,800	\$57,201,500
STATE FUNDS	\$19,513,350	\$23,890,150
FEDERAL FUNDS	\$30,127,460	\$33,311,320

**Purpose:**  
This policy change estimates the cost for providing Proposition 56 funded payments for developmental screenings.

**Authority:**  
AB 74 (Chapter 23, Statute of 2019)  
Families First Coronavirus Response Act (FFCRA)  
AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:** Proposition 56 Funds Transfer

Policy changes that may change if this policy change is revised.

**Background:**  
On November 8, 2016, California voters passed the California Healthcare, Research and

## November 2020 Medi-Cal Estimate

### Current Year (FY 2020-21) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Medical Care Services	FY 2020-21 Appropriation	Nov 2020 Estimate	Change	
			Amount	Percent
Total Funds	\$110,351.5	\$112,754.0	\$2,402.5	2.2%
Federal Funds	\$71,970.1	\$75,062.9	\$3,092.8	4.3%
<b>General Fund</b>	<b>\$22,591.2</b>	<b>\$21,344.4</b>	<b>(\$1,246.8)</b>	<b>-5.5%</b>
Other Non-Federal Funds	\$15,790.2	\$16,346.7	\$556.5	3.5%

County Administration	FY 2020-21 Appropriation	Nov 2020 Estimate	Change	
			Amount	Percent
Total Funds	\$4,716.4	\$4,712.3	(\$4.1)	-0.1%
Federal Funds	\$3,800.9	\$3,700.1	(\$100.8)	-2.7%
<b>General Fund</b>	<b>\$909.2</b>	<b>\$1,002.5</b>	<b>\$93.3</b>	<b>10.3%</b>
Other Non-Federal Funds	\$6.3	\$9.7	\$3.4	54.0%

Fiscal Intermediary	FY 2020-21 Appropriation	Nov 2020 Estimate	Change	
			Amount	Percent
Total Funds	\$350.7	\$385.0	\$34.3	9.8%
Federal Funds	\$227.2	\$260.5	\$33.3	14.7%
<b>General Fund</b>	<b>\$123.5</b>	<b>\$124.5</b>	<b>\$1.0</b>	<b>0.8%</b>
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	n/a

Total Expenditures	FY 2020-21 Appropriation	Nov 2020 Estimate	Change	
			Amount	Percent
Total Funds	\$115,418.7	\$117,851.2	\$2,432.6	2.1%
Federal Funds	\$75,998.2	\$79,023.4	\$3,025.2	4.0%
<b>General Fund</b>	<b>\$23,623.9</b>	<b>\$22,471.4</b>	<b>(\$1,152.5)</b>	<b>-4.9%</b>
Other Non-Federal Funds	\$15,796.5	\$16,356.4	\$559.9	3.5%

Note: Totals may not add due to rounding.

## November 2020 Medi-Cal Estimate

### Budget Year (FY 2021-22) Projected Expenditures Compared to Current Year (FY 2020-21)

(Dollars in Millions)

Medical Care Services	FY 2020-21 Estimate	FY 2021-22 Estimate	Change	
			Amount	Percent
Total Funds	\$112,754.0	\$117,149.1	\$4,395.1	3.9%
Federal Funds	\$75,062.9	\$77,513.3	\$2,450.4	3.3%
<b>General Fund</b>	<b>\$21,344.4</b>	<b>\$27,622.1</b>	<b>\$6,277.7</b>	<b>29.4%</b>
Other Non-Federal Funds	\$16,346.7	\$12,013.7	(\$4,333.0)	-26.5%

County Administration	FY 2020-21 Estimate	FY 2021-22 Estimate	Change	
			Amount	Percent
Total Funds	\$4,712.3	\$4,561.8	(\$150.5)	-3.2%
Federal Funds	\$3,700.1	\$3,922.7	\$222.6	6.0%
<b>General Fund</b>	<b>\$1,002.5</b>	<b>\$633.7</b>	<b>(\$368.8)</b>	<b>-36.8%</b>
Other Non-Federal Funds	\$9.7	\$5.4	(\$4.3)	-44.3%

Fiscal Intermediary	FY 2020-21 Estimate	FY 2021-22 Estimate	Change	
			Amount	Percent
Total Funds	\$385.0	\$463.8	\$78.8	20.5%
Federal Funds	\$260.5	\$319.6	\$59.1	22.7%
<b>General Fund</b>	<b>\$124.5</b>	<b>\$144.2</b>	<b>\$19.7</b>	<b>15.8%</b>
Other Non-Federal Funds	\$0.0	\$0.0	\$0.0	\$0.0

Total Expenditures	FY 2020-21 Estimate	FY 2021-22 Estimate	Change	
			Amount	Percent
Total Funds	\$117,851.2	\$122,174.6	\$4,323.4	3.7%
Federal Funds	\$79,023.4	\$81,755.6	\$2,732.2	3.5%
<b>General Fund</b>	<b>\$22,471.4</b>	<b>\$28,400.0</b>	<b>\$5,928.6</b>	<b>26.4%</b>
Other Non-Federal Funds	\$16,356.4	\$12,019.1	(\$4,337.3)	-26.5%

Note: Totals may not add due to rounding.

## **Medi-Cal Local Assistance Estimate Management Summary November 2020 Estimate**

This document is intended to provide the user with a high-level overview of the November 2020 Medi-Cal Local Assistance Estimate (Estimate). The Estimate is produced bi-annually in May and November.

DHCS estimates Medi-Cal spending to be \$117.9 billion total funds (\$22.5 billion General Fund) in Fiscal Year (FY) 2020-21 and \$122.2 billion total funds (\$28.4 billion General Fund) in FY 2021-22. This does not include Certified Public Expenditures of local governments or General Fund of other state departments.

This document is divided into several sections that provide more detail on estimated funding amounts and the primary factors driving the estimates. These sections include the following:

- FY 2020-21 Comparison
- FY 2020-21 to FY 2021-22 Year-Over-Year Comparison
- Other Key Issues
- Overview of Caseload Projections
- Significant Policy Change Detail Chart

**FY 2020-21 Fiscal Year Comparison**

(Dollars in Millions)

	May 2020 Estimate	Total Change: +\$2,432	November 2020 Estimate
<b>Total Funds</b>	\$115,419		\$117,851
<b>Federal Funds</b>	\$75,998	+\$3,025	\$79,023
<b>Other Non-Federal</b>	\$15,797	+\$559	\$16,356
<b>State General Fund</b>	\$23,624	-\$1,153	\$22,471

As displayed above, the November 2020 Estimate for FY 2020-21 projects a \$2.4 billion increase in total spending (a \$1.2 billion decrease in General Fund spending) compared to the May 2020 Estimate (the 2020-21 Budget Act). This reflects a 2.1 percent increase in estimated total spending and a 4.9 percent decrease in estimated General Fund spending for 2020-21.

The major drivers of the change in estimated General Fund spending are listed below:

**FY 2020-21 Fiscal Year Comparison – Major Drivers of Changes in Estimated General Fund Spending**

(Dollars in Millions)

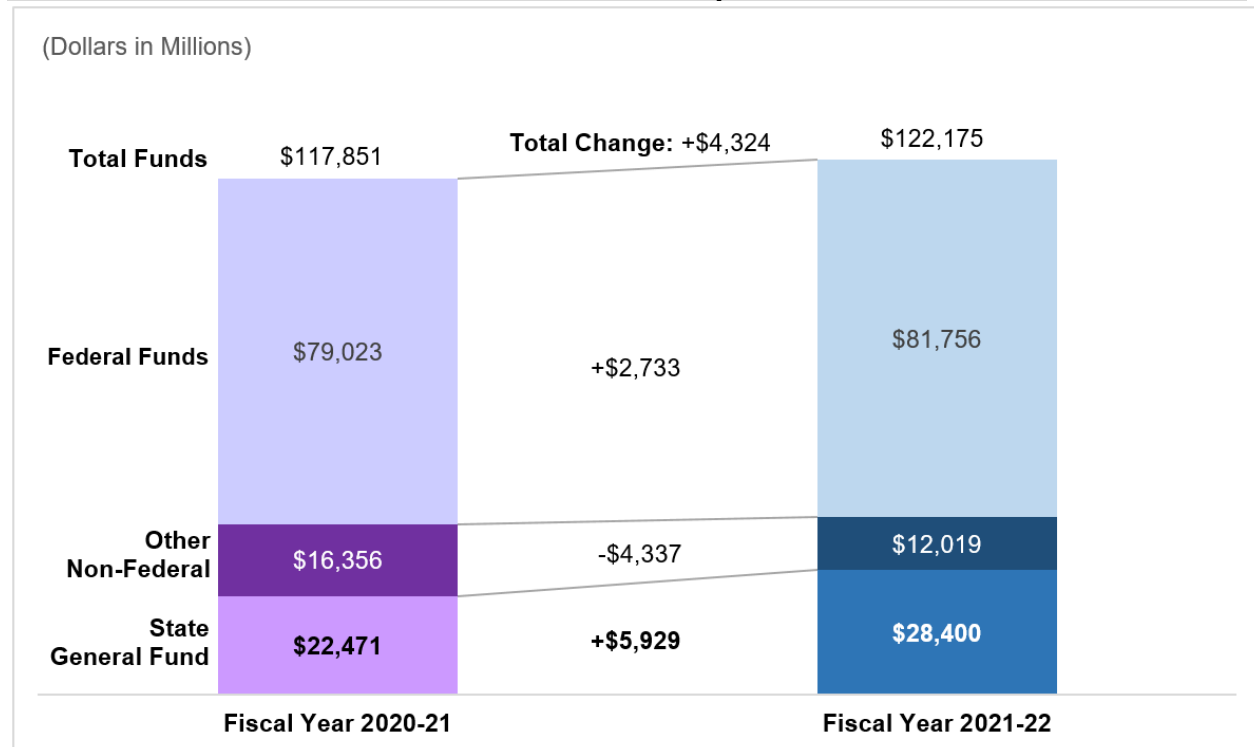
	Change in State General Fund from M20 to N20
COVID-19 impacts	-\$1,091
Reduced estimated repayments related to state only claiming	-\$418
Additional estimated Hospital Quality Assurance Fee funding for children's health care	-\$176
Costs from lengthening transition time for Medi-Cal Rx implementation <sup>a</sup>	\$121
Increase in withholding of federal payments	\$322
Managed care extended file correction	\$335
Various Other Adjustments	-\$245
<b>Total changes from M20 Estimate to N20 Estimate</b>	<b>-\$1,153</b>

a. Amount adjusted to remove impact of increased FMAP funding under the Families First Coronavirus Response Act, to avoid duplication with other items.

Explanation of major drivers:

- **COVID-19 Impacts.** Various factors related to COVID-19 total a net \$1.1 billion reduction in General Fund costs in Medi-Cal in 2020-21, compared to the previous Estimate. The major COVID-19 factors contributing to the change include:
  - **Reduced Estimated COVID-19 Caseload Impact.** In the previous Estimate, caseload impacts related to the COVID-19 pandemic were projected to increase General Fund costs by \$2.4 billion in FY 2020-21. COVID-19 caseload projections have been revised downward for FY 2020-21 based on more recent actual data, such that caseload costs are now estimated to be \$1.7 billion in FY 2020-21, a reduction of \$665 million. (See additional information on caseload in the next section of this document).
  - **Additional Savings from COVID-19 Increased Federal Medical Assistance Percentage (FMAP) Funding.** Under the Federal Families First Coronavirus Response Act (FFCRA), states may receive increased federal funding, referred to hereafter as “increased FMAP.” This Estimate takes a more comprehensive approach to estimating available increased FMAP across the Medi-Cal program. The Estimate assumes the public health emergency will continue through December 31, 2021. The Estimate projects General Fund costs in the Department of Health Care Services (DHCS) will be offset by \$2.9 billion in FY 2020-21. This reflects additional savings to the General Fund of \$366 million in FY 2020-21 compared to the previous Estimate.
  - **Vaccine Administration Costs.** The Estimate includes \$31.7 million in total funds (\$10.8 million General Fund) to reimburse providers for the administration of COVID-19 vaccines to Medi-Cal beneficiaries in 2020-21. (The cost of acquiring the vaccines will be covered by the federal government.)
  - **Other COVID-19 Impacts.** Changes in various other COVID-19 related impacts have a collective effect of reducing estimated General Fund spending in 2020-21 by about \$70 million compared to the previous Estimate. These impacts are described in greater detail in the COVID-19 section of the Significant Policy Change Detail Chart at the end of this document.
- **Reduced Estimated Repayments Related to State Only Claiming.** The May 2020 Estimate included significant General Fund costs related to the repayment of federal funding that was incorrectly claimed for individuals without satisfactory immigration status and related adjustments to correct claiming going forward. The November 2020 Estimate reduces the net cost to the General Fund related to state only claiming by \$418 million based on updated and more refined estimates of the magnitude of the required adjustment and the identification of underclaiming by the Department for certain beneficiaries, which offsets required repayments.

- ***Additional Hospital Quality Assurance Fee (HQAF) Funding Available for Children's Health Care.*** The Estimate reflects the availability of additional HQAF funding to cover children's health care costs in Medi-Cal, result in increased General Fund savings of \$176 million compared to the prior Estimate.
- ***Costs from Lengthening Transition Time for Medi-Cal Rx Implementation.*** DHCS, after careful consideration and in close partnership with Magellan Medicaid Administration, Inc., decided to lengthen the transition time to the full implementation of Medi-Cal Rx by three months, to April 1, 2021. Because of changes in the timing of payments due to the longer transition period, the Estimate assumes less savings from Medi-Cal Rx in FY 2020-21, increasing General Fund spending by \$121 million compared to the prior Estimate (after accounting for assumed changes in the increased FMAP). Savings are largely shifted to FY 2021-22.
- ***Increase in Withholding of Federal Repayments.*** When the federal government questions the basis for the state's claims for federal funding, it may withhold (or "defer") payments to the state. Based on a recent increase in deferrals, the Estimate increases General Fund costs related to deferrals by \$322 million in FY 2020-21 compared to the prior Estimate.
- ***Managed Care Extended File Correction.*** The Department is in the process of running and processing payments based on what is known as an "extended file" in the state's capitation payment system, known as CAPMAN. The extended file allows for the processing of enrollments and disenrollments in CAPMAN back to January 2014. This extended file process is needed to identify required corrections to capitation payments previously paid for beneficiaries who were incorrectly placed in an incorrect aid code or an incorrect category of aid. These corrections are currently expected to result in a total one-time net cost of \$300 million total funds (net cost of \$335 million General Fund).

**FY 2020-21 to FY 2021-22 Year-Over-Year Comparison**

Medi-Cal spending is projected to increase by \$4.3 billion total funds (\$5.9 billion General Fund) between 2020-21 and 2021-22. This reflects a 3.7 percent increase in total spending and a 26.4 percent increase in General Fund spending. The main drivers of the change in estimated General Fund spending are listed below:

**FY 2020-21 to FY 2021-22 Year-Over-Year Comparison – Major Drivers of Changes in Estimated General Fund Spending**

(Dollars in Millions)

	Change in State General Fund from 2020-21 to 2021-22
COVID-19 impacts	\$3,600
Underlying cost growth	\$1,112
Behavioral Health Continuum Infrastructure funding	\$750
CalAIM	\$521
Reduced HQAF funding available to support children's health care	\$390
General Fund support for Proposition 56 payments	\$275
Student behavioral health services incentive program	\$194
Bridge period capitated rate adjustment	\$186
Proposed remote patient monitoring benefit	\$34
Proposed continuous glucose monitoring benefit	\$4
Savings from full year of Medi-Cal Rx implementation <sup>a</sup>	-\$317
Eliminate one-time costs related to managed care extended file correction	-\$335
Assume resolution of various deferred claims	-\$768
Other changes	\$283
<b>Total changes from FY 2020-21 to FY 2021-22</b>	<b>\$5,929</b>

a. Amount adjusted to remove impact of increased FMAP funding under the Families First Coronavirus Response Act, to avoid duplication with other items.



Explanation of major drivers:

- **COVID-19 Impacts.** Factors related to COVID-19 are estimated to contribute to \$3.6 billion of the overall \$5.9 billion increase in estimated General Fund spending in Medi-Cal in FY 2021-22. Specifically:
  - **Continued and Growing COVID-19 Caseload Impact.** Under the FFCRA, Medi-Cal beneficiaries may not be disenrolled from the program except under limited circumstances as long as the federal public health emergency lasts in order to receive increased FMAP funding. This is referred to as the “continuous coverage requirement.” The Estimate assumes that the federal public health emergency will continue through December 2021. Medi-Cal caseload is projected to steadily grow while the continuous coverage requirement is in effect, as fewer individuals exit the program each month than would otherwise be the case. Beginning in January 2022, the continuous coverage requirement is assumed to end and individuals kept on the program under the requirement are assumed to be gradually disenrolled over 12 months. Additionally, the Estimate assumes that the Medi-Cal caseload will grow as individuals who have lost employment, income, and health insurance coverage due to labor market impacts of the pandemic become eligible for and enroll in Medi-Cal coverage. Collectively, these two COVID-related caseload impacts are projected to significantly increase the number of individuals enrolled in Medi-Cal in FY 2020-21 and FY 2021-22. Consistent with this assumption, the General Fund costs associated with COVID-19 caseload are projected to increase to \$4.3 billion in 2021-22, a \$2.6 billion increase over FY 2020-21.
  - **Savings from COVID-19 Increased FMAP.** Increased FMAP is assumed to be available through December 2021, consistent with the assumption of the federal public health emergency continuing until that time. The Estimate projects that General Fund savings related to the availability of increased FMAP funding will decline to \$2.2 billion in FY 2021-22, reflecting a \$689 million reduction in General Fund savings compared to FY 2020-21. This largely reflects the increased FMAP only being available for half of the year.
  - **Vaccine Administration Costs.** The Estimate includes \$316 million total funds (\$107 million of General Fund) to reimburse providers for the administration of COVID-19 vaccines to Medi-Cal beneficiaries in FY 2021-22. This reflects an increase of \$97 million in General Fund costs compared to FY 2020-21, consistent with an assumed ramp-up of vaccine distribution.
  - **Other COVID-19 Impacts.** Changes in various other COVID-19 related impacts have a collective effect of increasing estimated General Fund spending in FY 2021-22 by about \$220 million compared to FY 2020-21. These impacts are described in greater detail in the COVID-19 section of the Significant Policy Change Detail Chart at the end of this document.

- **Underlying Cost Growth.** As in most years, Medi-Cal spending is expected to increase due to underlying costs in health care costs (both in fee-for-service (FFS) and managed care) and changes in utilization. Growth in the FFS base and the managed care base is estimated to be roughly \$1.1 billion from the General Fund in FY 2021-22 relative to FY 2020-21.
- **Behavioral Health Continuum Infrastructure Funding.** As the state builds up the service spectrum through approaches like CalAIM and pursuit of the Serious Mental Illness/Serious Emotional Disturbance Institutions for Mental Disease (IMD) Waiver, DHCS aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days by appropriately utilizing community-based models of care. The budget proposes to invest \$750 million General Fund, available over three years, in critical gaps across the community-based behavioral health continuum, including the addition of at least 5,000 beds, units, or rooms to expand such capacity. These resources would provide a comprehensive continuum of services to address short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders, in the least-restrictive and least-costly setting.
- **California Advancing and Innovating Medi-Cal (CalAIM).** The Estimate includes \$521 million from the General Fund to implement various proposals related to CalAIM, including the following. For more information on the CalAIM proposal, see the Department's website: <https://www.dhcs.ca.gov/calaim>.
  - \$187.5 million total funds (\$93.7 million General Funds) for the enhanced care management.
  - \$47.9 million in total funds (\$24.0 million General Fund) for in-lieu-of services.
  - \$300.0 million in total funds (\$150.0 million General Fund) managed care plan incentives.
  - \$401.6 million total funds (\$174.7 million General Fund) related to the transition of certain populations largely from FFS to managed care. (Costs associated with this item are assumed to be temporary, as they relate to the timing, not the overall amount, of state costs for services for these populations.)
  - \$59.4 million total funds (\$30.0 million General Fund) for incentive payments to encourage dental preventive services.
  - \$43.5 million total funds (\$21.7 million General Fund) for performance payments to promote continuity of care for dental services.
  - \$9.0 million total funds (\$4.5 million General Fund) for dental caries risk assessments.
  - \$1.6 million total funds (\$0.8 million General Fund) to add coverage of the dental silver diamine fluoride benefit.
  - \$21.7 million General Fund for the Behavioral Health Quality Improvement Program, which will provide incentive payments to counties to prepare for implementation of CalAIM.

- \$4.7 million total funds (\$1.3 million General Fund) related to the transition of organ transplant services from FFS to managed care. (Costs associated with this item are assumed to be temporary, as they relate to the timing, not the overall amount, of state costs for these services.)
  - \$1.6 million total funds (\$0.8 million General Fund) related to the transition of the Multipurpose Senior Services Program entirely to FFS. (Costs associated with this item are assumed to be temporary, as they relate to the timing, not the overall amount, of state costs for these services.)
  - Savings of \$4.8 million total funds (\$2.3 million in General Funds) related to the carving out of specialty mental health services from certain Medi-Cal managed care plans that currently have responsibility for them, into FFS.
- **Reduced HQAF Funding Available for Children’s Health Care.** The Estimate projects that less HQAF funding will be available for children’s health care in FY 2021-22 than in FY 2020-21 because fewer quarters of payments will be processed. This results in estimated increases of General Fund costs of \$390 million.
  - **General Fund Support for Proposition 56 Payments Due to Reduced Available Proposition 56 Funding.** Beginning in FY 2021-22, General Fund is projected to partially support supplemental payment programs at current levels, now that program costs exceed declining tobacco tax revenues, primarily due to the assumed implementation of the ban on flavored tobacco and vaping products pursuant to Chapter 34, Statutes of 2020 (SB 793).
  - **Proposed Incentive Program to Increase Student Behavioral Health Services.** The Estimate includes \$389 million total funds (\$194 million General Fund) to implement a new incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of K-12 students receiving preventive and early intervention behavioral health services at school sites. This funding would be available over multiple years.
  - **Bridge Period Capitation Rate Adjustment.** As part of the enacted FY 2020-21 budget, the Department imposed a 1.5 percent rate reduction on certain managed care plan capitation payments during the bridge period, from July 2019 through December 2020, to reflect changes in utilization because of COVID-19 that were not accounted for when rates were developed. These adjustments are estimated to result in savings of \$603 million total funds (\$186 million General Fund) in FY 2020-21. Additional savings are not budgeted for this period in FY 2021-22.
  - **Proposed Remote Patient Monitoring Benefit.** As part of the Department’s telehealth proposal, the Estimate includes \$95 million total funds (\$34 million General Fund) to implement a remote patient monitoring benefit.
  - **Proposed Continuous Glucose Monitoring Benefit.** As part of the Department’s proposals related to health equity, the Estimate includes \$10.9 million total fund (\$3.8 million General Fund) to implement a continuous glucose monitoring benefit.

- **Savings from Full Year of Medi-Cal Rx Implementation.** Following implementation in April 2021, Medi-Cal Rx will be in effect for all of FY 2021-22, resulting in net savings of \$612 million total funds (\$238 million General Fund). This reflects an increase in General Fund savings of \$317 million compared to FY 2020-21 (after accounting for assumed changes in the increased FMAP.)
- **Eliminate One-Time Costs from Managed Care Extended File Correction.** As noted previously, the extended file correction is anticipated to result in a one-time payment in FY 2020-21. As a result, the Estimate assumes a reduction in spending of \$300 million (including a savings to the General Fund of \$335 million, partially offset by a federal funds increase of \$35 million).
- **Assumed Resolution of Various Withheld Federal Payments.** The Estimate assumes that a number of outstanding deferred payments will be resolved in 2021-22, with the state recovering a significant amount of previously deferred funds, resulting in \$768 million in General Fund savings compared to 2020-21 related to deferrals.

## Other Key Issues

In addition to the items described above, the Estimate includes assumptions on a number of additional key items:

- **Suspensions.** Current law requires that a number of DHCS expenditure items be suspended unless certain conditions related to revenues and expenditures in the state budget are met. Specifically, most Proposition 56 payments are subject to suspension effective July 2021 and certain adult optional benefits, a recent expansion to postpartum care eligibility, and additional substance use screening in primary care settings to beneficiaries over 21 years of age are subject to suspension after December 31, 2021.

Under the Governor's proposed budget, suspensions are delayed by one year, as shown on the table on the following page. For Proposition 56 payments for Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs), freestanding pediatric subacute facilities, and Community Based Adult Services, suspension is delayed 18 months to align with the managed care rate year. Suspension is no longer proposed for Proposition 56 payments for HIV/AIDS waiver providers, home health providers, and pediatric day health care facilities, because it is assumed such suspensions would not be approved by the federal government. For additional substance use screening, no suspension is proposed because this became a mandatory benefit due to a recent United States Preventive Services Task Force (USPSTF) recommendation.

### Current Law and Proposed Suspension Dates for Various DHCS Expenditure Items

Expenditure Item	Current Law Suspension Date	Proposed Suspension Date
<b><u>Proposition 56</u></b>		
Physician Services	July 1, 2021	July 1, 2022
Dental Services	July 1, 2021	July 1, 2022
Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). Including facilities providing continuous skilled nursing care to the developmentally disabled	July 1, 2021	January 1, 2023
HIV/AIDS waiver providers	July 1, 2021	No suspension
Home health providers for children and adults in the Medi-Cal fee-for-service system or through home and community-based service waivers	July 1, 2021	No suspension
Pediatric day health care facilities in the Medi-Cal fee-for-service system	July 1, 2021	No suspension
Trauma screenings for children and adults	July 1, 2021	July 1, 2022
Developmental screenings for children	July 1, 2021	July 1, 2022
Provider training for trauma screenings	July 1, 2021	July 1, 2022
Freestanding pediatric subacute facilities	July 1, 2021	January 1, 2023
Community-Based Adult Services	July 1, 2021	January 1, 2023
Nonemergency medical transportation	July 1, 2021	July 1, 2022
Value-Based Payments - Behavioral Health Integration	July 1, 2021	No suspension
Other Value-Based Payments	July 1, 2021	July 1, 2022
<b><u>Optional Benefits</u></b>		
Audiology and speech therapy, incontinence creams and washes, optician and optical lab services, podiatry	December 31, 2021	December 31, 2022
Provisional postpartum care extension	December 31, 2021	December 31, 2022
Expansion to screening for additional substances	December 31, 2021	No suspension

- Electronic Visit Verification Federal Penalties.** The Estimate includes a reduction of federal funding in the amount of \$20.7 million in 2020-21 and \$21.9 million in 2021-22 to reflect penalties for noncompliance with federal timelines for meeting electronic visit verification requirements. Of this amount, \$417,000 in 2020-21 and in 2021-22 will be backfilled by General Fund in the Department of Health Care Services. The remainder of the lost federal funds is backfilled with General Fund in other departments.

- **Drug Medi-Cal Parity.** The Estimate includes \$4.4 million total funds (\$1.5 million General Fund) in local assistance to support work by counties to perform utilization review and quality assurance activities related to parity requirements for State Plan Drug Medi-Cal. Effective July 1, 2021, the Department will standardize and align requirements for State Plan Drug Medi-Cal services with the requirements for medical/surgical health services to ensure parity across all delivery systems.

### Overview of Caseload Projections

	Prior Year (PY) FY 2019-20	Current Year (CY) FY 2020-21	Budget Year (BY) FY 2021-22
<b>November 2020</b>	12,692,300	13,970,800	15,603,800
<b>% Change between FYs</b>		10.07%	11.69%

Appropriation	13,038,000	14,241,600
Change from May 2020	-345,700	-270,800
% Change from May 2020	-2.65%	-1.90%

- Caseload projections displayed above include the impact of the COVID-19, minimum wage increases, and the Federal Poverty Level (FPL) Increase for Aged and Disabled Persons policy change.
- The decrease from the appropriation for both PY and CY is based on actual caseloads and the updated CY projection methodology for COVID-19 impacts.
- The increase in the BY from the CY is due to the national public health emergency and the related continuous coverage requirement being assumed until December 2021 and a shift in peak labor market impacts from FY 2020-21 to FY 2021-22.
- COVID-19 impacts are projected to result in 1,418,400 additional eligibles on average each month in FY 2020-21 and an additional 3,048,100 eligibles on average each month in FY 2021-22. This projection assumes that 155,000 Medi-Cal eligibles who previously would have lost eligibility each month will no longer do so under the continuous coverage requirement. The Estimate assumes that the number of eligibles remaining on Medi-Cal will continue to increase each month through December 2021, at which point the public health emergency is assumed to end, along with the FFCRA continuous coverage requirement. The Estimate also assumes that the labor market impact will cause the caseload to grow by 43,500 eligibles each month beginning January 2021 through December 2021, phasing down thereafter.
- Caseload projections are subject to considerable uncertainty and will be revised as additional actual data becomes available.

### Significant Policy Change Detail Chart

The following policy change detailed information is divided into several sections:

- New Proposals
- Recently Approved Items
- COVID-19
- State Only Claiming
- Proposition 56
- Managed Care
- Public Hospital Financing
- Medicare
- Supplemental Payments
- Waiver 2020
- Pharmacy
- Specialty Mental Health Services
- Drug Medi-Cal
- Freestanding Skilled Nursing Facilities
- Other Policy Changes

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>New Proposals</b>				
<b>Behavioral Health Continuum Infrastructure</b>	Amount		Amount	
PC 249	\$0.0	\$0.0	\$750.0	\$750.0
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$750.0	\$750.0
The budget includes \$750 million in General Fund resources, available over three years, to invest in critical gaps across the community-based behavioral health care continuum, including the addition of at least 5,000 beds, units, or rooms to expand capacity.				
<b>Increase Access to Student Behavioral Health Services</b>	Amount		Amount	
PC 248	\$0.0	\$0.0	\$389.0	\$194.5
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$389.0	\$194.5
The budget includes one-time funds to implement a new incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools to build infrastructure, partnerships and capacity statewide to increase the number students receiving preventive and early intervention behavioral health services. This funding would be available over multiple years.				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>California Advancing and Innovating Medi-Cal (CalAIM)</b>	Amount		Amount	
	\$0.0	\$0.0	\$1,073.7	\$520.8
PCs 225, 226, 227, 228, 229, 230, 231, 234, 235, 238	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$1,073.7	\$520.8
<ul style="list-style-type: none"> <li>• <b>ECM-ILOS-Plan Incentives.</b> This is a new policy change effective January 1, 2022, that estimates the costs to implement a statewide Enhanced Care Management benefit (ECM), In Lieu of Services (ILOS), and plan incentives to build infrastructure linked to reform within the Medi-Cal managed care delivery system.</li> <li>• <b>Transitioning Populations.</b> This is a new policy change effective January 1, 2022, that estimates the impact of transitioning populations to or from the Fee-for-Service and Managed Care delivery systems resulting from CalAIM.</li> <li>• <b>Dental Preventive Services.</b> This is a new policy change effective January 1, 2022, that estimates the cost of the incentive payments related to preventive services covered under the CalAIM Initiative.</li> <li>• <b>Dental Continuity of Care.</b> This is a new policy change effective January 1, 2022, that estimates the cost of performance payments intended to promote continuity of dental care under the CalAIM Initiative.</li> <li>• <b>Dental Caries Risk Assessment.</b> This is a new policy change effective January 1, 2022, that estimates the cost of the dental benefits related to the Caries Risk Assessment covered under the CalAIM Initiative.</li> <li>• <b>Dental Silver Diamine Fluoride.</b> This is a new policy change effective January 1, 2022, that estimates the cost of adding coverage of Silver Diamine Fluoride as a dental benefit for specific populations.</li> <li>• <b>Behavioral Health QIP.</b> The Behavioral Health Quality Improvement Program (BH-QIP) will provide incentive payments to counties to prepare to implement CalAIM.</li> <li>• <b>Organ Transplant.</b> Effective January 1, 2022, all organ transplant benefits will be standardized and covered statewide for all Medi-Cal managed care members.</li> <li>• <b>MSSP - Carve-out from CCI.</b> This is a new policy change effective January 1, 2002, that estimates the carve-out of the Multipurpose Senior Services Program (MSSP) from the Coordinated Care Initiative (CCI).</li> <li>• <b>Managed Care SMHS Carve-Out.</b> Effective January 1, 2022, the Specialty Mental Health Services (SMHS) benefits that are currently within the scope of the Medi-Cal managed care plans (MCP), in Solano and Sacramento County, will be carved out from the MCP responsibility and be provided through fee-for-service (FFS).</li> </ul>				
<b>Continuous Glucose Monitoring (CGM) Systems Benefit</b>	Amount		Amount	
	\$0.0	\$0.0	\$10.9	\$3.8
PC 233	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$10.9	\$3.8
<p>Effective January 1, 2022, the Department will add CGMs as a covered Medi-Cal benefit for beneficiaries ages 21 and older with Type I diabetes. The fiscal impact in FY 2021-22 includes the estimated CGM benefit costs, three months of estimated rebate savings, and estimated savings from decreased usage of medical supplies associated with the self-monitoring of blood glucose.</p>				



<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Remote Patient Monitoring</b>	Amount		Amount	
PC 239	\$0.0	\$0.0	\$94.8	\$34.0
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$94.8	\$34.0
The Department proposes to make permanent and expand certain telehealth flexibilities put in place during the COVID-19 pandemic. Among the telehealth proposals, the budget includes funding to implement remote patient monitoring services as an allowable telehealth modality in fee-for-service and managed care delivery systems.				
<b>Medi-Cal Nonmedical Transportation</b>	Amount		Amount	
OA 84	\$0.0	\$0.0	\$1.7	\$0.5
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$1.7	\$0.5
This new policy change estimates the Medical Fiscal Intermediary (FI) Contract and mileage reimbursement costs related to the second phase of the Medi-Cal nonmedical transportation (NMT) implementation for FFS beneficiaries.				
<b>OTC Adult Acetaminophen &amp; Cough/Cold Products</b>	Amount		Amount	
PC 52	(\$20.9)	(\$7.7)	(\$21.0)	(\$7.8)
	Change from May 2020		Change from 2020-21	
	(\$18.4)	(\$6.5)	(\$0.1)	(\$0.1)
The Department proposes to reinstate over-the-counter (OTC) adult acetaminophen & cough/cold products, effective July 1, 2021. The May 2020 Estimate included the impact of the reinstatement of these drug products on a temporary basis during the COVID-19 public health emergency (PHE) period, in the COVID-19 Additional Impacts policy change.				
<b>Federal Funding for Health Care Payments Data Program</b>	Amount		Amount	
OA 80	\$1.0	\$0.0	\$5.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$1.0	\$0.0	\$4.0	\$0.0
This is a new policy change that estimates the federal reimbursement process between Department of Health Care Services (DHCS) and the Office of Statewide Health Planning and Development (OSHPD) for the Health Care Payments Data Program.				
<b>Subtotals</b>	Amount		Amount	
	(\$19.9)	(\$7.7)	\$2,304.1	\$1,495.8
	Change from May 2020		Change from 2020-21	
	(\$17.4)	(\$6.5)	\$2,324.0	\$1,503.5

<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>Recently Approved Items</b>				
<b>Medical Interpreters Pilot Project</b>	Amount		Amount	
PC 43	\$1.0	\$1.0	\$2.0	\$2.0
	Change from May 2020		Change from 2020-21	
	\$1.0	\$1.0	\$1.0	\$1.0
SB 165 (Chapter 365, Statutes of 2019) appropriated \$5 million GF for the support of medical interpreters pilot projects through June 30, 2024. The change from the prior estimate, for FY 2020-21 is an increase due to the shift in payments from FY 2019-20 caused by a delay in implementation. The prior estimate also assumed payments would be a one-time, lump-sum payment while these payments are now estimated to be made on a quarterly basis. The increase from FY 2020-21 to FY 2021-22 is due to estimating four quarters of costs in FY 2021-22.				
<b>Hearing Aid Coverage</b>	Amount		Amount	
PC 46, OA 11	\$0.0	\$0.0	\$15.5	\$15.5
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$15.5	\$15.5
PC 46 is a new policy change that estimates the cost of providing hearing aids and associated services to non-Medi-Cal children who otherwise do not have health insurance coverage for these services, and includes \$8.8 million GF for the benefit in 2021-22. OA 11 includes, among other things, \$6.7 million GF for hearing aid coverage administrative costs.				
<b>Expansion to Screening for Additional Substances</b>	Amount		Amount	
PC 42	\$1.6	\$0.6	\$1.7	\$0.6
	Change from May 2020		Change from 2020-21	
	\$0.2	\$0.1	\$0.2	\$0.1
Effective June 9, 2020, the USPSTF assigned a "B" rating to "Unhealthy Drug Use Screening" for adults 18 and older, making these screenings a mandatory benefit in the Department's approved Medicaid State Plan. The change from the prior estimate for FY 2020-21 is due to a FFS caseload projection increase and retroactive claims for FY 2019-20 are expected to be paid in FY 2020-21. The change from FY 2020-21 to FY 2021-22 is due to full year implementation in FY 2021-22.				
<b>Undocumented Young Adults Full Scope Expansion</b>	Amount		Amount	
PC 3	\$265.4	\$182.9	\$323.0	\$218.9
	Change from May 2020		Change from 2020-21	
	(\$78.5)	(\$56.0)	\$57.6	\$36.0
The change from the prior estimate, for FY 2020-21, is a decrease due to a reduced restricted scope population and due to slower than anticipated ramp-up for the population that is eligible, but has not enrolled into Medi-Cal. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to a higher year-end population as phase-in continues in FY 2021-22 for the population that is eligible, but has not enrolled into Medi-Cal.				

<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>FPL Increase for Aged and Disabled Persons</b>	Amount		Amount	
PC 1	\$100.5	\$50.2	\$208.6	\$104.3
	Change from May 2020		Change from 2020-21	
	(\$35.0)	(\$17.5)	\$108.1	\$54.1
The change for FY 2020-21, in the current estimate, is a decrease due to a delay in the program implementation to December 2020. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase as FY 2021-22 calculates a full year of costs.				
<b>Medicare Part B Disregard</b>	Amount		Amount	
PC 10	\$1.1	\$1.1	\$1.9	\$1.9
	Change from May 2020		Change from 2020-21	
	\$0.6	\$0.6	\$0.8	\$0.8
The increase from the prior estimate, for FY 2020-21, is due to a projected earlier implementation date. The increase from FY 2020-21 to FY 2021-22, in the current estimate, is due to the program implementing in FY 2020-21, resulting in a partial year of costs for FY 2020-21.				
<b>Provisional Postpartum Care Extension</b>	Amount		Amount	
PC 11	\$0.0	\$0.0	\$27.1	\$27.1
	Change from May 2020		Change from 2020-21	
	(\$34.3)	(\$34.3)	\$27.1	\$27.1
The change from the prior estimate, for FY 2020-21, is a decrease due to costs for this program being calculated in the COVID-19 Caseload Impact policy change until the PHE ends. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to six months of costs transitioning from the COVID-19 Caseload Impact policy change in FY 2021-22. This item is assumed to be suspended effective January 2023.				
<b>Managed Care Efficiencies</b>	Amount		Amount	
PC 112	(\$199.6)	(\$64.5)	(\$481.4)	(\$155.5)
	Change from May 2020		Change from 2020-21	
	(\$17.5)	(\$5.2)	(\$281.9)	(\$91.1)
The change in FY 2020-21 is an increase in savings due to applying updated enrollment projections and refining the following efficiency adjustments: Low Acuity Non-Emergent Services and Healthcare Common Procedure Coding Systems. Savings from the underwriting gain reduction was also updated. The increase in savings from FY 2020-21 to FY 2021-22 is due to budgeting five months of savings in current year and 12 months in budget year, as well as assumed growth in calendar year 2022 rates to which the efficiency adjustments are applied.				
<b>Adjust MC Cap Payments for July 2019 – Dec 2020</b>	Amount		Amount	
PC 113	(\$603.3)	(\$186.3)	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	(\$17.4)	(\$4.3)	\$603.3	\$186.3
The change in FY 2020-21 is an increase in savings due to applying updated enrollment projections. Savings are not budgeted for FY 2021-22 since the Department has not yet determined whether further rate reduction savings are required for budget year.				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Health Enrollment Navigators</b>	Amount		Amount	
OA 14	\$28.6	\$14.3	\$30.7	\$15.4
	Change from May 2020		Change from 2020-21	
	(\$25.8)	(\$12.9)	\$2.1	\$1.1
The change from the prior estimate, for FY 2020-21, is a decrease due to project delays resulting from COVID-19 impacts and the timing of prior estimate decisions. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase based on payment timing for activities provided.				
<b>Optional Benefit Restorations</b>	Amount		Amount	
PC 35, 40	\$52.4	\$18.9	\$53.0	\$19.1
	Change from May 2020		Change from 2020-21	
	\$1.9	\$0.9	\$0.6	\$0.2
The Budget Act of 2019 restored Medi-Cal coverage for audiology, optician and optical lab, incontinence creams and washes, podiatry, and speech therapy effective January 1, 2020. These optional benefits are set to be suspended on December 31, 2021. The current estimate assumes a one-year delay in the suspension of the optional benefits to December 31, 2022.				
<b>Subtotals</b>	Amount		Amount	
	(\$352.3)	\$18.2	\$182.1	\$249.3
	Change from May 2020		Change from 2020-21	
	(\$204.8)	(\$127.6)	\$534.4	\$231.1
<b>COVID-19</b>				
<b>COVID-19 Caseload Impact</b>	Amount		Amount	
PC 172	\$5,428.9	\$1,742.3	\$13,531.6	\$4,336.1
	Change from May 2020		Change from 2020-21	
	(\$1,401.0)	(\$665.9)	\$8,102.7	\$2,593.8
Change from the prior estimate for FY 2020-21 is due to revised estimates of caseload increases due to the COVID-19 pandemic, by aid categories. Change from FY 2020-21 to FY 2021-22 is because the national public health emergency is assumed to end in December 2021, with counties disenrolling individuals under the continuous coverage requirement in the following year. The labor market impact is assumed beginning January through December 2021, phasing out thereafter.				
<b>COVID-19 Behavioral Health</b>	Amount		Amount	
PC 173	\$269.4	\$17.2	\$480.8	\$28.3
	Change from May 2020		Change from 2020-21	
	\$191.7	\$9.5	\$211.4	\$11.1
This policy change estimates the cost of increasing interim rates for certain Medi-Cal Behavioral Health programs during the COVID-19 PHE period assumed through December 2021. The change for FY 2020-21 from the prior estimate is due to including delayed payments for FY 2019-20 and including estimates for payments through the assumed end of the public health emergency through December 2021. (Note: Amounts displayed above differ from those displayed in the policy change as COVID-19 increased FMAP has been backed out to avoid double counting in this table.)				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>COVID-19 FFS Reimbursement Rates</b>	Amount		Amount	
PC 174	\$334.8	\$167.4	\$251.1	\$125.6
	Change from May 2020		Change from 2020-21	
	\$334.8	\$167.4	(\$83.7)	(\$41.8)
This policy change estimates the costs of increasing long term care (LTC) and clinical lab rates during the COVID-19 PHE period assumed through December 2021. The May 2020 Estimate included the impact of the COVID-19 LTC and clinical lab rate increases in the COVID-19 Additional Impacts policy change. These FFS rate increases are now displayed in this new policy change.				
<b>COVID-19 Base Recoveries</b>	Amount		Amount	
PC 175	\$216.3	\$91.1	(\$34.0)	(\$14.3)
	Change from May 2020		Change from 2020-21	
	\$216.3	\$91.1	(\$250.3)	(\$105.4)
This is a new policy change. These expenditures were previously budgeted in the COVID-19 Additional Impact policy change, which was deactivated in the November 2020 Estimate. Compared with the former COVID-19 Additional Impacts policy change, the change for FY 2020-21 is because an estimate of the impact of COVID-19 on general estate and other Medi-Cal provider collections was added. FY 2021-22 assumes the resumption of the additional other health insurance recovery efforts.				
<b>COVID-19 Eligibility</b>	Amount		Amount	
PC 176	\$36.3	\$24.7	\$17.3	\$12.3
	Change from May 2020		Change from 2020-21	
	\$26.1	\$19.4	(\$19.0)	(\$12.5)
The change for FY 2020-21, from the prior estimate, is an increase due to using actual expenditures to project costs, and due to including expenditures for the Waive Share of Cost (SOC) and COVID-19 Hospital Presumptive Eligibility (HPE) Expansion groups in this policy change. In the May 2020 Estimate, the Waive SOC and COVID-19 HPE Expansion groups were previously budgeted in the COVID-19 Additional Impact policy change, which was deactivated in the November 2020 Estimate. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the PHE being assumed to end in December 2021.				
<b>COVID-19 – Sick Leave Benefits</b>	Amount		Amount	
PC 177	\$36.9	\$0.1	\$18.5	\$0.1
	Change from May 2020		Change from 2020-21	
	\$36.9	\$0.1	(\$18.5)	\$0.1
This is a new policy change for a one-time cost in FY 2020-21. These expenditures were previously budgeted in the COVID-19 Additional Impact policy change, which was deactivated in the November 2020 Estimate. The change from FY 2020-21 to FY 2021-22 is a decrease due to the PHE being assumed to end in December 2021.				

<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>COVID-19 Utilization Change</b>	Amount		Amount	
PC 179	(\$947.4)	(\$377.8)	(\$22.1)	(\$8.9)
	Change from May 2020		Change from 2020-21	
	(\$551.7)	(\$231.0)	\$925.3	\$368.8
<p>For FY 2020-21, estimates are updated to reflect initial data on changes in medical and dental FFS utilization that the Department estimates are associated with COVID-19 and the related stay-at-home order. For the change from FY 2020-21 to FY 2021-22, the Department projects no utilization impact for medical FFS due to COVID-19 or stay-at-home orders in FY 2021-22. Additionally, there is a utilization impact related to the Dental Transformation Initiative (DTI) based on payment timing.</p>				
<b>COVID-19 Vaccine Administration</b>	Amount		Amount	
PC 247	\$31.7	\$10.8	\$315.7	\$107.4
	Change from May 2020		Change from 2020-21	
	\$31.7	\$10.8	\$284.0	\$96.6
<p>The Centers for Medicare and Medicaid Services (CMS) expects the initial supply of COVID-19 vaccines to be federally purchased. Medicaid programs will provide reimbursement to providers for the administration of the COVID-19 vaccine. The administration of the COVID-19 vaccine to Medi-Cal beneficiaries is estimated to begin in January 2021. The fiscal impact in FY 2020-21 and FY 2021-22 assumes Medi-Cal providers will be reimbursed \$28.39 to administer single-dose vaccines and \$45.33 for vaccines requiring a series of two or more doses.</p>				
<b>COVID-19 Increased FMAP Rollup (DHCS, ADMIN, Extensions, &amp; Various Other PCs)</b>	Amount		Amount	
PC 178, PC 246, OA 45, OA 86, Various Other PCs	\$1,553.7	(\$2,921.8)	\$850.1	(\$2,232.5)
	Change from May 2020		Change from 2020-21	
	\$257.6	(\$365.7)	(\$703.6)	\$689.3
<p>The increase in General Fund savings from the prior estimate for FY 2020-21 is due to updates to various policy changes receiving the increased FMAP. The decrease in GF savings from FY 2020-21 to FY 2021-22 is due to the end of the public health emergency being assumed in December 2021.</p> <p>This value includes four consolidated PCs which capture the increased FMAP for numerous PCs, as well as various other PCs which already capture the increase FMAP.</p> <p>This value also has overlaps with dollars identified in other sections of this summary document.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>COVID-19 Additional Impacts</b>	Amount		Amount	
N/A	\$0.0	\$0.0	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	(\$286.6)	(\$126.6)	\$0.0	\$0.0
This policy change was deactivated. Fiscal impacts previously estimated in this policy change were shifted to new PCs, including COVID-19 Base Recoveries, COVID-19 FFS Reimbursement Rates, COVID-19 Eligibility, and COVID-19 Sick Leave Benefits.				
<b>Subtotals</b>	Amount		Amount	
	\$6,960.5	(\$1,246.1)	\$15,408.8	\$2,353.8
	Change from May 2020		Change from 2020-21	
	(\$1,144.2)	(\$1,090.9)	\$8,448.3	\$3,599.9
<b>State Only Claiming</b>				
<b>State Only Claiming Adjustments</b>	Amount		Amount	
PC 221, 244, 245	(\$3.2)	\$249.8	\$139.2	\$279.1
	Change from May 2020		Change from 2020-21	
	(\$3.2)	(\$418.4)	\$142.4	\$29.4
<p>The state only claiming adjustments, related to the claiming of ineligible benefits provided to individuals without satisfactory immigrant status in full scope Medi-Cal coverage, are estimated in three policy changes. PC 221 estimates the state only claiming adjustments for managed care, pharmacy, dental, services provided by the California Department of Developmental Services (CDDS), and underclaiming related to immigration status change. The Specialty Mental Health Services (SMHS) and State Plan Drug Medi-Cal (DMC) costs are estimated in PC 244. Targeted Case Management program impacts are estimated in PC 245.</p> <p>Compared to the prior estimate, the multiple state only claiming adjustment policy changes now include separate displays for the (1) federal financial participation (FFP) repayments and the (2) prospective adjustments. PC 221 additionally includes the impact for the additional FFP claims for certain immigrant populations where the state has previously underclaimed. For FY 2020-21, the change from the prior estimate is due to updated and more refined estimates of the magnitude of the required adjustment and the identification of underclaiming by the Department for certain beneficiaries, which offsets required repayments. The change from FY 2020-21 to FY 2021-22 is primarily due to the end of one-time adjustments in FY 2020-21 not continuing into FY 2021-22.</p>				
<b>Proposition 56</b>				
<b>Proposition 56 Payments</b>	Amount		Amount	
PCs 121, 126, 138, 140, 141, 154, 155, 156, 160, 161, 162, 164, 165, 166, 167, 170, 190, 199, 242	\$3,257.0	\$0.0	\$3,192.5	\$275.3
	Change from May 2020		Change from 2020-21	
	\$118.5	\$0.0	(\$64.5)	\$275.3
<p>AB 80 (Chapter 12, Statutes of 2020) suspends most Proposition 56 payments, effective July 1, 2021. Under the Governor's proposed budget, the Department assumes the continuation of these Proposition 56 payments through 2021-22.</p> <p>Beginning in FY 2021-22, General Fund is projected to be needed to partially support supplemental payment programs at current levels due to program costs exceeding declining tobacco tax revenues, primarily due to the assumed implementation of the ban on flavored tobacco and vaping products pursuant to Chapter 34, Statutes of 2020 (SB 793).</p>				



<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>Managed Care</b>				
<b>Two-Plan, COHS, GMC, Regional</b>	Amount		Amount	
PC 86, 87, 88, 94	\$34,145.1	\$11,631.4	\$34,170.1	\$11,717.1
	Change from May 2020		Change from 2020-21	
	(\$260.5)	(\$82.2)	\$25.0	\$85.7
The FY 2020-21 estimate for the managed care base PCs decreased due to applying updated weighted draft rates. Although eligibles are expected to be higher overall (higher for County Organized Health System(COHS) and Geographic Managed Care (GMC), lower for Two-Plan (TP) and Regional Model (RM)), the dollar impact of the updated rates are expected to drive costs lower in the current year. The change from FY 2020-21 to FY 2021-22 is an overall increase due to an anticipated growth in the aged aid categories (PA-OAS and MN-OAS). Total funds for COHS decreased due to its anticipated decrease in eligibles from current year to budget year. The increase in general fund is due to the funding share increase for Title 21 beneficiaries.				
<b>Capitated Rate Adjustment FY 2021-22</b>	Amount		Amount	
PC 105	\$0.0	\$0.0	\$1,185.5	\$407.1
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$1,185.5	\$407.1
The anticipated increase from FY 2020-21 to FY 2021-22 is a 3.45% average rate increase across all managed care models on a cash basis. This increase accounts for the capitated rate adjustment for calendar year 2022 rates.				
<b>PACE (Other M/C)</b>	Amount		Amount	
PC 95	\$803.3	\$401.6	\$948.4	\$474.2
	Change from May 2020		Change from 2020-21	
	(\$75.7)	(\$37.9)	\$145.2	\$72.6
The change from the prior estimate, for FY 2020-21, is a decrease due to lower than estimated actuals through June 2020 and an estimate lower 2021 rate adjustment. The change from FY 2020-21 to FY 2021-22, is a net increase due to a projected increase in enrollment and higher rates.				
<b>Retro MC Rate Adjustments</b>	Amount		Amount	
PC 96	\$403.1	\$224.1	\$174.9	\$82.3
	Change from May 2020		Change from 2020-21	
	\$39.8	\$13.0	(\$228.2)	(\$141.8)
The FY 2020-21 estimate increased due to applying projected final rates and higher anticipated enrollment for CCI full duals for the January-June 2020 rating period. The decrease from FY 2020-21 to FY 2021-22 is due to no retroactive payments associated to CCI occurring in FY 2021-22.				
<b>Health Insurer Fee</b>	Amount		Amount	
PC 24	\$284.3	\$97.4	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.3	(\$284.3)	(\$97.4)
The change in FY 2020-21 is due to updating funding levels with more recent member mix data. There is no change to total funds. The change from FY 2020-21 to FY 2021-22 is a decrease due to a suspension placed on Calendar Year (CY) 2020 revenue year fees which would have been paid in CY 2021.				



<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>ACA Optional Expansion MLR Risk Corridor</b>	Amount		Amount	
PC 237	\$0.0	\$0.0	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$100.0	\$5.5	\$0.0	\$0.0
The change in FY 2020-21 is due to the receipt of medical loss ratio (MLR) data from most managed care plans for the FY 2017-18 rating period. A net \$0 in recoupments is expected across all plans. A \$100M TF placeholder was used in the May 2020 estimate. A risk corridor is not in place at this time for the FY 2018-19 period.				
<b>Health Homes for Patients with Complex Needs</b>	Amount		Amount	
PC 98	\$138.6	\$0.0	\$98.8	\$14.0
	Change from May 2020		Change from 2020-21	
	(\$65.3)	\$0.0	(\$39.8)	\$14.0
The change from the prior estimate, for FY 2020-21, is a decrease due to updated enrollment projections. The change in the current estimate, from FY 2020-21 to FY 2021-22, is a decrease due to the Health Homes Program (HHP) ending effective December 31, 2021. There is however an inclusion of GF in FY 2021-22 due to the exhaustion of the HHP fund in FY 2021-22.				
<b>Coordinated Care Initiative (CCI) Risk Mitigation</b>	Amount		Amount	
PC 110	\$0.0	\$0.0	(\$111.3)	(\$55.6)
	Change from May 2020		Change from 2020-21	
	\$111.3	\$55.6	(\$111.3)	(\$55.6)
Due to a delay in the system implementation of the required CCI data logic fix and the need to recollect data from MCPs, recoupments were delayed. As a result, the previously budgeted FY 2020-21 recoupments are now shifting to FY 2021-22. There are no costs for FY 2020-21.				
<b>Managed Care Extended File Correction</b>	Amount		Amount	
PC 97	\$300.0	\$335.2	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$300.0	\$335.2	(\$300.0)	(\$335.2)
This is a new policy change and a one-time payment correction occurring in FY 2020-21. There are no costs for FY 2021-22				
<b>Managed Care Reimbursements to the General Fund</b>	Amount		Amount	
PC 108	\$0.0	(\$1,852.7)	\$0.0	(\$1,113.9)
	Change from May 2020		Change from 2020-21	
	\$0.0	(\$568.6)	\$0.0	\$738.8
This policy change estimates reimbursements to the GF by intergovernmental transfer from allowable public entities for Medi-Cal payment contributions and administration and processing fees. Changes are due to the GF reimbursement collection in this PC being updated to align with the most recent corresponding GF expenditure payments and expected GF reimbursement levels.				
<b>Subtotals</b>	Amount		Amount	
	\$36,074.4	\$10,837.0	\$36,466.4	\$11,525.2
	Change from May 2020		Change from 2020-21	
	\$149.6	(\$279.1)	\$392.1	\$688.2

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Public Hospital Financing</b>				
<b>Managed Care Public Hospital Enhanced Payment Program (EPP)</b>	Amount		Amount	
PC 91	\$2,517.2	\$697.2	\$1,208.3	\$403.4
	Change from May 2020		Change from 2020-21	
	\$976.1	\$335.6	(\$1,308.9)	(\$293.8)
The change for FY 2020-21 is an increase due to the earlier timing of payments for a portion of the Bridge Period Capitated sub-pool (July 1, 2019, through June 30, 2020), resulting in costs shifting from BY to CY. The change from FY 2020-21 to FY 2021-22 is a decrease due to fewer program periods anticipated to pay, on a cash basis, in FY 2021-22 compared to FY 2020-21. Additionally, for both FY 2020-21 and FY 2021-22, the funding splits have been revised based on updated enrollment data for FY 2018-19 and the Bridge Period (July 1, 2019 through December 31, 2020).				
<b>Managed Care Health Care Financing Program</b>	Amount		Amount	
PC 92	\$1,928.6	\$656.9	\$1,061.5	\$369.5
	Change from May 2020		Change from 2020-21	
	\$10.8	\$3.2	(\$867.1)	(\$287.4)
The change for FY 2020-21 is an increase due to updated program participation levels. The change from FY 2020-21 to FY 2021-22 is a decrease due to FY 2020-21 total payments consisting of the first twelve months of the 18-month Bridge Period (July 2019 through December 2020) and FY 2021-22 total payments consisting of the final six months of the 18-month Bridge Period.				
<b>Managed Care Public Hospital QIP</b>	Amount		Amount	
PC 93	\$1,324.7	\$315.8	\$962.8	\$247.0
	Change from May 2020		Change from 2020-21	
	\$656.9	\$160.9	(\$362.0)	(\$68.9)
The change for FY 2020-21 is an increase due to payment for the first 12 months of the 18-month Bridge Period (July 1, 2019 through December 31, 2020) shifting from FY 2021-22 to FY 2020-21. The change from FY 2020-21 to FY 2021-22 is a decrease due to FY 2020-21 total payments consisting of the first twelve months of the 18-month Bridge Period and FY 2021-22 total payments consisting of the final six months of the 18-month Bridge Period.				
<b>Subtotals</b>	Amount		Amount	
	\$5,770.5	\$1,669.9	\$3,232.6	\$1,019.9
	Change from May 2020		Change from 2020-21	
	\$1,643.8	\$499.7	(\$2,538.0)	(\$650.1)
<b>Medicare</b>				
<b>Medicare Payments - Buy-In Parts A &amp; B</b>	Amount		Amount	
PC 181	\$3,640.9	\$1,934.2	\$3,829.3	\$2,034.9
	Change from May 2020		Change from 2020-21	
	\$16.6	\$9.9	\$188.5	\$100.7
The projected Part B Premium for 2021 increased \$3.30 since the previous Estimate and both the Part A and B premiums are projected to increase in 2022 by \$18.00 and \$4.40, respectively.				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Medicare Payments - Part D Phased-Down</b>	Amount		Amount	
PC 183	\$2,188.8	\$2,188.8	\$2,476.4	\$2,476.4
	Change from May 2020		Change from 2020-21	
	(\$176.8)	(\$176.8)	\$287.5	\$287.5
<p>The Families First Coronavirus Response Act (FFCRA) has resulted in a reduced PMPM through the end of the national public health emergency. This temporary reduction resulted in lower payments for FY 2020-21, including a retroactive adjustment for January to May 2020. FY 2021-22 includes an estimated increase in the PMPM (unadjusted for the FFCRA) of \$5.68 for 2022. The projected reduction in payments from FFCRA that are not already reflected in FY 2020-21 expenditures are budgeted in the COVID-19 Increased FMAP – DHCS policy changes.</p>				
<b>Subtotals</b>	Amount		Amount	
	\$5,829.7	\$4,123.0	\$6,305.7	\$4,511.3
	Change from May 2020		Change from 2020-21	
	(\$160.2)	(\$166.9)	\$476.0	\$388.2
<b>Supplemental Payments</b>				
<b>Hospital Quality Assurance Fee (HQAF)</b>	Amount		Amount	
PCs 134,135,136, and 216	\$10,352.4	(\$1,151.9)	\$8,478.6	(\$761.6)
	Change from May 2020		Change from 2020-21	
	\$190.7	(\$175.9)	(\$1,873.8)	\$390.4
<p>The HQAF program assesses a fee on eligible general acute care hospitals and matches the fee with federal financial participation providing FFS and managed care supplemental payments to hospitals. The HQAF also provides additional funding for children's health care coverage.</p> <p>The changes in FY 2020-21 are due to:</p> <p>(1) Changes to the Hospital QAF - FFS Payments (PC 134) to include FFCRA adjustments and updated FY 2019-20 ACA adjustments.</p> <p>(2) The Hospital QAF - Managed Care Payments (PC 135) had no total fund change, but the funding assumptions were updated and the FFCRA increased FFP was included for the applicable periods.</p> <p>(3) There was no change in the estimate Managed Care Private Hospital Directed Payments (PC 136). However, the funding splits were updated based on revised managed care enrollment and payment data.</p> <p>(4) There is an increase in GF savings estimated in HQAF - Children's Health Care (PC 216). Increased GF savings are expected for FY 2019-20 HQAF VI based on the available funding estimated for that period; and increased savings due to the shifting the HQAF IV reconciliation payments to FY 2020-21.</p> <p>The change from FY 2020-21 to FY 2021-22 is a net decrease due to fewer quarters of HQAF- FFS payments estimated in FY 2021-22; lower HQAF - Managed Care Payments due to resuming a 12-month period for Calendar Year 2021 payments, and a higher Managed Care Private Hospital Directed Payments (PHDP) based on the approved FY 2019-20 PHDP pool size. The GF savings decrease in HQAF - Children's Health Care payments is due to fewer quarters of payments estimated in FY 2021-22.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Private Hospital Supplemental Payment</b>	Amount		Amount	
PC 142	\$429.9	\$126.3	\$308.2	\$118.4
	Change from May 2020		Change from 2020-21	
	\$117.1	\$0.0	(\$121.7)	(\$7.9)
<p>These policy changes estimates supplemental payments to private hospitals. The increase in FY 2020-21 is due to including additional payments to providers from (1) additional federal funds drawn for the Affordable Care Act (ACA) newly eligible adjustments from FY 2013-14 through FY 2018-19; and (2) unused GF appropriation payments resulting from the additional federal funding provided by the FFCRA increased FMAP. The change from FY 2020-21 to FY 2021-22 is due to completing the prior year ACA payments in FY 2020-21 and completion of GF repayments to Special Fund #3097 in FY 2020-21.</p>				
<b>Subtotals</b>	Amount		Amount	
	\$10,782.3	(\$1,025.6)	\$8,786.8	(\$643.2)
	Change from May 2020		Change from 2020-21	
	\$307.8	(\$175.9)	(\$1,995.5)	\$382.5
<b>Waiver 2020</b>				
<b>Global Payment Program (GPP)</b>	Amount		Amount	
PC 78	\$2,209.6	\$0.0	\$2,387.1	\$0.0
	Change from May 2020		Change from 2020-21	
	\$9.0	\$0.0	\$177.5	\$0.0
<p>GPP payments to Designated Public Hospitals (DPHs) are authorized under the Medi-Cal 2020 Waiver, and are assumed to be extended in the one-year extension of the Medi-Cal 2020 Waiver and in the next 1115 Waiver renewal. The FY 2020-21 estimate increased due to updated payment estimates for Program Years (PY) 2017-18 through 2020-21. (Program years correspond to state fiscal years.) The FY 2020-21 to FY 2021-22 increase is due to including six months of Safety Net Care Pool (SNCP) funding for PY 2021-22.</p>				
<b>Public Hospital Redesign &amp; Incentives in Medi-Cal</b>	Amount		Amount	
PC 79	\$1,039.2	\$0.0	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$427.2	\$0.0	(\$1,039.2)	\$0.0
<p>The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, authorized under the Medi-Cal 2020 Waiver, ended June 30, 2020. The FY 2020-21 estimated increase is due to including prior year payments from demonstration years (DY) 2017-18 and 2018-19 and delayed payments from DY 2019-20. The change from FY 2020-21 to FY 2021-22 is due to completing the Medi-Cal 2020 PRIME program payments in FY 2020-21.</p>				
<b>Medi-Cal 2020 Whole Person Care Pilots</b>	Amount		Amount	
PC 80	\$1,038.6	\$0.0	\$600.0	\$0.0
	Change from May 2020		Change from 2020-21	
	\$367.4	\$0.0	(\$438.6)	\$0.0
<p>The change from the prior estimate for FY 2020-21 is due to an increase in unexpended funding from PY4 (CY 2019) having rolled into PY 5 (CY 2020) in addition to delayed invoice processing since DHCS allowed Lead Entities to submit their invoices a month later than usual due to the impact of COVID-19. The change from FY 2020-21 to FY 2021-22 is a decrease due to updated dollars for the requested extension program year.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Medi-Cal 2020 Dental Transformation Initiative</b>	Amount		Amount	
PC 81	\$242.0	\$106.0	\$205.4	\$102.7
	Change from May 2020		Change from 2020-21	
	\$67.8	\$18.9	(\$36.7)	(\$3.3)
<p>The change from the prior estimate, for FY 2020-21, is a net increase due to an increase in Domain 3 payments made in July 2020, an increase in Domain 2 estimate due to updated check write data, and the extension of the Medi-Cal Waiver 2020 for an additional year of Domains 1-3. However, there is a slight decrease in Domain 1 payments in FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to the phase out of Domains 1-3 and costs for Domain 4 concluding in FY 2020-21.</p>				
<b>Medi-Cal 2020 Designated State Health Programs (DSHP)</b>	Amount		Amount	
PC 83	\$0.0	(\$94.5)	\$0.0	(\$158.9)
	Change from May 2020		Change from 2020-21	
	\$0.0	(\$2.3)	\$0.0	(\$64.4)
<p>This policy change estimates the additional FFP received for Certified Public Expenditures (CPEs) from state only programs authorized in the Medi-Cal 2020 Waiver. General Fund savings realized under this program will be used as the state share to fund the Dental Transformation Initiative (DTI). The Medi-Cal 2020 DSHP is assumed to be extended through the one-year extension of the Medi-Cal 2020 Waiver. (In late December 2020, CMS notified the state that Medi-Cal 2020 DSHP would not be renewed through the one-year extension. The DHCS is currently reviewing the language in the notification and consulting with CMS for further information regarding the implications for the state budget and the DTI.)</p> <p>The FY 2020-21 estimate increased based on updated actual DTI expenditure data. The change from FY 2020-21 to FY 2021-22 is due to higher projected claims in FY 2021-22.</p>				
<b>Uncompensated Care Payments for Tribal Health</b>	Amount		Amount	
PC 82	\$0.3	\$0.0	\$0.3	\$0.0
	Change from May 2020		Change from 2020-21	
	\$0.1	\$0.0	\$0.0	\$0.0
<p>This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities. The program is assumed to be extended through the one-year extension of the Medi-Cal 2020 Waiver. There is no material change in the FY 2020-21 and FY 2021-22 estimates.</p>				
<b>Subtotals</b>	Amount		Amount	
	\$4,529.7	\$11.5	\$3,192.8	(\$56.2)
	Change from May 2020		Change from 2020-21	
	\$871.5	\$16.6	(\$1,337.0)	(\$67.7)

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Pharmacy</b>				
<b>Medi-Cal Rx</b>	Amount		Amount	
PC 54, 55, 57, 153, OA 8	\$220.0	\$70.2	(\$612.0)	(\$238.1)
	Change from May 2020		Change from 2020-21	
	\$341.6	\$112.0	(\$832.0)	(\$308.3)
<p>DHCS, after careful consideration and in close partnership with Magellan Medicaid Administration, Inc., decided to lengthen the transition time to the full implementation of Medi-Cal Rx by three months, to April 1, 2021. In addition to the impact of the longer implementation timeline, the updated Medi-Cal Rx estimate in FY 2020-21 and FY 2021-22 includes updated MC savings and FFS cost estimates, decreased estimates of the Maximum Allowable Ingredient Cost (MAIC) savings, updated supplemental rebate savings, and updated administrative costs.</p>				
<b>Drug Rebates</b>	Amount		Amount	
PC 48, 49, 51, 56, 58, 114	(\$3,209.8)	(\$1,490.9)	(\$3,127.5)	(\$1,542.2)
	Change from May 2020		Change from 2020-21	
	(\$137.0)	\$152.7	\$82.3	(\$51.3)
<p>These policy changes estimate the revenues collected from the Breast and Cervical Cancer Treatment, Family Planning, Access, Care and Treatment, State Supplemental, Federal and Managed Care drug rebates, and the transfer from the Medi-Cal Drug Rebate Fund to the GF. The estimated Drug rebate savings have been updated based on actual rebates collected through June 2020. The decreased GF transfer in FY 2020-21 is due to less rebate savings estimated as a result of FFCRA increased FMAP impact where savings were shifted to the federal government and GF costs to repay manufacturers for California Children's Services (CCS) Healthy Families blood factor rebates that were ineligible for rebates.</p>				
<b>Pharmacy Retroactive Adjustments</b>	Amount		Amount	
PC 232	(\$120.7)	(\$25.7)	(\$74.0)	(\$33.3)
	Change from May 2020		Change from 2020-21	
	\$69.1	\$28.3	\$46.7	(\$7.6)
<p>Retroactive pharmacy adjustments for the 23-month period, from April 1, 2017 to February 23, 2019, will be implemented via the Erroneous Payment Correction (EPC) process. The first iteration of the EPC, for one month of claims (April 2017), was installed on May 23, 2019. The remaining retroactive adjustments were paused after the first iteration for considerations related to the lawsuit <i>California Pharmacists Association, et al. v. Kent, et al.</i> The prior estimate assumed the pharmacy retroactive adjustments would resume in July 2020. In the current estimate, the timeframe for the pharmacy retroactive adjustments has been delayed to start in February 2021.</p>				
<b>Subtotals</b>	Amount		Amount	
	(\$3,110.5)	(\$1,446.4)	(\$3,813.5)	(\$1,813.6)
	Change from May 2020		Change from 2020-21	
	\$273.7	\$293.0	(\$703.0)	(\$367.2)

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Specialty Mental Health Services (SMHS)</b>				
<b>SMHS for Adults</b>	Amount		Amount	
PC 67	\$1,589.6	\$75.0	\$1,667.3	\$88.8
	Change from May 2020		Change from 2020-21	
	\$44.9	(\$2.2)	\$77.7	\$13.8
<p>This policy change estimates the base cost for SMHS provided to adults (21 years of age and older). The change in FY 2020-21, from the prior estimate, is due to updated ACA utilization estimate and costs for Short Doyle/Medi-Cal (SD/MC) based on additional paid claims data through March 31, 2020. The General Fund cost decreased due to updating funding assumptions and including FFCRA Increased FMAP. The increase from FY 2020-21 to FY 2021-22 is due to an overall increase of SD/MC, FFS Inpatient and ACA utilization for FY 2020-21, based on projections.</p>				
<b>SMHS for Children</b>	Amount		Amount	
PC 68	\$1,295.1	\$46.2	\$1,343.0	\$54.1
	Change from May 2020		Change from 2020-21	
	\$86.3	(\$14.8)	\$47.9	\$7.9
<p>This policy change estimates the base cost for SMHS provided to children through 20 years of age. The net increase in FY 2020-21 from the prior estimate is due to updated utilization and costs for SD/MC through March 31, 2020 and FFS Inpatient clients through January 31, 2020 and updated estimated funding for full scope undocumented children at 100% GF. The General Fund cost decreased due to updating funding assumptions and including FFCRA Increased FMAP. The increase from FY 2020-21 to FY 2021-22 is due to an increase of SD/MC, FFS Inpatient and ACA utilization for FY 2021-22 based on projections.</p>				
<b>Short-Term Residential Therapeutic Programs (STRTPs) / Qualified Residential Therapeutic Programs (QRTPs)</b>	Amount		Amount	
PC 75	\$0.0	\$0.0	\$0.0	\$3.4
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$0.0	\$3.4
<p>This new policy change estimates the FFP that may need to be returned to CMS for ineligible claims for services provided in STRTPs or QRTPs that are classified as Institutes for Mental Diseases (IMDs). The Department estimates to repay \$3.4 million FFP in FY 2021-22.</p>				



<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Mental Health Plan (MHP) Costs for Families First Prevention Services Act (FFPSA)</b>	Amount		Amount	
PC 240, 241	\$0.0	\$0.0	\$22.6	\$10.7
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$22.6	\$10.7
<p>Congress enacted the FFPSA on February 9, 2018, implementing child welfare reforms. FFPSA requirements that have been identified to impact Medi-Cal MHPs include the requirements to (1) have an independently certified Qualified Individual (QI) perform various detailed assessments and (2) provide discharge planning and family-based aftercare support for at least 6 months after a child or youth is discharged from a STRTP. The QI requirement is estimated to have a Proposition 30 impact.</p> <p>In FY 2021-22, PC 240 estimates the costs fo MHPs for the costs of a QI at \$21.4 million TF (\$10.7 million GF), with costs shared between the state and federal government. PC 241 estimates the costs to MHPs for the costs of aftercare services at \$1.3 million county funds and \$1.3 million federal funds.</p>				
<b>Subtotals</b>	Amount		Amount	
	\$2,884.7	\$121.2	\$3,032.9	\$157.0
	Change from May 2020		Change from 2020-21	
	\$131.2	(\$17.0)	\$148.2	\$35.8
<b>Drug Medi-Cal</b>				
<b>Drug Medi-Cal Organized Delivery System Waiver</b>	Amount		Amount	
PC 59	\$419.5	\$41.6	\$404.2	\$44.6
	Change from May 2020		Change from 2020-21	
	\$24.8	(\$19.8)	(\$15.3)	\$3.0
<p>This policy change estimates the cost of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program. The increase from the prior estimate, for FY 2020-21 is due to increased cost according to updated claims data. The General Fund cost decreased due to updating funding assumptions and including FFCRA Increased FMAP. The decrease from FY 2020-21 to FY 2021-22 is due to fewer prior year claims estimated in FY 2021-22.</p>				
<b>Drug Medi-Cal Utilization Review (UR) &amp; Quality Assurance (QA) Admin</b>	Amount		Amount	
OA 16	\$23.0	\$0.0	\$10.7	\$0.0
	Change from May 2020		Change from 2020-21	
	\$19.6	\$0.0	(\$12.3)	\$0.0
<p>This policy change estimates the federal fund reimbursement for Drug Medi-Cal (DMC) UR/QA administrative costs under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The increase from the prior estimate, for FY 2020-21 is due to payments shifting from FY 2019-20 to FY 2020-21. Also, more invoices were received from counties including LA county which significantly increased the estimate. The decrease from FY 2020-21 to FY 2021-22 is due to no payment shifts expected in FY 2021-22.</p>				



<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>Drug Medi-Cal Parity Rule Administration</b>	Amount		Amount	
OA 44	\$0.0	\$0.0	\$4.4	\$1.5
	Change from May 2020		Change from 2020-21	
	\$0.0	\$0.0	\$4.4	\$1.5
This is a new policy change to estimate the local assistance funding to support work by counties to perform utilization review and quality assurance activities related to parity requirements in the State Plan Drug Medi-Cal. Effective July 1, 2021, DHCS will standardize and align requirements for State Plan Drug Medi-Cal services with requirement for medical/surgical health services to ensure parity across all delivery systems.				
<b>Drug Medi-Cal Base</b>	Amount		Amount	
PC 60, 61, 62, & 65	\$13.7	\$1.0	\$14.1	\$1.0
	Change from May 2020		Change from 2020-21	
	(\$22.3)	(\$1.5)	\$0.4	\$0.0
Decrease from the prior Estimate is due to counties shifting to the Drug Medi-Cal Organized Delivery System (ODS) Waiver resulting in lower users.				
<b>Subtotals</b>	Amount		Amount	
	\$456.2	\$42.6	\$433.4	\$47.1
	Change from May 2020		Change from 2020-21	
	(\$2.7)	(\$1.5)	(\$22.8)	\$4.5
<b>Freestanding Skilled Nursing Facilities</b>				
<b>AB 1629 Annual Rate Adjustments</b>	Amount		Amount	
PC 120	\$299.3	\$149.6	\$390.2	\$195.1
	Change from May 2020		Change from 2020-21	
	\$23.4	\$13.0	\$90.9	\$45.5
AB 81 extended the existing AB 1629 QAF program from August 2020 through December 2022. The extension changes the August rate year structure into Calendar Years (CY), starting CY 2021. Included in the extension is a 3.62% rate increase for the 5-month period from August 2020 to December 2020; a 3.5% rate increase for CY 2021, and a 2.4% rate increase for CY 2022. Also, Freestanding Pediatric Subacute facilities are now exempt from the QAF assessment after July 31, 2020.				
The increase in FY 2020-21 is due to including the ongoing AB 1629 extension beginning August 2020 in this policy change. In addition, certain add-ons that would have ended for the August 2020 to December 2020 rating period was extended. Increases in FY 2020-21 also includes updated RY 2019-20 Freestanding Adult Subacute rates which were higher than previously estimated. Finally, the increase for FY 2020-21 reflects the deactivation of the former Nursing Facility Financing Reform policy change in the previous estimate. (Ongoing costs related to nursing facility financing are reflected in the AB 1629 Annual Rate Adjustments policy change.) The increase from CY to BY is due to including a full year impact of the August 2020 to December 2020 and CY 2021 rate adjustments, and 6 months of the CY 2022 rate adjustments in FY 2021-22.				

<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>Long Term Care Quality Assurance Fund Expenditures</b>	Amount		Amount	
PC 129	\$0.0	(\$628.6)	\$0.0	(\$532.8)
	Change from May 2020		Change from 2020-21	
	\$0.0	(\$4.6)	\$0.0	\$95.8
<p>This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to the General Fund (GF) to partially offset GF costs associated with providing long term care services. The FY 2020-21 estimate has increased slightly based on collections and transfer data through August 2020. The decreased GF transfer estimate from FY 2020-21 to FY 2021-22 is based on the projected monthly average transfers used in FY 2021-22 and fewer prior year QAF withhold transfers expected to occur in FY 2021-22.</p>				
<b>Quality and Accountability Supplemental Payments (QASP)</b>	Amount		Amount	
PC 150	\$81.0	\$47.0	\$81.0	\$47.0
	Change from May 2020		Change from 2020-21	
	(\$1.0)	\$0.0	\$0.0	\$0.0
<p>AB 81 also extended the QASP program for two calendar years, through December 2022. The estimated California Department of Public Health (CDPH) administrative costs estimate has increased resulting in decreased supplemental payments in FY 2020-21. In addition, the penalty revenue estimates have increased from the prior estimate. There is no change estimated from FY 2020-21 to FY 2021-22.</p>				
<b>Subtotals</b>	Amount		Amount	
	\$380.3	(\$432.0)	\$471.2	(\$290.7)
	Change from May 2020		Change from 2020-21	
	\$22.4	\$8.4	\$90.9	\$141.3
<b>Other</b>				
<b>Medical Fiscal Intermediary (FI)</b>	Amount		Amount	
OA 48, 49, 50, 51, 52, 53, 54, 55, 56	\$237.0	\$62.7	\$210.5	\$57.7
	Change from May 2020		Change from 2020-21	
	\$31.1	\$1.2	(\$26.5)	(\$5.0)
<p>These policy changes estimate the costs for the current Medical FI contract. The increase from the prior estimate for FY 2020-21 is due to unpaid invoices for FY 2019-20 to be paid in FY 2020-21. There are also increased expenditures estimated due to COVID-19 related cost, an increase in system development notice (SDN) hours and projects, extending FI's scope of work as a result of unanticipated tasks, and stabilization and refresh of subsystems. Funding assumptions were also revised to show correct allocations between 50% FF / 50% GF, 75% FF / 25% GF, 100% GF, and Title XXI funding. In addition, Title XXI FFCRA increased FMAP funding was included in the PCs in FY 2020-21. The decrease from FY 2020-21 to FY 2021-22 is mainly due to no anticipated payment delays in FY 2021-22.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Behavioral Health Treatment</b>	Amount		Amount	
PC 30	\$937.0	\$392.1	\$1,118.5	\$537.3
	Change from May 2020		Change from 2020-21	
	(\$56.8)	(\$77.2)	\$181.5	\$145.2
<p>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), or Behavioral Intervention Services for the same age group who do not have an ASD diagnosis. The decrease in FY 2020-21, from the prior estimate, is due to supplemental payment claims data for managed care showing a slight decrease in utilization, and a lower rate for the bridge period January 2021 through June 2021. The increase from FY 2020-21 to FY 2021-22 is due to a projected increase utilization for BHT services and capitation payments and an assumed rate increase in FY 2021-22.</p>				
<b>Multipurpose Senior Services Program - CDA</b>	Amount		Amount	
PC 36	\$20.2	(\$10.7)	\$20.2	(\$10.1)
	Change from May 2020		Change from 2020-21	
	\$0.0	(\$11.3)	\$0.0	\$0.6
<p>The change for FY 2020-21, from the prior estimate, is an increase in FF due to the availability of the FFCRA Increased FMAP through June 30, 2021. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in FF due to the FFCRA Increased FMAP ending in FY 2021-22.</p>				
<b>California Community Transitions Costs and CCT Fund Transfer to CDSS</b>	Amount		Amount	
PC 38, PC 44	\$10.3	\$2.3	\$14.0	\$5.9
	Change from May 2020		Change from 2020-21	
	\$6.0	\$1.3	\$3.7	\$3.6
<p>The change from the prior estimate, for FY 2020-21, is an increase due to the extension of the grant, which increased the number of projected transitions, as well as the delay in payment of DDS invoices that were shifted from FY 2019-20 to FY 2020-21. The change from FY 2020-21 to FY 2021-22 is an increase due to an increase in the number of eligible participants due to SB 214.</p>				
<b>Electronic Visit Verification Federal Penalties</b>	Amount		Amount	
PC 180	(\$20.2)	\$0.4	(\$21.5)	\$0.4
	Change from May 2020		Change from 2020-21	
	(\$15.1)	\$0.0	(\$1.3)	\$0.0
<p>The change for both FY 2020-21 and FY 2021-22, is a reduction of federal funds to reflect federal penalties for noncompliance with federal timelines for meeting the EVV implementation requirements.</p>				
<b>Dental Services</b>	Amount		Amount	
PC 185	\$1,604.0	\$639.6	\$1,617.5	\$652.4
	Change from May 2020		Change from 2020-21	
	\$588.0	\$230.1	\$13.5	\$12.9
<p>The Dental Services base estimate has transitioned to a 36-month trend analysis and now includes Proposition 56 Supplemental Payments and some Dental Transformation Initiative costs that are processed by the fiscal intermediary, increasing FY 2020-21 from the prior Estimate.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
<b>Home and Community-Based Alternatives (HCBA) Waiver</b>	Amount		Amount	
PC 204	\$168.2	\$84.1	\$154.0	\$77.0
	Change from May 2020		Change from 2020-21	
	\$195.4	\$97.7	(\$14.1)	(\$7.1)
<p>In FY 2020-21 there is increase in costs due to an update in the methodology. The policy change only accounts for new enrollments into the waiver with savings from the transition of beneficiaries in a skilled nursing facility to the waiver. Previously, the policy change accounted for savings cumulatively. It is now assumed that the prior savings are in the base estimates. In FY 2021-22, there is an increase in savings due to the additional enrollment from institutional facilities to the HCBA Waiver.</p>				
<b>Audit Settlements</b>	Amount		Amount	
PC 209	\$0.0	\$47.6	\$0.0	\$69.6
	Change from May 2020		Change from 2020-21	
	\$0.0	\$46.9	\$0.0	\$22.0
<p>The change from the prior estimate, for FY 2020-21, in an overall increase due to additional audit findings requiring repayment and one Payment Error Rate Measurement (PERM) recovery to be paid. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to additional audit findings anticipated to be paid in the budget year.</p>				
<b>ACA Disproportionate Share Hospital (DSH) Reduction</b>	Amount		Amount	
PC 29	(\$640.1)	(\$78.9)	(\$1,568.4)	(\$188.8)
	Change from May 2020		Change from 2020-21	
	\$50.4	\$11.2	(\$928.4)	(\$109.9)
<p>Pursuant to the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, the DSH reductions were delayed to December 1, 2020. The change in FY 2020-21 is due to including the FFCRA increased FFP in the DSH Payment, Private DSH Replacement, and GPP PCs, which resulted in less GF reductions in the ACA DSH Reduction PC. The change from FY 2020-21 to FY 2021-22 is due to an increase in the national ACA DSH reduction from \$4 billion in federal fiscal year (FFY) 2021 to \$8 billion in FFY 2022.</p>				

<i>(Dollars in Millions)</i> Issue	FY 2020-21		FY 2021-22	
	TF	GF	TF	GF
<b>Centers for Medicare and Medicaid Services (CMS) Deferrals</b>	Amount		Amount	
PC 214, OA 46, OA 57	\$0.0	\$751.5	\$0.0	(\$16.4)
	Change from May 2020		Change from 2020-21	
	\$0.0	\$321.5	\$0.0	(\$767.9)
<p>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.</p> <p>The FY 2020-21 deferral costs have increased based on updates that include four quarters of actual deferral amounts and updated assumptions on the resolution of the Cost Allocation Plan (CAP) administration deferral. For benefit deferrals, the State Only Costs repayments totaling \$316 million are included in the FY 2020-21 total. Additionally, the CAP administration deferrals are projected to take longer to be fully resolved and released. The May 2020 Estimate assumed the entire CAP deferral would be released in FY 2020-21 while the current estimate assumes the release to occur over three years, beginning in FY 2020-21.</p> <p>The decrease from FY 2020-21 to FY 2021-22 is due to higher actual deferral amounts in FY 2020-21, not assuming CAP administration deferrals continue in FY 2021-22, and including CAP deferral resolutions in FY 2021-22.</p>				
<b>Base Recoveries</b>	Amount		Amount	
PC 224	(\$460.4)	(\$193.8)	(\$364.9)	(\$153.7)
	Change from May 2020		Change from 2020-21	
	\$37.5	\$74.5	\$95.5	\$40.2
<p>The change from the prior estimate, for FY 2020-21, a decline in Estate and Provider recoveries resulting from the economic impact of the public health emergency. The change between fiscal years is primarily due to additional one-time recovery efforts for health insurance recoveries budgeted in FY 2020-21. The ongoing impact of the public health emergency is budgeted in the COVID-19 Base Recoveries policy change.</p>				
<b>Home Health and Pediatric Day Health Care (PDHC) Recoupments</b>	Amount		Amount	
PC 243	(\$51.4)	(\$25.0)	\$0.0	\$0.0
	Change from May 2020		Change from 2020-21	
	(\$51.4)	\$25.0	\$51.4	\$25.0
<p>In August 2020, recoupments from the home health and PDHC base rate payments for claims from July 2018 to December 2018 were necessary when the additional Proposition 56 erroneous payment correction was implemented for these services. The recoupments are estimated as a one-time impact in FY 2020-21.</p>				
<b>CS3 Proxy Adjustment</b>	Amount		Amount	
PC 18	\$0.0	(\$155.5)	\$0.0	(\$57.8)
	Change from May 2020		Change from 2020-21	
	\$0.0	(\$32.8)	\$0.0	\$97.7
<p>In FY 2020-21 there is a GF decrease due to a shift in some FY 2019-20 memos being processed in FY 2020-21. In FY 2021-22, there is a GF increase due to the reduction in the Title XXI Federal Medical Assistance Percentage in FY 2020-21. Also, the Department will process additional claiming memos in FY 2020-21 in order to reduce the current adjustment lag.</p>				

<i>(Dollars in Millions)</i>	FY 2020-21		FY 2021-22	
Issue	TF	GF	TF	GF
Subtotals	Amount		Amount	
	\$1,804.6	\$1,516.4	\$1,179.9	\$973.6
	Change from May 2020		Change from 2020-21	
	\$785.1	\$688.1	(\$624.7)	(\$542.8)

**Medi-Cal Funding Summary  
November 2020 Estimate Compared to Appropriation  
Fiscal Year 2020 - 2021**

**TOTAL FUNDS**

	<b>Total Appropriation</b>	<b>Nov 2020 Estimate</b>	<b>Difference Incr./(Decr.)</b>
<b>Benefits:</b>			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$84,311,851,000	\$85,828,862,000	\$1,517,011,000
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$92,170,000	\$92,170,000	\$0
4260-101-0233 Prop 99 Physician Srvc. Acct	\$26,639,000	\$26,639,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$41,848,000	\$41,848,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$6,626,000	\$7,004,000	\$378,000
4260-101-3305 Healthcare Treatment Fund	\$863,756,000	\$838,196,000	(\$25,560,000)
4260-101-3366 Electronic Cigarette Product Tax	\$9,600,000	\$0	(\$9,600,000)
4260-101-3375 Prop 56 Loan Repayment Program	\$0	\$0	\$0
4260-102-0001/0890 Capital Debt	\$77,555,000	\$80,427,000	\$2,872,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$15,200,000	\$15,108,000	(\$92,000)
4260-103-3305 Prop 56 Value-Based Payment	\$178,281,000	\$137,513,000	(\$40,768,000)
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,900,000	\$1,664,000	(\$236,000)
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	\$132,461,000	\$234,655,000	\$102,194,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-106-0890 Money Follows Person Federal Grant	\$3,319,000	\$7,983,000	\$4,664,000
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$4,000,566,000	\$4,082,277,000	\$81,711,000
4260-601-0942142 Local Trauma Centers	\$81,883,000	\$65,640,000	(\$16,243,000)
4260-601-0942 Health Homes Program Account	\$22,749,000	\$15,887,000	(\$6,862,000)
4260-601-0995 Reimbursements	\$1,777,423,000	\$2,265,601,000	\$488,178,000
4260-601-3156 MCO Tax Fund	\$100,000,000	\$100,000,000	\$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$306,000,000	\$440,129,000	\$134,129,000
4260-601-3213 LTC QA Fund	\$623,984,000	\$628,556,000	\$4,572,000
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3311 Healthcare Service Fines and Penalties	\$36,552,000	\$20,000,000	(\$16,552,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$68,312,000	\$65,820,000	(\$2,492,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,643,642,000	\$1,490,899,000	(\$152,743,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,769,658,000	\$2,769,657,000	(\$1,000)
4260-601-7502 Demonstration DSH Fund	\$58,544,000	\$73,500,000	\$14,956,000
4260-601-7503 Health Care Support Fund	\$92,553,000	\$68,845,000	(\$23,708,000)
4260-601-8107 Whole Person Care Pilot Fund	\$335,600,000	\$414,481,000	\$78,881,000
4260-601-8108 Global Payment Program Fund	\$876,470,000	\$716,011,000	(\$160,459,000)
4260-601-8113 DPH GME Special Fund	\$378,759,000	\$552,929,000	\$174,170,000
4260-602-0309 Perinatal Insurance Fund	\$26,853,000	\$13,772,000	(\$13,081,000)
4260-605-0001 SNF Quality & Accountability	\$46,979,000	\$46,979,000	\$0
4260-605-3167 SNF Quality & Accountability	\$41,000,000	\$40,500,000	(\$500,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$46,979,000)	(\$46,979,000)	\$0
4260-606-0834 SB 1100 DSH	\$211,063,000	\$104,955,000	(\$106,108,000)
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$7,214,000	\$7,214,000
4260-611-3158/0890 Hospital Quality Assurance	\$11,137,757,000	\$11,504,347,000	\$366,590,000
<b>Total Benefits</b>	<b>\$110,351,490,000</b>	<b>\$112,754,005,000</b>	<b>\$2,402,515,000</b>
<b>County Administration:</b>			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$4,623,975,000	\$4,617,563,000	(\$6,412,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-106-0890 Money Follow Person Fed. Grant	\$360,000	\$360,000	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$72,964,000	\$72,752,000	(\$212,000)
4260-117-0001/0890 HIPPA	\$12,772,000	\$11,899,000	(\$873,000)
4260-601-0942 Health Homes Program Account	\$163,000	\$320,000	\$157,000
4260-601-0995 Reimbursements	\$189,000	\$26,000	(\$163,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$489,000	\$646,000	\$157,000
4260-605-3167 SNF Quality & Accountability Admin.	\$5,432,000	\$8,607,000	\$3,175,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$100,000	\$99,000	(\$1,000)
<b>Total County Administration</b>	<b>\$4,716,444,000</b>	<b>\$4,712,272,000</b>	<b>(\$4,172,000)</b>
<b>Fiscal Intermediary:</b>			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$345,960,000	\$342,242,000	(\$3,718,000)
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$3,766,000	\$41,806,000	\$38,040,000
4260-117-0001/0890 HIPAA	\$1,001,000	\$920,000	(\$81,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
<b>Total Fiscal Intermediary</b>	<b>\$350,727,000</b>	<b>\$384,968,000</b>	<b>\$34,241,000</b>
<b>Grand Total - Total Funds</b>	<b>\$115,418,661,000</b>	<b>\$117,851,245,000</b>	<b>\$2,432,584,000</b>

**Medi-Cal Funding Summary**  
**November 2020 Estimate Compared to Appropriation**  
**Fiscal Year 2020 - 2021**

**STATE FUNDS**

	<b>State Funds Appropriation</b>	<b>Nov 2020 Estimate</b>	<b>Difference Incr./(Decr.)</b>
<b>Benefits:</b>			
4260-101-0001 Medi-Cal General Fund*	\$21,438,108,000	\$20,269,393,000	(\$1,168,715,000)
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$92,170,000	\$92,170,000	\$0
4260-101-0233 Prop 99 Physician Srvc. Acct	\$26,639,000	\$26,639,000	\$0
4260-101-0236 Prop 99 Unallocated Account	\$41,848,000	\$41,848,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$6,626,000	\$7,004,000	\$378,000
4260-101-3305 Healthcare Treatment Fund	\$863,756,000	\$838,196,000	(\$25,560,000)
4260-101-3366 Electronic Cigarette Product Tax	\$9,600,000	\$0	(\$9,600,000)
4260-101-3375 Prop 56 Loan Repayment Program	\$0	\$0	\$0
4260-102-0001 Capital Debt *	\$26,770,000	\$28,105,000	\$1,335,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$15,200,000	\$15,108,000	(\$92,000)
4260-103-3305 Prop 56 Value-Based Payment	\$178,281,000	\$137,513,000	(\$40,768,000)
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,900,000	\$1,664,000	(\$236,000)
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	\$132,461,000	\$234,655,000	\$102,194,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$959,057,000	\$879,623,000	(\$79,434,000)
4260-601-0942142 Local Trauma Centers	\$81,883,000	\$65,640,000	(\$16,243,000)
4260-601-0942 Health Homes Program Account	\$22,749,000	\$15,887,000	(\$6,862,000)
4260-601-0995 Reimbursements	\$1,777,423,000	\$2,265,601,000	\$488,178,000
4260-601-3156 MCO Tax Fund	\$100,000,000	\$100,000,000	\$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$306,000,000	\$440,129,000	\$134,129,000
4260-601-3213 LTC QA Fund	\$623,984,000	\$628,556,000	\$4,572,000
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3311 Healthcare Service Fines and Penalties	\$36,552,000	\$20,000,000	(\$16,552,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$68,312,000	\$65,820,000	(\$2,492,000)
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,643,642,000	\$1,490,899,000	(\$152,743,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,769,658,000	\$2,769,657,000	(\$1,000)
4260-601-8107 Whole Person Care Pilot Fund	\$335,600,000	\$414,481,000	\$78,881,000
4260-601-8108 Global Payment Program Fund	\$876,470,000	\$716,011,000	(\$160,459,000)
4260-601-8113 DPH GME Special Fund	\$378,759,000	\$552,929,000	\$174,170,000
4260-602-0309 Perinatal Insurance Fund	\$26,853,000	\$13,772,000	(\$13,081,000)
4260-605-0001 SNF Quality & Accountability *	\$46,979,000	\$46,979,000	\$0
4260-605-3167 SNF Quality & Accountability	\$41,000,000	\$40,500,000	(\$500,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$46,979,000)	(\$46,979,000)	\$0
4260-606-0834 SB 1100 DSH	\$211,063,000	\$104,955,000	(\$106,108,000)
4260-607-8502 LIHP IGT (Non-GF)	\$0	\$7,214,000	\$7,214,000
4260-611-3158 Hospital Quality Assurance Revenue	\$5,288,065,000	\$5,406,254,000	\$118,189,000
<b>Total Benefits</b>	<b>\$38,381,344,000</b>	<b>\$37,691,139,000</b>	<b>(\$690,205,000)</b>
<b>Total Benefits General Fund *</b>	<b>\$22,591,213,000</b>	<b>\$21,344,400,000</b>	<b>(\$1,246,813,000)</b>
<b>County Administration:</b>			
4260-101-0001 Medi-Cal General Fund *	\$892,630,000	\$989,532,000	\$96,902,000
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$14,316,000	\$10,763,000	(\$3,553,000)
4260-117-0001 HIPAA *	\$2,226,000	\$2,215,000	(\$11,000)
4260-601-0942 Health Homes Program Account	\$163,000	\$320,000	\$157,000
4260-601-0995 Reimbursements	\$189,000	\$26,000	(\$163,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$489,000	\$646,000	\$157,000
4260-605-3167 SNF Quality & Accountability Admin.	\$5,432,000	\$8,607,000	\$3,175,000
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$100,000	\$99,000	(\$1,000)
<b>Total County Administration</b>	<b>\$915,545,000</b>	<b>\$1,012,208,000</b>	<b>\$96,663,000</b>
<b>Total County Administration General Fund *</b>	<b>\$909,172,000</b>	<b>\$1,002,510,000</b>	<b>\$93,338,000</b>
<b>Fiscal Intermediary:</b>			
4260-101-0001 Medi-Cal General Fund *	\$122,132,000	\$112,787,000	(\$9,345,000)
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$1,210,000	\$1,510,000	\$10,300,000
4260-117-0001 HIPAA *	\$198,000	\$180,000	(\$18,000)
4260-601-0995 Reimbursements	\$0	\$0	\$0
<b>Total Fiscal Intermediary</b>	<b>\$123,540,000</b>	<b>\$124,477,000</b>	<b>\$937,000</b>
<b>Total Fiscal Intermediary General Fund *</b>	<b>\$123,540,000</b>	<b>\$124,477,000</b>	<b>\$937,000</b>
<b>Grand Total - State Funds</b>	<b>\$39,420,429,000</b>	<b>\$38,827,824,000</b>	<b>(\$592,605,000)</b>
<b>Grand Total - General Fund*</b>	<b>\$23,623,925,000</b>	<b>\$22,471,387,000</b>	<b>(\$1,152,538,000)</b>



**Medi-Cal Funding Summary**  
**November 2020 Estimate Compared to Appropriation**  
**Fiscal Year 2020 - 2021**

**FEDERAL FUNDS**

	<b>Federal Funds Appropriation</b>	<b>Nov 2020 Estimate</b>	<b>Difference Incr./(Decr.)</b>
<b>Benefits:</b>			
4260-101-0890 Federal Funds	\$62,873,743,000	\$65,559,469,000	\$2,685,726,000
4260-102-0890 Capital Debt	\$50,785,000	\$52,322,000	\$1,537,000
4260-106-0890 Money Follows Person Federal Grant	\$3,319,000	\$7,983,000	\$4,664,000
4260-113-0890 Childrens Health Insurance Fund	\$3,041,509,000	\$3,202,654,000	\$161,145,000
4260-601-7502 Demonstration DSH Fund	\$58,544,000	\$73,500,000	\$14,956,000
4260-601-7503 Health Care Support Fund	\$92,553,000	\$68,845,000	(\$23,708,000)
4260-611-0890 Hospital Quality Assurance	\$5,849,692,000	\$6,098,093,000	\$248,401,000
<b>Total Benefits</b>	<b>\$71,970,145,000</b>	<b>\$75,062,866,000</b>	<b>\$3,092,721,000</b>
<b>County Administration:</b>			
4260-101-0890 Federal Funds	\$3,731,345,000	\$3,628,031,000	(\$103,314,000)
4260-106-0890 Money Follows Person Fed. Grant	\$360,000	\$360,000	\$0
4260-113-0890 Childrens Health Insurance Fund	\$58,648,000	\$61,989,000	\$3,341,000
4260-117-0890 HIPAA	\$10,546,000	\$9,684,000	(\$862,000)
<b>Total County Administration</b>	<b>\$3,800,899,000</b>	<b>\$3,700,064,000</b>	<b>(\$100,835,000)</b>
<b>Fiscal Intermediary:</b>			
4260-101-0890 Federal Funds	\$223,828,000	\$229,455,000	\$5,627,000
4260-113-0890 Childrens Health Insurance Fund	\$2,556,000	\$30,296,000	\$27,740,000
4260-117-0890 HIPAA	\$803,000	\$740,000	(\$63,000)
<b>Total Fiscal Intermediary</b>	<b>\$227,187,000</b>	<b>\$260,491,000</b>	<b>\$33,304,000</b>
<b>Grand Total - Federal Funds</b>	<b>\$75,998,231,000</b>	<b>\$79,023,421,000</b>	<b>\$3,025,190,000</b>

**Medi-Cal Funding Summary**  
**November 2020 Estimate Comparison of FY 2020-21 to FY 2021-22**

**TOTAL FUNDS**

<u>Benefits:</u>	<u>FY 2020-21 Estimate</u>	<u>FY 2021-22 Estimate</u>	<u>Difference Incr./(Decr.)</u>
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$85,828,862,000	\$95,251,593,000	\$9,422,731,000
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	\$92,170,000	\$77,295,000	(\$14,875,000)
4260-101-0233 Prop 99 Physician Srvc. Acct	\$26,639,000	\$22,072,000	(\$4,567,000)
4260-101-0236 Prop 99 Unallocated Account	\$41,848,000	\$32,503,000	(\$9,345,000)
4260-101-3168 Emergency Air Transportation Fund	\$7,004,000	\$3,446,000	(\$3,558,000)
4260-101-3305 Healthcare Treatment Fund	\$838,196,000	\$562,374,000	(\$275,822,000)
4260-101-3366 Electronic Cigarette Product Tax	\$0	\$0	\$0
4260-101-3375 Prop 56 Loan Repayment Program	\$0	\$29,092,000	\$29,092,000
4260-102-0001/0890 Capital Debt	\$80,427,000	\$79,819,000	(\$608,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$15,108,000	\$0	(\$15,108,000)
4260-103-3305 Prop 56 Value-Based Payment	\$137,513,000	\$155,509,000	\$17,996,000
4260-104-0001 NDPH Hosp Supp	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,664,000	\$1,900,000	\$236,000
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	\$234,655,000	\$145,316,000	(\$89,339,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-106-0890 Money Follows Person Federal Grant	\$7,983,000	\$8,087,000	\$104,000
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$4,082,277,000	\$4,050,178,000	(\$32,099,000)
4260-601-0942142 Local Trauma Centers	\$65,640,000	\$68,225,000	\$2,585,000
4260-601-0942 Health Homes Program Account	\$15,887,000	\$12,713,000	(\$3,174,000)
4260-601-0995 Reimbursements	\$2,265,601,000	\$1,309,859,000	(\$955,742,000)
4260-601-3156 MCO Tax Fund	\$100,000,000	\$0	(\$100,000,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$440,129,000	\$0	(\$440,129,000)
4260-601-3213 LTC QA Fund	\$628,556,000	\$532,752,000	(\$95,804,000)
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3311 Healthcare Service Fines and Penalties	\$20,000,000	\$0	(\$20,000,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$65,820,000	\$69,466,000	\$3,646,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,490,899,000	\$1,456,697,000	(\$34,202,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,769,657,000	\$2,517,458,000	(\$252,199,000)
4260-601-7502 Demonstration DSH Fund	\$73,500,000	\$40,716,000	(\$32,784,000)
4260-601-7503 Health Care Support Fund	\$68,845,000	\$159,216,000	\$90,371,000
4260-601-8107 Whole Person Care Pilot Fund	\$414,481,000	\$273,790,000	(\$140,691,000)
4260-601-8108 Global Payment Program Fund	\$716,011,000	\$671,268,000	(\$44,743,000)
4260-601-8113 DPH GME Special Fund	\$552,929,000	\$206,740,000	(\$346,189,000)
4260-602-0309 Perinatal Insurance Fund	\$13,772,000	\$16,795,000	\$3,023,000
4260-605-0001 SNF Quality & Accountability	\$46,979,000	\$46,979,000	\$0
4260-605-3167 SNF Quality & Accountability	\$40,500,000	\$40,500,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$46,979,000)	(\$46,979,000)	\$0
4260-606-0834 SB 1100 DSH	\$104,955,000	\$112,738,000	\$7,783,000
4260-607-8502 LIHP IGT (Non-GF)	\$7,214,000	\$0	(\$7,214,000)
4260-611-3158/0890 Hospital Quality Assurance	\$11,504,347,000	\$9,240,065,000	(\$2,264,282,000)
<b>Total Benefits</b>	<b>\$112,754,005,000</b>	<b>\$117,149,098,000</b>	<b>\$4,395,093,000</b>
<b>County Administration:</b>			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$4,617,563,000	\$4,466,911,000	(\$150,652,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-106-0890 Money Follow Person Fed. Grant	\$360,000	\$360,000	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$72,752,000	\$77,178,000	\$4,426,000
4260-117-0001/0890 HIPAA	\$11,899,000	\$12,036,000	\$137,000
4260-601-0942 Health Homes Program Account	\$320,000	\$162,000	(\$158,000)
4260-601-0995 Reimbursements	\$26,000	\$0	(\$26,000)
4260-602-3311 Healthcare Srvc. Plans Fines and Penalties Fund	\$646,000	\$0	(\$646,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$8,607,000	\$5,007,000	(\$3,600,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$99,000	\$100,000	\$1,000
<b>Total County Administration</b>	<b>\$4,712,272,000</b>	<b>\$4,561,754,000</b>	<b>(\$150,518,000)</b>
<b>Fiscal Intermediary:</b>			
4260-101-0001/0890 Medi-Cal General and Federal Funds	\$342,242,000	\$440,421,000	\$98,179,000
4260-111-0001 CHDP State Only	\$0	\$0	\$0
4260-113-0001/0890 Children's Health Insurance Program	\$41,806,000	\$21,959,000	(\$19,847,000)
4260-117-0001/0890 HIPAA	\$920,000	\$1,373,000	\$453,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
<b>Total Fiscal Intermediary</b>	<b>\$384,968,000</b>	<b>\$463,753,000</b>	<b>\$78,785,000</b>
<b>Grand Total - Total Funds</b>	<b>\$117,851,245,000</b>	<b>\$122,174,605,000</b>	<b>\$4,323,360,000</b>

**Medi-Cal Funding Summary  
November 2020 Estimate Comparison of FY 2020-21 to FY 2021-22**

**STATE FUNDS**

<u>Benefits:</u>	<u>FY 2020-21 Estimate</u>	<u>FY 2021-22 Estimate</u>	<u>Difference Incr./(Decr.)</u>
4260-101-0001 Medi-Cal General Fund*	\$20,269,393,000	\$26,351,118,000	\$6,081,725,000
4260-101-0080 CLPP Funds	\$916,000	\$916,000	\$0
4260-101-0232 Prop 99 Hospital Srv. Acct.	\$92,170,000	\$77,295,000	(\$14,875,000)
4260-101-0233 Prop 99 Physician Srv. Acct	\$26,639,000	\$22,072,000	(\$4,567,000)
4260-101-0236 Prop 99 Unallocated Account	\$41,848,000	\$32,503,000	(\$9,345,000)
4260-101-3168 Emergency Air Transportation Fund	\$7,004,000	\$3,446,000	(\$3,558,000)
4260-101-3305 Healthcare Treatment Fund	\$838,196,000	\$562,374,000	(\$275,822,000)
4260-101-3366 Electronic Cigarette Product Tax	\$0	\$0	\$0
4260-101-3375 Prop 56 Loan Repayment Program	\$0	\$29,092,000	\$29,092,000
4260-102-0001 Capital Debt *	\$28,105,000	\$27,008,000	(\$1,097,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$15,108,000	\$0	(\$15,108,000)
4260-103-3305 Prop 56 Value-Based Payment	\$137,513,000	\$155,509,000	\$17,996,000
4260-104-0001 NDPH Hosp Supp *	\$1,900,000	\$1,900,000	\$0
4260-601-3096 NDPH Suppl	\$1,664,000	\$1,900,000	\$236,000
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	\$234,655,000	\$145,316,000	(\$89,339,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$118,400,000)	(\$118,400,000)	\$0
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$879,623,000	\$1,076,652,000	\$197,029,000
4260-601-0942142 Local Trauma Centers	\$65,640,000	\$68,225,000	\$2,585,000
4260-601-0942 Health Homes Program Account	\$15,887,000	\$12,713,000	(\$3,174,000)
4260-601-0995 Reimbursements	\$2,265,601,000	\$1,309,859,000	(\$955,742,000)
4260-601-3156 MCO Tax Fund	\$100,000,000	\$0	(\$100,000,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$440,129,000	\$0	(\$440,129,000)
4260-601-3213 LTC QA Fund	\$628,556,000	\$532,752,000	(\$95,804,000)
4260-601-3293 MCO Tax Fund 2016	\$0	\$0	\$0
4260-601-3311 Healthcare Service Fines and Penalties	\$20,000,000	\$0	(\$20,000,000)
4260-601-3323 Medi-Cal Emergency Transport Fund	\$65,820,000	\$69,466,000	\$3,646,000
4260-601-3331 Medi-Cal Drug Rebates Fund	\$1,490,899,000	\$1,456,697,000	(\$34,202,000)
4260-601-3334 MCO Tax (HCS Special Fund)	\$2,769,657,000	\$2,517,458,000	(\$252,199,000)
4260-601-8107 Whole Person Care Pilot Fund	\$414,481,000	\$273,790,000	(\$140,691,000)
4260-601-8108 Global Payment Program Fund	\$716,011,000	\$671,268,000	(\$44,743,000)
4260-601-8113 DPH GME Special Fund	\$552,929,000	\$206,740,000	(\$346,189,000)
4260-602-0309 Perinatal Insurance Fund	\$13,772,000	\$16,795,000	\$3,023,000
4260-605-0001 SNF Quality & Accountability *	\$46,979,000	\$46,979,000	\$0
4260-605-3167 SNF Quality & Accountability	\$40,500,000	\$40,500,000	\$0
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	(\$46,979,000)	(\$46,979,000)	\$0
4260-606-0834 SB 1100 DSH	\$104,955,000	\$112,738,000	\$7,783,000
4260-607-8502 LIHP IGT (Non-GF)	\$7,214,000	\$0	(\$7,214,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$5,406,254,000	\$3,861,602,000	(\$1,544,652,000)
<b>Total Benefits</b>	<b>\$37,691,139,000</b>	<b>\$39,635,804,000</b>	<b>\$1,944,665,000</b>
<b>Total Benefits General Fund *</b>	<b>\$21,344,400,000</b>	<b>\$27,622,057,000</b>	<b>\$6,277,657,000</b>
<b>County Administration:</b>			
4260-101-0001 Medi-Cal General Fund *	\$989,532,000	\$614,877,000	(\$374,655,000)
4260-102-3305 Prop 56 Loan Forgiveness Program	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$10,763,000	\$16,782,000	\$6,019,000
4260-117-0001 HIPAA *	\$2,215,000	\$2,083,000	(\$132,000)
4260-601-0942 Health Homes Program Account	\$320,000	\$162,000	(\$158,000)
4260-601-0995 Reimbursements	\$26,000	\$0	(\$26,000)
4260-602-3311 Healthcare Srv. Plans Fines and Penalties Fund	\$646,000	\$0	(\$646,000)
4260-605-3167 SNF Quality & Accountability Admin.	\$8,607,000	\$5,007,000	(\$3,600,000)
4260-611-3158 Hosp. Quality Assurance Rev-SB 335	\$99,000	\$100,000	\$1,000
<b>Total County Administration</b>	<b>\$1,012,208,000</b>	<b>\$639,011,000</b>	<b>(\$373,197,000)</b>
<b>Total County Administration General Fund *</b>	<b>\$1,002,510,000</b>	<b>\$633,742,000</b>	<b>(\$368,768,000)</b>
<b>Fiscal Intermediary:</b>			
4260-101-0001 Medi-Cal General Fund *	\$112,787,000	\$137,133,000	\$24,346,000
4260-111-0001 CHDP State Only *	\$0	\$0	\$0
4260-113-0001 Childrens Health Insurance Program *	\$11,510,000	\$6,726,000	(\$4,784,000)
4260-117-0001 HIPAA *	\$180,000	\$294,000	\$114,000
4260-601-0995 Reimbursements	\$0	\$0	\$0
<b>Total Fiscal Intermediary</b>	<b>\$124,477,000</b>	<b>\$144,153,000</b>	<b>\$19,676,000</b>
<b>Total Fiscal Intermediary General Fund *</b>	<b>\$124,477,000</b>	<b>\$144,153,000</b>	<b>\$19,676,000</b>
<b>Grand Total - State Funds</b>	<b>\$38,827,824,000</b>	<b>\$40,418,968,000</b>	<b>\$1,591,144,000</b>
<b>Grand Total - General Fund*</b>	<b>\$22,471,387,000</b>	<b>\$28,399,952,000</b>	<b>\$5,928,565,000</b>

**Medi-Cal Funding Summary**  
**November 2020 Estimate Comparison of FY 2020-21 to FY 2021-22**

**FEDERAL FUNDS**

<b>Benefits:</b>	<b>FY 2020-21 Estimate</b>	<b>FY 2021-22 Estimate</b>	<b>Difference Incr./(Decr.)</b>
4260-101-0890 Federal Funds	\$65,559,469,000	\$68,900,475,000	\$3,341,006,000
4260-102-0890 Capital Debt	\$52,322,000	\$52,811,000	\$489,000
4260-106-0890 Money Follows Person Federal Grant	\$7,983,000	\$8,087,000	\$104,000
4260-113-0890 Childrens Health Insurance Fund	\$3,202,654,000	\$2,973,526,000	(\$229,128,000)
4260-601-7502 Demonstration DSH Fund	\$73,500,000	\$40,716,000	(\$32,784,000)
4260-601-7503 Health Care Support Fund	\$68,845,000	\$159,216,000	\$90,371,000
4260-611-0890 Hospital Quality Assurance	\$6,098,093,000	\$5,378,463,000	(\$719,630,000)
<b>Total Benefits</b>	<b>\$75,062,866,000</b>	<b>\$77,513,294,000</b>	<b>\$2,450,428,000</b>
<b>County Administration:</b>			
4260-101-0890 Federal Funds	\$3,628,031,000	\$3,852,034,000	\$224,003,000
4260-106-0890 Money Follows Person Fed. Grant	\$360,000	\$360,000	\$0
4260-113-0890 Childrens Health Insurance Fund	\$61,989,000	\$60,396,000	(\$1,593,000)
4260-117-0890 HIPAA	\$9,684,000	\$9,953,000	\$269,000
<b>Total County Administration</b>	<b>\$3,700,064,000</b>	<b>\$3,922,743,000</b>	<b>\$222,679,000</b>
<b>Fiscal Intermediary:</b>			
4260-101-0890 Federal Funds	\$229,455,000	\$303,288,000	\$73,833,000
4260-113-0890 Childrens Health Insurance Fund	\$30,296,000	\$15,233,000	(\$15,063,000)
4260-117-0890 HIPAA	\$740,000	\$1,079,000	\$339,000
<b>Total Fiscal Intermediary</b>	<b>\$260,491,000</b>	<b>\$319,600,000</b>	<b>\$59,109,000</b>
<b>Grand Total - Federal Funds</b>	<b>\$79,023,421,000</b>	<b>\$81,755,637,000</b>	<b>\$2,732,216,000</b>

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*The Current Year section provides a summary of medical assistance benefits (base and regular policy change) expenditures for the current fiscal year. It highlights expenditures by service category, compares current year data to the previous appropriation estimate, and provides an overview of the current year cost per eligible expenditures.*

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## MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2020-21

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<b>I. BASE ESTIMATES</b>				
A. C/Y FFS BASE	\$17,772,840,460	\$8,886,420,230	\$8,886,420,230	\$0
B. C/Y BASE POLICY CHANGES	\$50,789,124,000	\$33,831,928,450	\$16,829,672,560	\$127,523,000
C. BASE ADJUSTMENTS	(\$126,178,000)	(\$217,564,570)	\$91,386,570	\$0
<b>D. ADJUSTED BASE</b>	<b>\$68,435,786,460</b>	<b>\$42,500,784,110</b>	<b>\$25,807,479,350</b>	<b>\$127,523,000</b>
<b>II. REGULAR POLICY CHANGES</b>				
A. ELIGIBILITY	\$104,690,140	(\$656,161,090)	\$758,205,230	\$2,646,000
B. AFFORDABLE CARE ACT	\$5,286,879,000	\$5,491,730,730	(\$30,802,730)	(\$174,049,000)
C. BENEFITS	\$2,115,677,670	\$1,606,725,290	\$484,093,380	\$24,859,000
D. PHARMACY	(\$1,746,866,600)	(\$1,720,876,710)	(\$1,516,888,880)	\$1,490,899,000
E. DRUG MEDI-CAL	\$420,630,500	\$378,882,170	\$41,748,320	\$0
F. MENTAL HEALTH	(\$27,197,000)	(\$39,957,500)	\$12,560,500	\$200,000
G. WAIVER--MH/UCD & BTR	\$4,431,341,520	\$2,699,718,670	(\$20,261,140)	\$1,751,884,000
H. MANAGED CARE	\$10,481,674,920	\$5,832,800,220	\$10,642,190	\$4,638,232,500
I. PROVIDER RATES	\$984,310,350	\$1,131,076,540	(\$848,146,020)	\$701,379,830
J. SUPPLEMENTAL PMNTS.	\$16,411,109,440	\$10,193,174,520	\$110,917,420	\$6,107,017,500
K. COVID-19	\$5,285,569,280	\$6,304,552,960	(\$1,018,983,680)	\$0
L. STATE ONLY CLAIMING	(\$3,169,000)	(\$480,674,000)	\$249,752,000	\$227,753,000
M. OTHER DEPARTMENTS	(\$20,248,000)	(\$20,665,000)	\$417,000	\$0
N. OTHER	\$593,814,330	\$1,841,753,910	(\$2,696,332,580)	\$1,448,393,000
<b>O. TOTAL CHANGES</b>	<b>\$44,318,216,540</b>	<b>\$32,562,080,710</b>	<b>(\$4,463,078,990)</b>	<b>\$16,219,214,820</b>
<b>III. TOTAL MEDI-CAL ESTIMATE</b>	<b>\$112,754,003,000</b>	<b>\$75,062,864,810</b>	<b>\$21,344,400,370</b>	<b>\$16,346,737,820</b>

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>ELIGIBILITY</u></b>					
1	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$100,498,000	\$50,249,000	\$50,249,000	\$0
2	MEDI-CAL STATE INMATE PROGRAMS	\$70,059,000	\$70,059,000	\$0	\$0
3	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$67,671,140	\$21,027,810	\$46,643,320	\$0
4	BREAST AND CERVICAL CANCER TREATMENT	\$63,661,000	\$38,513,250	\$25,147,750	\$0
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$14,938,000	(\$11,348,680)	\$26,286,680	\$0
8	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$3,232,000	(\$2,615,000)	\$5,847,000	\$0
10	MEDICARE PART B DISREGARD	\$1,115,000	\$0	\$1,115,000	\$0
12	MEDI-CAL COUNTY INMATE PROGRAMS	\$0	\$0	\$0	\$0
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$2,270,000)	\$2,270,000
14	NON-OTLIP CHIP	\$0	\$99,627,380	(\$99,627,380)	\$0
15	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,008,412,530)	\$1,008,412,530	\$0
16	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$95,528,900	(\$95,528,900)	\$0
17	CDCR RETRO REPAYMENT	\$0	(\$410,000)	\$410,000	\$0
18	CS3 PROXY ADJUSTMENT	\$0	\$155,547,330	(\$155,547,330)	\$0
19	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$376,000)	\$376,000
20	CCHIP DELIVERY SYSTEM	(\$361,720)	(\$245,520)	(\$116,200)	\$0
21	CHIP PREMIUMS	(\$64,198,000)	(\$43,574,340)	(\$20,623,660)	\$0
22	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$151,924,280)	(\$120,107,710)	(\$31,816,570)	\$0
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$104,690,130</b>	<b>(\$656,161,100)</b>	<b>\$758,205,230</b>	<b>\$2,646,000</b>
<b><u>AFFORDABLE CARE ACT</u></b>					
23	COMMUNITY FIRST CHOICE OPTION	\$5,620,436,000	\$5,620,436,000	\$0	\$0
24	HEALTH INSURER FEE	\$284,312,000	\$186,901,910	\$97,410,090	\$0
25	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$22,231,000	\$22,231,000	\$0	\$0
26	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$44,084,820	(\$44,084,820)	\$0
27	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$5,250,000	(\$5,250,000)	\$0
28	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$32,000)	(\$32,000)	\$0	\$0
29	ACA DSH REDUCTION	(\$640,068,000)	(\$387,141,000)	(\$78,878,000)	(\$174,049,000)
237	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	\$0	\$0	\$0	\$0
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$5,286,879,000</b>	<b>\$5,491,730,730</b>	<b>(\$30,802,730)</b>	<b>(\$174,049,000)</b>
<b><u>BENEFITS</u></b>					
30	BEHAVIORAL HEALTH TREATMENT	\$936,977,000	\$544,844,180	\$392,132,820	\$0
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$568,296,000	\$568,296,000	\$0	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>BENEFITS</u></b>					
32	FAMILY PACT PROGRAM	\$354,323,000	\$269,919,500	\$84,403,500	\$0
33	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$106,617,000	\$106,617,000	\$0	\$0
34	LEA EXPANSION	\$64,911,000	\$64,911,000	\$0	\$0
35	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	\$28,035,920	\$17,910,320	\$10,125,600	\$0
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,232,000	\$10,743,000	(\$10,743,000)	\$20,232,000
37	CCS DEMONSTRATION PROJECT	\$11,306,000	\$5,958,580	\$5,347,420	\$0
38	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$10,020,000	\$7,748,000	\$2,272,000	\$0
39	MSSP SUPPLEMENTAL PAYMENTS	\$4,933,000	\$4,933,000	(\$4,627,000)	\$4,627,000
40	OPTIONAL BENEFITS RESTORATION	\$5,390,630	\$3,443,770	\$1,946,860	\$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,600,000	\$0	\$1,600,000	\$0
42	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,566,290	\$1,003,130	\$563,160	\$0
43	MEDICAL INTERPRETERS PILOT PROJECT	\$1,000,000	\$0	\$1,000,000	\$0
44	CCT FUND TRANSFER TO CDSS	\$267,000	\$267,000	\$0	\$0
45	DIABETES PREVENTION PROGRAM	\$202,830	\$130,810	\$72,020	\$0
	<b>BENEFITS SUBTOTAL</b>	<b>\$2,115,677,670</b>	<b>\$1,606,725,290</b>	<b>\$484,093,380</b>	<b>\$24,859,000</b>
<b><u>PHARMACY</u></b>					
48	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,490,899,000)	\$1,490,899,000
49	BCCTP DRUG REBATES	(\$4,682,000)	(\$4,682,000)	\$0	\$0
50	LITIGATION SETTLEMENTS	(\$19,201,000)	\$0	(\$19,201,000)	\$0
51	FAMILY PACT DRUG REBATES	(\$10,497,000)	(\$10,497,000)	\$0	\$0
52	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	(\$14,192,760)	(\$8,936,570)	(\$5,256,190)	\$0
53	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	(\$32,391,840)	(\$20,841,250)	(\$11,550,590)	\$0
54	MEDICAL SUPPLY REBATES	(\$22,271,000)	(\$11,135,500)	(\$11,135,500)	\$0
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$7,619,000)	(\$5,198,100)	(\$2,420,900)	\$0
56	STATE SUPPLEMENTAL DRUG REBATES	(\$119,571,000)	(\$119,571,000)	\$0	\$0
57	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$174,437,000	\$125,169,250	\$49,267,750	\$0
58	FEDERAL DRUG REBATES	(\$1,570,146,000)	(\$1,570,146,000)	\$0	\$0
232	PHARMACY RETROACTIVE ADJUSTMENTS	(\$120,732,000)	(\$95,038,540)	(\$25,693,460)	\$0
	<b>PHARMACY SUBTOTAL</b>	<b>(\$1,746,866,600)</b>	<b>(\$1,720,876,710)</b>	<b>(\$1,516,888,880)</b>	<b>\$1,490,899,000</b>
<b><u>DRUG MEDI-CAL</u></b>					
59	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$419,478,000	\$377,838,850	\$41,639,150	\$0
63	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$758,250	\$695,100	\$63,150	\$0
64	DRUG MEDI-CAL MAT BENEFIT	\$348,250	\$288,220	\$60,020	\$0

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## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>DRUG MEDI-CAL</u></b>					
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$46,000	\$60,000	(\$14,000)	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$420,630,500</b>	<b>\$378,882,180</b>	<b>\$41,748,320</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>					
69	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$23,862,000	\$12,234,500	\$11,627,500	\$0
70	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$9,861,000	\$9,861,000	\$0	\$0
71	PATHWAYS TO WELL-BEING	\$961,000	\$961,000	\$0	\$0
72	LATE CLAIMS FOR SMHS	\$30,000	\$0	\$30,000	\$0
73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
76	CHART REVIEW	(\$41,000)	(\$41,000)	\$0	\$0
77	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$61,870,000)	(\$62,973,000)	\$1,103,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>(\$27,197,000)</b>	<b>(\$39,957,500)</b>	<b>\$12,560,500</b>	<b>\$200,000</b>
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>					
78	GLOBAL PAYMENT PROGRAM	\$2,209,581,000	\$1,319,521,000	\$0	\$890,060,000
79	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,039,219,000	\$599,090,000	\$0	\$440,129,000
80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$1,038,646,000	\$624,165,000	\$0	\$414,481,000
81	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$169,592,520	\$95,311,670	\$74,280,860	\$0
82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$324,000	\$324,000	\$0	\$0
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$94,542,000	(\$94,542,000)	\$0
84	BTR - LIHP - MCE	\$0	(\$7,214,000)	\$0	\$7,214,000
85	MH/UCD—SAFETY NET CARE POOL	(\$26,021,000)	(\$26,021,000)	\$0	\$0
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$4,431,341,520</b>	<b>\$2,699,718,670</b>	<b>(\$20,261,140)</b>	<b>\$1,751,884,000</b>
<b><u>MANAGED CARE</u></b>					
89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$3,176,921,000	\$2,034,165,280	\$1,142,755,720	\$0
90	CCI-MANAGED CARE PAYMENTS	\$2,895,788,920	\$1,447,894,460	\$1,447,894,460	\$0
91	MANAGED CARE PUBLIC HOSPITAL EPP	\$2,517,179,000	\$1,820,023,660	\$697,155,340	\$0
92	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,928,567,000	\$1,271,694,640	\$656,872,360	\$0
93	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,324,714,000	\$1,008,873,520	\$315,840,480	\$0
96	RETRO MC RATE ADJUSTMENTS	\$403,089,000	\$178,970,620	\$224,118,380	\$0
97	EXTENDED FILE CORRECTION	\$300,000,000	(\$35,205,360)	\$335,205,360	\$0
98	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$138,589,000	\$122,702,500	\$0	\$15,886,500

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## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>MANAGED CARE</u></b>					
101	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$30,000,000	\$0	\$30,000,000	\$0
102	CCI-QUALITY WITHHOLD REPAYMENTS	\$18,830,000	\$9,415,000	\$9,415,000	\$0
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,760,119,000)	\$1,760,119,000
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$1,009,538,000)	\$1,009,538,000
108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,852,689,000)	\$1,852,689,000
111	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	(\$1,166,000)	(\$708,350)	(\$457,650)	\$0
112	MANAGED CARE EFFICIENCIES	(\$199,574,000)	(\$135,104,050)	(\$64,469,950)	\$0
113	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	(\$603,348,000)	(\$417,040,700)	(\$186,307,300)	\$0
114	MANAGED CARE DRUG REBATES	(\$1,504,915,000)	(\$1,504,915,000)	\$0	\$0
242	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$57,000,000	\$32,034,000	\$24,966,000	\$0
<b>MANAGED CARE SUBTOTAL</b>		<b>\$10,481,674,920</b>	<b>\$5,832,800,220</b>	<b>\$10,642,190</b>	<b>\$4,638,232,500</b>
<b><u>PROVIDER RATES</u></b>					
115	DPH INTERIM RATE GROWTH	\$191,384,860	\$95,692,430	\$95,692,430	\$0
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$196,236,000	\$137,555,010	(\$7,138,830)	\$65,819,830
117	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$157,132,330	\$96,743,790	\$60,388,530	\$0
118	DPH INTERIM & FINAL RECONS	\$136,116,000	\$136,116,000	\$0	\$0
119	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$134,994,000	\$134,994,000	\$0	\$0
120	AB 1629 ANNUAL RATE ADJUSTMENTS	\$90,917,050	\$45,458,530	\$45,458,530	\$0
121	PROP 56 - HOME HEALTH RATE INCREASE	\$74,574,520	\$40,188,060	\$34,386,460	\$0
122	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$44,610,000	\$27,465,800	\$17,144,200	\$0
123	LTC RATE ADJUSTMENT	\$30,134,830	\$15,067,410	\$15,067,410	\$0
124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$13,972,000	\$9,178,000	(\$2,210,000)	\$7,004,000
125	HOSPICE RATE INCREASES	\$9,025,010	\$4,512,510	\$4,512,510	\$0
126	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$3,107,920	\$1,721,490	\$1,386,440	\$0
127	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,301,300	\$1,150,650	\$1,150,650	\$0
128	DPH INTERIM RATE	\$0	\$436,092,100	(\$436,092,100)	\$0
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$628,556,000)	\$628,556,000
130	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$2,003,970)	(\$1,097,650)	(\$906,320)	\$0
131	REDUCTION TO RADIOLOGY RATES	(\$3,222,080)	(\$1,611,040)	(\$1,611,040)	\$0
132	10% PROVIDER PAYMENT REDUCTION	(\$13,936,310)	(\$6,968,150)	(\$6,968,150)	\$0
133	LABORATORY RATE METHODOLOGY CHANGE	(\$29,641,130)	(\$14,820,560)	(\$14,820,560)	\$0

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## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>PROVIDER RATES</u></b>					
243	HOME HEALTH & PDHC RECOUPMENTS	(\$51,392,000)	(\$26,361,840)	(\$25,030,160)	\$0
	<b>PROVIDER RATES SUBTOTAL</b>	<b>\$984,310,350</b>	<b>\$1,131,076,540</b>	<b>(\$848,146,020)</b>	<b>\$701,379,830</b>
<b><u>SUPPLEMENTAL PMNTS.</u></b>					
134	HOSPITAL QAF - FFS PAYMENTS	\$5,179,786,000	\$2,559,730,000	\$0	\$2,620,056,000
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$2,846,100,000	\$1,991,208,000	\$0	\$854,892,000
136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$2,326,556,000	\$1,547,155,000	\$0	\$779,401,000
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$1,287,506,000	\$762,566,000	\$0	\$524,940,000
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,210,196,750	\$830,446,430	\$379,750,320	\$0
139	PRIVATE HOSPITAL DSH REPLACEMENT	\$608,040,000	\$341,810,000	\$266,230,000	\$0
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$46,539,860	\$30,330,420	\$16,209,430	\$0
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$364,513,000	\$251,966,100	\$112,546,900	\$0
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$429,933,000	\$178,836,000	\$126,275,000	\$124,822,000
143	DSH PAYMENT	\$327,845,000	\$239,241,500	\$19,641,000	\$68,962,500
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$291,729,000	\$291,729,000	\$0	\$0
145	DPH PHYSICIAN & NON-PHYS. COST	\$268,004,000	\$268,004,000	\$0	\$0
146	FFP FOR LOCAL TRAUMA CENTERS	\$136,157,000	\$70,517,500	\$0	\$65,639,500
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$121,860,000	\$73,304,730	\$4,659,270	\$43,896,000
148	CAPITAL PROJECT DEBT REIMBURSEMENT	\$97,776,000	\$75,053,500	\$22,722,500	\$0
149	NDPH IGT SUPPLEMENTAL PAYMENTS	\$54,971,000	\$26,410,500	(\$7,432,000)	\$35,992,500
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$81,000,000	\$40,500,000	\$46,979,000	(\$6,479,000)
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$71,812,000	\$71,812,000	\$0	\$0
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$55,960,000	\$55,960,000	\$0	\$0
153	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$26,250,000	\$14,753,000	\$11,497,000	\$0
154	PROP 56 - DEVELOPMENTAL SCREENINGS	\$49,640,820	\$30,127,460	\$19,513,350	\$0
155	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$38,648,000	\$21,720,000	\$16,928,000	\$0
156	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$36,985,860	\$23,884,050	\$13,101,810	\$0
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,857,000	\$14,857,000	\$0	\$0
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,620,000	\$4,380,000	\$0
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,496,000	\$3,504,000	\$0

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## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>					
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$7,279,240	\$4,176,710	\$3,102,530	\$0
161	PROP 56 - MEDI-CAL FAMILY PLANNING	\$398,489,100	\$358,640,190	\$39,848,910	\$0
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$4,501,760	\$3,874,660	\$627,100	\$0
163	NDPH SUPPLEMENTAL PAYMENT	\$4,256,000	\$2,592,000	\$1,900,000	(\$236,000)
164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	\$4,000,000	\$2,248,000	\$1,752,000	\$0
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$1,917,060	\$1,114,760	\$802,300	\$0
166	PROPOSITION 56 FUNDS TRANSFER	\$0	\$0	(\$975,709,000)	\$975,709,000
167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
168	IGT PAYMENTS FOR HOSPITAL SERVICES	\$0	(\$1,510,000)	\$10,077,000	(\$8,567,000)
169	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$27,989,000)	\$27,989,000
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$16,411,109,440</b>	<b>\$10,193,174,520</b>	<b>\$110,917,420</b>	<b>\$6,107,017,500</b>
<b><u>COVID-19</u></b>					
172	COVID-19 CASELOAD IMPACT	\$5,279,055,550	\$3,584,832,750	\$1,694,222,810	\$0
173	COVID-19 BEHAVIORAL HEALTH	\$287,307,000	\$270,629,760	\$16,677,240	\$0
174	COVID-19 FFS REIMBURSEMENT RATES	\$334,768,000	\$167,384,000	\$167,384,000	\$0
175	COVID-19 BASE RECOVERIES	\$202,958,040	\$117,503,590	\$85,454,450	\$0
176	COVID-19 ELIGIBILITY	\$36,319,700	\$11,606,060	\$24,713,650	\$0
177	COVID-19 - SICK LEAVE BENEFITS	\$36,900,000	\$36,799,000	\$101,000	\$0
178	COVID-19 INCREASED FMAP - DHCS	(\$220,134,000)	\$2,517,758,000	(\$2,737,892,000)	\$0
179	COVID-19 UTILIZATION CHANGE	(\$703,255,020)	(\$422,849,190)	(\$280,405,830)	\$0
247	COVID-19 VACCINE ADMINISTRATION	\$31,650,000	\$20,889,000	\$10,761,000	\$0
	<b>COVID-19 SUBTOTAL</b>	<b>\$5,285,569,280</b>	<b>\$6,304,552,960</b>	<b>(\$1,018,983,680)</b>	<b>\$0</b>
<b><u>STATE ONLY CLAIMING</u></b>					
221	STATE ONLY CLAIMING ADJUSTMENTS	\$0	(\$293,749,000)	\$65,996,000	\$227,753,000
244	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$3,169,000)	(\$142,294,000)	\$139,125,000	\$0
245	STATE ONLY CLAIMING ADJUSTMENTS - TCM	\$0	(\$44,631,000)	\$44,631,000	\$0
	<b>STATE ONLY CLAIMING SUBTOTAL</b>	<b>(\$3,169,000)</b>	<b>(\$480,674,000)</b>	<b>\$249,752,000</b>	<b>\$227,753,000</b>
<b><u>OTHER DEPARTMENTS</u></b>					
180	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$20,248,000)	(\$20,665,000)	\$417,000	\$0
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>(\$20,248,000)</b>	<b>(\$20,665,000)</b>	<b>\$417,000</b>	<b>\$0</b>
<b><u>OTHER</u></b>					
187	CCI IHSS RECONCILIATION	\$142,263,000	\$142,263,000	\$0	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b>OTHER</b>					
188	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$102,878,000	\$102,878,000	\$0	\$0
190	PROP 56 - PROVIDER ACES TRAININGS	\$61,924,000	\$30,962,000	\$30,962,000	\$0
193	INFANT DEVELOPMENT PROGRAM	\$48,322,000	\$48,322,000	\$0	\$0
194	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$32,679,230	\$16,339,620	\$16,339,620	\$0
196	SELF-DETERMINATION PROGRAM - CDDS	\$8,365,000	\$8,365,000	\$0	\$0
197	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$16,891,000	\$9,160,000	\$7,731,000	\$0
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$15,108,000	\$0	\$0	\$15,108,000
200	INDIAN HEALTH SERVICES	\$9,203,060	\$6,119,910	\$3,083,140	\$0
201	ARRA HITECH - PROVIDER PAYMENTS	\$8,651,000	\$8,651,000	\$0	\$0
202	QAF WITHHOLD TRANSFER	\$7,816,000	\$11,284,000	(\$3,468,000)	\$0
203	CCS SAR EPC	\$6,166,000	\$3,136,760	\$3,222,240	(\$193,000)
204	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$168,175,000	\$84,087,500	\$84,087,500	\$0
205	WPCS WORKERS' COMPENSATION	\$3,324,000	\$1,662,000	\$1,662,000	\$0
206	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$1,780,000	\$1,317,700	\$462,300	\$0
209	AUDIT SETTLEMENTS	\$0	(\$47,589,000)	\$47,589,000	\$0
210	IMD ANCILLARY SERVICES	\$0	(\$15,930,000)	\$15,930,000	\$0
211	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$160,657,000)	\$160,657,000
212	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,898,984,800	(\$1,898,984,800)	\$0
213	FUNDING ADJUST.—OTLICP	\$0	\$105,944,100	(\$105,944,100)	\$0
214	CMS DEFERRED CLAIMS	\$0	(\$567,553,000)	\$567,553,000	\$0
215	CLPP FUND	\$0	\$0	(\$916,000)	\$916,000
216	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$1,151,905,000)	\$1,151,905,000
217	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	\$0	(\$10,370,000)	\$10,370,000	\$0
218	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$12,500,000	(\$12,500,000)	\$0
219	FUND 3156 TRANSFER TO THE GENERAL FUND	\$0	\$0	(\$100,000,000)	\$100,000,000
220	FUND 3311 TRANSFER TO THE GENERAL FUND	\$0	\$0	(\$20,000,000)	\$20,000,000
222	ASSISTED LIVING WAIVER EXPANSION	(\$17,562,960)	(\$8,781,480)	(\$8,781,480)	\$0
223	COUNTY SHARE OF OTLICP-CCS COSTS	(\$22,168,000)	\$0	(\$22,168,000)	\$0
<b>OTHER SUBTOTAL</b>		<b>\$593,814,330</b>	<b>\$1,841,753,910</b>	<b>(\$2,696,332,580)</b>	<b>\$1,448,393,000</b>
<b>GRAND TOTAL</b>		<b>\$44,318,216,550</b>	<b>\$32,562,080,710</b>	<b>(\$4,463,078,990)</b>	<b>\$16,219,214,830</b>

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

## MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2020-21

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b>PROFESSIONAL</b>	\$8,458,894,960	\$5,235,511,920	\$1,969,937,370	\$1,253,445,670
PHYSICIANS	\$1,101,865,000	\$798,829,670	\$245,393,550	\$57,641,770
OTHER MEDICAL	\$4,901,103,180	\$2,964,760,460	\$1,687,908,950	\$248,433,770
CO. & COMM. OUTPATIENT	\$2,455,926,780	\$1,471,921,790	\$36,634,870	\$947,370,130
<b>PHARMACY</b>	\$3,151,081,290	\$1,580,660,110	(\$89,802,260)	\$1,660,223,440
<b>HOSPITAL INPATIENT</b>	\$13,904,297,040	\$8,909,674,930	\$1,354,651,780	\$3,639,970,320
COUNTY INPATIENT	\$3,378,934,770	\$2,414,573,710	(\$21,517,880)	\$985,878,940
COMMUNITY INPATIENT	\$10,525,362,270	\$6,495,101,230	\$1,376,169,660	\$2,654,091,380
<b>LONG TERM CARE</b>	\$3,618,456,710	\$2,099,134,890	\$1,334,773,130	\$184,548,690
NURSING FACILITIES	\$3,135,426,760	\$1,826,802,030	\$1,153,081,260	\$155,543,470
ICF-DD	\$483,029,960	\$272,332,860	\$181,691,870	\$29,005,220
<b>OTHER SERVICES</b>	\$1,675,366,550	\$1,016,680,120	\$587,992,050	\$70,694,380
MEDICAL TRANSPORTATION	\$190,326,010	\$146,819,560	\$33,188,340	\$10,318,110
OTHER SERVICES	\$1,183,059,750	\$694,767,740	\$436,478,070	\$51,813,950
HOME HEALTH	\$301,980,790	\$175,092,820	\$118,325,640	\$8,562,320
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$30,808,096,560</b>	<b>\$18,841,661,980</b>	<b>\$5,157,552,080</b>	<b>\$6,808,882,500</b>
<b>MANAGED CARE</b>	\$57,147,054,800	\$37,531,671,200	\$11,239,400,930	\$8,375,982,680
TWO PLAN MODEL	\$35,035,119,700	\$23,120,039,980	\$6,879,653,390	\$5,035,426,320
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,242,607,730	\$8,664,959,160	\$2,501,393,660	\$2,076,254,900
GEOGRAPHIC MANAGED CARE	\$5,934,016,110	\$3,872,784,200	\$1,147,385,000	\$913,846,910
PHP & OTHER MANAG. CARE	\$1,077,498,130	\$620,475,030	\$434,279,950	\$22,743,150
REGIONAL MODEL	\$1,857,813,140	\$1,253,412,820	\$276,688,920	\$327,711,390
<b>DENTAL</b>	\$1,786,389,910	\$1,045,318,990	\$552,184,580	\$188,886,350
<b>MENTAL HEALTH</b>	\$3,222,810,700	\$2,949,728,930	\$58,596,400	\$214,485,360
<b>AUDITS/ LAWSUITS</b>	\$16,800,010	(\$597,141,500)	\$613,941,500	\$0
<b>EPSDT SCREENS</b>	\$0	\$0	\$0	\$0
<b>MEDICARE PAYMENTS</b>	\$6,172,827,470	\$2,316,832,400	\$3,855,995,070	\$0
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$43,737,400	\$45,533,200	(\$1,795,800)	\$0
<b>MISC. SERVICES</b>	\$13,302,358,000	\$12,639,155,740	(\$95,298,680)	\$758,500,940
<b>RECOVERIES</b>	(\$253,271,960)	(\$161,504,410)	(\$91,767,540)	\$0
<b>DRUG MEDI-CAL</b>	\$507,200,110	\$451,608,290	\$55,591,820	\$0
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$112,754,003,000</b>	<b>\$75,062,864,810</b>	<b>\$21,344,400,370</b>	<b>\$16,346,737,820</b>

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

<u>SERVICE CATEGORY</u>	<u>2020-21 APPROPRIATION</u>	<u>NOV. 2020 EST. FOR 2020-21</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
<b>PROFESSIONAL</b>	\$8,355,086,150	\$8,458,894,960	\$103,808,810	1.24%
PHYSICIANS	\$1,124,228,240	\$1,101,865,000	(\$22,363,240)	-1.99%
OTHER MEDICAL	\$4,797,309,140	\$4,901,103,180	\$103,794,040	2.16%
CO. & COMM. OUTPATIENT	\$2,433,548,770	\$2,455,926,780	\$22,378,010	0.92%
<b>PHARMACY</b>	\$4,452,172,270	\$3,151,081,290	(\$1,301,090,970)	-29.22%
<b>HOSPITAL INPATIENT</b>	\$13,857,015,080	\$13,904,297,040	\$47,281,960	0.34%
COUNTY INPATIENT	\$3,576,744,770	\$3,378,934,770	(\$197,810,000)	-5.53%
COMMUNITY INPATIENT	\$10,280,270,310	\$10,525,362,270	\$245,091,950	2.38%
<b>LONG TERM CARE</b>	\$3,399,855,600	\$3,618,456,710	\$218,601,110	6.43%
NURSING FACILITIES	\$2,906,025,140	\$3,135,426,760	\$229,401,620	7.89%
ICF-DD	\$493,830,460	\$483,029,960	(\$10,800,510)	-2.19%
<b>OTHER SERVICES</b>	\$1,633,170,590	\$1,675,366,550	\$42,195,970	2.58%
MEDICAL TRANSPORTATION	\$225,769,070	\$190,326,010	(\$35,443,050)	-15.70%
OTHER SERVICES	\$1,123,792,330	\$1,183,059,750	\$59,267,430	5.27%
HOME HEALTH	\$283,609,200	\$301,980,790	\$18,371,590	6.48%
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$31,697,299,680</b>	<b>\$30,808,096,560</b>	<b>(\$889,203,120)</b>	<b>-2.81%</b>
<b>MANAGED CARE</b>	\$55,317,226,190	\$57,147,054,800	\$1,829,828,610	3.31%
TWO PLAN MODEL	\$33,242,204,480	\$35,035,119,700	\$1,792,915,220	5.39%
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,283,347,610	\$13,242,607,730	(\$40,739,880)	-0.31%
GEOGRAPHIC MANAGED CARE	\$5,723,858,550	\$5,934,016,110	\$210,157,560	3.67%
PHP & OTHER MANAG. CARE	\$1,109,634,160	\$1,077,498,130	(\$32,136,030)	-2.90%
REGIONAL MODEL	\$1,958,181,400	\$1,857,813,140	(\$100,368,260)	-5.13%
<b>DENTAL</b>	\$1,815,068,960	\$1,786,389,910	(\$28,679,040)	-1.58%
<b>MENTAL HEALTH</b>	\$3,151,709,200	\$3,222,810,700	\$71,101,500	2.26%
<b>AUDITS/ LAWSUITS</b>	\$32,350,000	\$16,800,010	(\$15,549,990)	-48.07%
<b>MEDICARE PAYMENTS</b>	\$6,173,798,800	\$6,172,827,470	(\$971,330)	-0.02%
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$33,774,000	\$43,737,400	\$9,963,400	29.50%
<b>MISC. SERVICES</b>	\$12,179,412,170	\$13,302,358,000	\$1,122,945,830	9.22%
<b>RECOVERIES</b>	(\$500,822,280)	(\$253,271,960)	\$247,550,330	-49.43%
<b>DRUG MEDI-CAL</b>	\$451,671,380	\$507,200,110	\$55,528,730	12.29%
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$110,351,488,100</b>	<b>\$112,754,003,000</b>	<b>\$2,402,514,900</b>	<b>2.18%</b>
<b>GENERAL FUNDS</b>	<b>\$22,591,213,360</b>	<b>\$21,344,400,370</b>	<b>(\$1,246,812,990)</b>	<b>-5.52%</b>
<b>OTHER STATE FUNDS</b>	<b>\$15,790,129,350</b>	<b>\$16,346,737,820</b>	<b>\$556,608,470</b>	<b>3.53%</b>

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b>ELIGIBILITY</b>								
7	1	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$135,468,000	\$67,734,000	\$100,498,000	\$50,249,000	(\$34,970,000)	(\$17,485,000)
2	2	MEDI-CAL STATE INMATE PROGRAMS	\$84,662,000	\$0	\$70,059,000	\$0	(\$14,603,000)	\$0
1	3	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$343,844,000	\$238,921,000	\$265,377,000	\$182,915,000	(\$78,467,000)	(\$56,006,000)
3	4	BREAST AND CERVICAL CANCER TREATMENT	\$65,865,000	\$41,404,900	\$63,661,000	\$25,147,750	(\$2,204,000)	(\$16,257,150)
17	6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$14,940,000	\$27,371,410	\$14,938,000	\$26,286,680	(\$2,000)	(\$1,084,730)
232	8	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$2,892,000	\$2,892,000	\$3,232,000	\$5,847,000	\$340,000	\$2,955,000
216	10	MEDICARE PART B DISREGARD	\$478,000	\$478,000	\$1,115,000	\$1,115,000	\$637,000	\$637,000
8	12	MEDI-CAL COUNTY INMATE PROGRAMS	\$62,295,000	\$2,622,600	\$42,506,000	\$2,340,000	(\$19,789,000)	(\$282,600)
11	13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$2,516,000)	\$0	(\$2,270,000)	\$0	\$246,000
13	14	NON-OTLIPC CHIP	\$0	(\$101,316,930)	\$0	(\$99,627,380)	\$0	\$1,689,540
14	15	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$969,518,000	\$0	\$1,008,412,530	\$0	\$38,894,530
15	16	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$76,358,720)	\$0	(\$95,528,900)	\$0	(\$19,170,180)
--	17	CDCR RETRO REPAYMENT	\$0	\$0	\$0	\$410,000	\$0	\$410,000
10	18	CS3 PROXY ADJUSTMENT	\$0	(\$122,728,680)	\$0	(\$155,547,330)	\$0	(\$32,818,640)
--	19	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	\$0	(\$376,000)	\$0	(\$376,000)
16	20	CCHIP DELIVERY SYSTEM	(\$3,097,000)	(\$969,520)	(\$3,936,000)	(\$1,264,440)	(\$839,000)	(\$294,920)
18	21	CHIP PREMIUMS	(\$62,224,000)	(\$19,989,460)	(\$64,198,000)	(\$20,623,660)	(\$1,974,000)	(\$634,200)
19	22	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$542,006,000)	(\$116,102,000)	(\$542,006,000)	(\$113,509,000)	\$0	\$2,593,000
9	--	PROVISIONAL POSTPARTUM CARE EXTENSION	\$34,291,000	\$34,291,000	\$0	\$0	(\$34,291,000)	(\$34,291,000)
266	--	HEARING AID COVERAGE - ADMIN	\$195,000	\$195,000	\$0	\$0	(\$195,000)	(\$195,000)
<b>ELIGIBILITY SUBTOTAL</b>			<b>\$137,603,000</b>	<b>\$945,446,580</b>	<b>(\$48,754,000)</b>	<b>\$813,976,240</b>	<b>(\$186,357,000)</b>	<b>(\$131,470,340)</b>

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



**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>AFFORDABLE CARE ACT</u></b>								
20	23	COMMUNITY FIRST CHOICE OPTION	\$4,423,366,000	\$0	\$5,620,436,000	\$0	\$1,197,070,000	\$0
22	24	HEALTH INSURER FEE	\$284,312,000	\$97,151,740	\$284,312,000	\$97,410,090	\$0	\$258,350
21	25	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$12,504,000	\$0	\$22,231,000	\$0	\$9,727,000	\$0
23	26	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$44,211,240)	\$0	(\$44,084,820)	\$0	\$126,420
24	27	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$3,212,000)	\$0	(\$5,250,000)	\$0	(\$2,038,000)
26	28	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$69,000)	\$0	(\$32,000)	\$0	\$37,000	\$0
28	29	ACA DSH REDUCTION	(\$690,472,000)	(\$90,044,000)	(\$640,068,000)	(\$78,878,000)	\$50,404,000	\$11,166,000
27	237	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	(\$100,000,000)	(\$5,500,000)	\$0	\$0	\$100,000,000	\$5,500,000
<b>AFFORDABLE CARE ACT SUBTOTAL</b>			<b>\$3,929,641,000</b>	<b>(\$45,815,500)</b>	<b>\$5,286,879,000</b>	<b>(\$30,802,730)</b>	<b>\$1,357,238,000</b>	<b>\$15,012,770</b>
<b><u>BENEFITS</u></b>								
29	30	BEHAVIORAL HEALTH TREATMENT	\$993,767,000	\$469,364,430	\$936,977,000	\$392,132,820	(\$56,790,000)	(\$77,231,610)
31	31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$388,005,000	\$0	\$568,296,000	\$0	\$180,291,000	\$0
30	32	FAMILY PACT PROGRAM	\$366,733,000	\$87,337,600	\$354,323,000	\$84,403,500	(\$12,410,000)	(\$2,934,100)
32	33	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$129,016,000	\$0	\$106,617,000	\$0	(\$22,399,000)	\$0
33	34	LEA EXPANSION	\$80,468,000	\$0	\$64,911,000	\$0	(\$15,557,000)	\$0
34	35	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	\$34,913,300	\$12,335,520	\$34,948,780	\$12,622,280	\$35,480	\$286,760
38	36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,232,000	\$521,000	\$20,232,000	(\$10,743,000)	\$0	(\$11,264,000)
39	37	CCS DEMONSTRATION PROJECT	\$6,456,000	\$3,026,080	\$11,306,000	\$5,347,420	\$4,850,000	\$2,321,340
36	38	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$4,074,000	\$930,000	\$10,020,000	\$2,272,000	\$5,946,000	\$1,342,000
35	39	MSSP SUPPLEMENTAL PAYMENTS	\$4,933,000	(\$4,933,000)	\$4,933,000	(\$4,627,000)	\$0	\$306,000
37	40	OPTIONAL BENEFITS RESTORATION	\$16,202,480	\$5,725,100	\$17,445,420	\$6,300,530	\$1,242,940	\$575,430

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>BENEFITS</u></b>								
41	41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,430,000	\$1,430,000	\$1,600,000	\$1,600,000	\$170,000	\$170,000
48	42	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,293,970	\$466,710	\$1,566,290	\$563,160	\$272,320	\$96,450
--	43	MEDICAL INTERPRETERS PILOT PROJECT	\$0	\$0	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
45	44	CCT FUND TRANSFER TO CDSS	\$175,000	\$0	\$267,000	\$0	\$92,000	\$0
46	45	DIABETES PREVENTION PROGRAM	\$536,740	\$189,920	\$202,830	\$72,020	(\$333,910)	(\$117,900)
40	--	MEDI-CAL NONMEDICAL TRANSPORTATION	\$24,625,300	\$9,545,450	\$0	\$0	(\$24,625,300)	(\$9,545,450)
42	--	YOUTH REGIONAL TREATMENT CENTERS	\$2,203,000	\$19,000	\$0	\$0	(\$2,203,000)	(\$19,000)
<b>BENEFITS SUBTOTAL</b>			<b>\$2,075,063,800</b>	<b>\$585,957,810</b>	<b>\$2,134,645,330</b>	<b>\$490,943,730</b>	<b>\$59,581,530</b>	<b>(\$95,014,080)</b>
<b><u>PHARMACY</u></b>								
53	48	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,643,642,000)	\$0	(\$1,490,899,000)	\$0	\$152,743,000
56	49	BCCTP DRUG REBATES	(\$5,081,000)	\$0	(\$4,682,000)	\$0	\$399,000	\$0
--	50	LITIGATION SETTLEMENTS	\$0	\$0	(\$19,201,000)	(\$19,201,000)	(\$19,201,000)	(\$19,201,000)
57	51	FAMILY PACT DRUG REBATES	(\$10,016,000)	\$0	(\$10,497,000)	\$0	(\$481,000)	\$0
--	52	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	\$0	\$0	(\$20,958,000)	(\$7,761,650)	(\$20,958,000)	(\$7,761,650)
54	53	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	(\$35,642,570)	(\$13,066,870)	(\$35,907,150)	(\$12,804,110)	(\$264,580)	\$262,760
59	54	MEDICAL SUPPLY REBATES	(\$43,098,000)	(\$21,549,000)	(\$22,271,000)	(\$11,135,500)	\$20,827,000	\$10,413,500
55	55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$57,381,000)	(\$21,088,600)	(\$7,619,000)	(\$2,420,900)	\$49,762,000	\$18,667,700
60	56	STATE SUPPLEMENTAL DRUG REBATES	(\$114,100,000)	\$0	(\$119,571,000)	\$0	(\$5,471,000)	\$0
52	57	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	(\$132,951,000)	(\$54,570,800)	\$174,437,000	\$49,267,750	\$307,388,000	\$103,838,550
62	58	FEDERAL DRUG REBATES	(\$1,439,215,000)	\$0	(\$1,570,146,000)	\$0	(\$130,931,000)	\$0
237	232	PHARMACY RETROACTIVE ADJUSTMENTS	(\$189,800,000)	(\$54,016,050)	(\$120,732,000)	(\$25,693,460)	\$69,068,000	\$28,322,590

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>PHARMACY SUBTOTAL</b>	<b>(\$2,027,284,570)</b>	<b>(\$1,807,933,320)</b>	<b>(\$1,757,147,150)</b>	<b>(\$1,520,647,870)</b>	<b>\$270,137,420</b>	<b>\$287,285,460</b>
		<b><u>DRUG MEDI-CAL</u></b>						
63	59	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$394,701,000	\$61,474,060	\$419,478,000	\$41,639,150	\$24,777,000	(\$19,834,920)
67	63	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$3,267,860	\$332,650	\$758,250	\$63,150	(\$2,509,610)	(\$269,500)
69	64	DRUG MEDI-CAL MAT BENEFIT	\$511,500	\$16,500	\$348,250	\$60,020	(\$163,250)	\$43,520
--	66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$0	\$0	\$46,000	(\$14,000)	\$46,000	(\$14,000)
		<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$398,480,360</b>	<b>\$61,823,210</b>	<b>\$420,630,500</b>	<b>\$41,748,320</b>	<b>\$22,150,140</b>	<b>(\$20,074,890)</b>
		<b><u>MENTAL HEALTH</u></b>						
74	69	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$24,651,000	\$13,207,000	\$23,862,000	\$11,627,500	(\$789,000)	(\$1,579,500)
--	70	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$0	\$0	\$9,861,000	\$0	\$9,861,000	\$0
75	71	PATHWAYS TO WELL-BEING	\$484,000	\$0	\$961,000	\$0	\$477,000	\$0
76	72	LATE CLAIMS FOR SMHS	\$30,000	\$30,000	\$30,000	\$30,000	\$0	\$0
77	73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
79	76	CHART REVIEW	(\$371,000)	\$0	(\$41,000)	\$0	\$330,000	\$0
80	77	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$53,739,000)	\$0	(\$61,870,000)	\$1,103,000	(\$8,131,000)	\$1,103,000
		<b>MENTAL HEALTH SUBTOTAL</b>	<b>(\$28,945,000)</b>	<b>\$13,037,000</b>	<b>(\$27,197,000)</b>	<b>\$12,560,500</b>	<b>\$1,748,000</b>	<b>(\$476,500)</b>
		<b><u>WAIVER--MH/UCD &amp; BTR</u></b>						
81	78	GLOBAL PAYMENT PROGRAM	\$2,200,578,000	\$0	\$2,209,581,000	\$0	\$9,003,000	\$0
82	79	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$612,000,000	\$0	\$1,039,219,000	\$0	\$427,219,000	\$0
83	80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$671,201,000	\$0	\$1,038,646,000	\$0	\$367,445,000	\$0
85	81	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$174,230,000	\$87,115,000	\$242,033,000	\$106,009,500	\$67,803,000	\$18,894,500

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>WAIVER--MH/UCD &amp; BTR</u></b>						
89	82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$263,000	\$0	\$324,000	\$0	\$61,000	\$0
243	83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	(\$92,290,000)	\$0	(\$94,542,000)	\$0	(\$2,252,000)
--	84	BTR - LIHP - MCE	\$0	\$0	\$0	\$0	\$0	\$0
--	85	MH/UCD—SAFETY NET CARE POOL	\$0	\$0	(\$26,021,000)	\$0	(\$26,021,000)	\$0
		<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$3,658,272,000</b>	<b>(\$5,175,000)</b>	<b>\$4,503,782,000</b>	<b>\$11,467,500</b>	<b>\$845,510,000</b>	<b>\$16,642,500</b>
		<b><u>MANAGED CARE</u></b>						
220	89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$3,177,119,000	\$1,083,012,760	\$3,176,921,000	\$1,142,755,720	(\$198,000)	\$59,742,950
95	90	CCI-MANAGED CARE PAYMENTS	\$8,539,346,000	\$4,269,673,000	\$8,489,560,000	\$4,244,780,000	(\$49,786,000)	(\$24,893,000)
97	91	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,541,109,000	\$361,561,850	\$2,517,179,000	\$697,155,340	\$976,070,000	\$335,593,490
96	92	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,917,686,000	\$653,666,820	\$1,928,567,000	\$656,872,360	\$10,881,000	\$3,205,540
100	93	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$667,840,000	\$154,921,040	\$1,324,714,000	\$315,840,480	\$656,874,000	\$160,919,440
103	96	RETRO MC RATE ADJUSTMENTS	\$363,335,000	\$211,153,890	\$403,089,000	\$224,118,380	\$39,754,000	\$12,964,500
--	97	EXTENDED FILE CORRECTION	\$0	\$0	\$300,000,000	\$335,205,360	\$300,000,000	\$335,205,360
104	98	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$203,895,000	\$0	\$138,589,000	\$0	(\$65,306,000)	\$0
234	101	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$0	\$0
107	102	CCI-QUALITY WITHHOLD REPAYMENTS	\$16,822,000	\$8,411,000	\$18,830,000	\$9,415,000	\$2,008,000	\$1,004,000
218	106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,686,645,000)	\$0	(\$1,760,119,000)	\$0	(\$73,474,000)
219	107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$1,083,013,000)	\$0	(\$1,009,538,000)	\$0	\$73,475,000
113	108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$1,284,053,000)	\$0	(\$1,852,689,000)	\$0	(\$568,636,000)
--	111	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	\$0	\$0	(\$1,166,000)	(\$457,650)	(\$1,166,000)	(\$457,650)

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b>MANAGED CARE</b>								
258	112	MANAGED CARE EFFICIENCIES	(\$182,058,000)	(\$59,253,000)	(\$199,574,000)	(\$64,469,950)	(\$17,516,000)	(\$5,216,950)
255	113	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	(\$585,917,000)	(\$181,978,300)	(\$603,348,000)	(\$186,307,300)	(\$17,431,000)	(\$4,329,000)
116	114	MANAGED CARE DRUG REBATES	(\$1,504,444,000)	\$0	(\$1,504,915,000)	\$0	(\$471,000)	\$0
--	242	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$0	\$0	\$57,000,000	\$24,966,000	\$57,000,000	\$24,966,000
110	--	CAPITATED RATE ADJUSTMENT FOR FY 2020-21	\$0	\$0	\$0	\$0	\$0	\$0
114	--	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	\$0	\$0	\$111,260,000	\$55,630,000
<b>MANAGED CARE SUBTOTAL</b>			<b>\$14,073,473,000</b>	<b>\$2,421,828,060</b>	<b>\$16,075,446,000</b>	<b>\$2,807,527,740</b>	<b>\$2,001,973,000</b>	<b>\$385,699,670</b>
<b>PROVIDER RATES</b>								
122	115	DPH INTERIM RATE GROWTH	\$35,388,120	\$17,694,060	\$192,578,850	\$96,289,420	\$157,190,730	\$78,595,360
117	116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$215,459,000	(\$7,980,000)	\$226,313,000	(\$8,233,000)	\$10,854,000	(\$253,000)
118	117	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$263,435,630	\$101,430,810	\$157,132,330	\$60,388,530	(\$106,303,310)	(\$41,042,280)
124	118	DPH INTERIM & FINAL RECONS	\$159,698,000	\$0	\$136,116,000	\$0	(\$23,582,000)	\$0
--	119	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$0	\$0	\$134,994,000	\$0	\$134,994,000	\$0
119	120	AB 1629 ANNUAL RATE ADJUSTMENTS	\$205,698,000	\$102,849,000	\$299,266,150	\$149,633,070	\$93,568,150	\$46,784,070
121	121	PROP 56 - HOME HEALTH RATE INCREASE	\$92,754,000	\$44,971,860	\$167,320,000	\$77,151,580	\$74,566,000	\$32,179,720
120	122	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$73,390,000	\$28,257,400	\$44,610,000	\$17,144,200	(\$28,780,000)	(\$11,113,200)
123	123	LTC RATE ADJUSTMENT	\$56,443,020	\$28,221,510	\$56,836,720	\$28,418,360	\$393,700	\$196,850
127	124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$10,000,000	(\$1,626,000)	\$13,972,000	(\$2,210,000)	\$3,972,000	(\$584,000)
128	125	HOSPICE RATE INCREASES	\$7,393,260	\$3,696,630	\$9,260,220	\$4,630,110	\$1,866,960	\$933,480
125	126	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$14,246,000	\$6,959,800	\$17,353,000	\$7,741,120	\$3,107,000	\$781,330

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>PROVIDER RATES</u></b>								
226	127	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$6,988,220	\$3,494,110	\$2,301,300	\$1,150,650	(\$4,686,920)	(\$2,343,460)
129	128	DPH INTERIM RATE	\$0	(\$401,766,100)	\$0	(\$436,092,100)	\$0	(\$34,326,000)
130	129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$623,984,000)	\$0	(\$628,556,000)	\$0	(\$4,572,000)
132	130	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$2,366,570)	(\$1,089,590)	(\$2,464,000)	(\$1,114,380)	(\$97,430)	(\$24,780)
136	131	REDUCTION TO RADIOLOGY RATES	(\$9,162,080)	(\$4,581,040)	(\$4,027,600)	(\$2,013,800)	\$5,134,490	\$2,567,240
134	132	10% PROVIDER PAYMENT REDUCTION	(\$171,841,000)	(\$85,920,500)	(\$171,841,000)	(\$85,920,500)	\$0	\$0
133	133	LABORATORY RATE METHODOLOGY CHANGE	(\$19,524,430)	(\$9,762,220)	(\$29,641,130)	(\$14,820,560)	(\$10,116,700)	(\$5,058,350)
--	243	HOME HEALTH & PDHC RECOUPMENTS	\$0	\$0	(\$51,392,000)	(\$25,030,160)	(\$51,392,000)	(\$25,030,160)
223	--	NURSING FACILITY FINANCING REFORM	\$70,171,540	\$33,741,700	\$0	\$0	(\$70,171,540)	(\$33,741,700)
<b>PROVIDER RATES SUBTOTAL</b>			<b>\$1,008,170,710</b>	<b>(\$765,392,580)</b>	<b>\$1,198,687,840</b>	<b>(\$761,443,440)</b>	<b>\$190,517,130</b>	<b>\$3,949,140</b>
<b><u>SUPPLEMENTAL PMNTS.</u></b>								
137	134	HOSPITAL QAF - FFS PAYMENTS	\$4,989,101,000	\$0	\$5,179,786,000	\$0	\$190,685,000	\$0
139	135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$2,846,100,000	\$0	\$2,846,100,000	\$0	\$0	\$0
138	136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$2,326,556,000	\$0	\$2,326,556,000	\$0	\$0	\$0
140	137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$1,063,771,000	\$0	\$1,287,506,000	\$0	\$223,735,000	\$0
141	138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,191,399,000	\$426,106,610	\$1,276,175,000	\$400,453,780	\$84,776,000	(\$25,652,820)
142	139	PRIVATE HOSPITAL DSH REPLACEMENT	\$608,335,000	\$304,167,500	\$608,040,000	\$266,230,000	(\$295,000)	(\$37,937,500)
143	140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$522,826,000	\$207,292,150	\$518,839,000	\$180,707,180	(\$3,987,000)	(\$26,584,980)
146	141	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$459,503,000	\$178,279,640	\$364,513,000	\$112,546,900	(\$94,990,000)	(\$65,732,740)
147	142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$312,824,000	\$126,275,000	\$429,933,000	\$126,275,000	\$117,109,000	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>SUPPLEMENTAL PMNTS.</u></b>						
145	143	DSH PAYMENT	\$495,326,000	\$24,952,000	\$327,845,000	\$19,641,000	(\$167,481,000)	(\$5,311,000)
148	144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$253,433,000	\$0	\$291,729,000	\$0	\$38,296,000	\$0
159	145	DPH PHYSICIAN & NON-PHYS. COST	\$224,686,000	\$0	\$268,004,000	\$0	\$43,318,000	\$0
150	146	FFP FOR LOCAL TRAUMA CENTERS	\$163,862,000	\$0	\$136,157,000	\$0	(\$27,705,000)	\$0
151	147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$118,812,000	\$0	\$121,860,000	\$4,659,270	\$3,048,000	\$4,659,270
149	148	CAPITAL PROJECT DEBT REIMBURSEMENT	\$94,555,000	\$26,770,000	\$97,776,000	\$22,722,500	\$3,221,000	(\$4,047,500)
152	149	NDPH IGT SUPPLEMENTAL PAYMENTS	\$83,684,000	(\$5,856,000)	\$54,971,000	(\$7,432,000)	(\$28,713,000)	(\$1,576,000)
154	150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$82,000,000	\$46,979,000	\$81,000,000	\$46,979,000	(\$1,000,000)	\$0
153	151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$85,239,000	\$0	\$71,812,000	\$0	(\$13,427,000)	\$0
155	152	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$80,700,000	\$0	\$55,960,000	\$0	(\$24,740,000)	\$0
227	153	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$52,500,000	\$26,250,000	\$26,250,000	\$11,497,000	(\$26,250,000)	(\$14,753,000)
156	154	PROP 56 - DEVELOPMENTAL SCREENINGS	\$49,039,570	\$22,229,820	\$53,222,710	\$20,921,360	\$4,183,140	(\$1,308,460)
157	155	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$30,992,000	\$15,496,000	\$38,648,000	\$16,928,000	\$7,656,000	\$1,432,000
158	156	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$37,593,600	\$15,158,940	\$41,972,150	\$14,868,140	\$4,378,540	(\$290,800)
162	157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$8,271,000	\$0	\$14,857,000	\$0	\$6,586,000	\$0
160	158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$4,380,000	\$0	(\$620,000)
163	159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$3,504,000	\$0	(\$496,000)
164	160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$31,394,000	\$14,799,530	\$25,988,000	\$11,076,500	(\$5,406,000)	(\$3,723,040)
144	161	PROP 56 - MEDI-CAL FAMILY PLANNING	\$394,485,000	\$39,448,500	\$436,844,000	\$43,684,400	\$42,359,000	\$4,235,900

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>								
169	162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$211,293,000	\$26,796,000	\$154,170,000	\$21,476,000	(\$57,123,000)	(\$5,320,000)
165	163	NDPH SUPPLEMENTAL PAYMENT	\$4,273,000	\$1,900,000	\$4,256,000	\$1,900,000	(\$17,000)	\$0
166	164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	\$2,000,000	\$2,000,000	\$4,000,000	\$1,752,000	\$2,000,000	(\$248,000)
167	165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$9,048,000	\$4,135,980	\$9,155,000	\$3,831,400	\$107,000	(\$304,580)
168	166	PROPOSITION 56 FUNDS TRANSFER	\$0	(\$1,042,035,000)	\$0	(\$975,709,000)	\$0	\$66,326,000
161	167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,935,410	\$3,259,810	\$7,925,000	\$3,664,100	(\$10,410)	\$404,300
221	168	IGT PAYMENTS FOR HOSPITAL SERVICES	\$0	\$10,077,000	\$0	\$10,077,000	\$0	\$0
171	169	IGT ADMIN. & PROCESSING FEE	\$0	(\$28,652,000)	\$0	(\$27,989,000)	\$0	\$663,000
170	170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,800,000	\$3,400,000	\$6,800,000	\$2,978,000	\$0	(\$422,000)
<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>			<b>\$16,866,336,590</b>	<b>\$458,230,490</b>	<b>\$17,186,649,860</b>	<b>\$341,622,530</b>	<b>\$320,313,270</b>	<b>(\$116,607,950)</b>
<b><u>COVID-19</u></b>								
251	172	COVID-19 CASELOAD IMPACT	\$6,829,878,000	\$2,408,249,000	\$5,428,893,000	\$1,742,310,580	(\$1,400,985,000)	(\$665,938,420)
249	173	COVID-19 BEHAVIORAL HEALTH	\$77,705,000	\$7,652,000	\$287,307,000	\$16,677,240	\$209,602,000	\$9,025,240
--	174	COVID-19 FFS REIMBURSEMENT RATES	\$0	\$0	\$334,768,000	\$167,384,000	\$334,768,000	\$167,384,000
--	175	COVID-19 BASE RECOVERIES	\$0	\$0	\$216,304,000	\$91,073,700	\$216,304,000	\$91,073,700
245	176	COVID-19 ELIGIBILITY	\$10,177,000	\$5,362,000	\$36,319,700	\$24,713,650	\$26,142,700	\$19,351,650
--	177	COVID-19 - SICK LEAVE BENEFITS	\$0	\$0	\$36,900,000	\$101,000	\$36,900,000	\$101,000
250	178	COVID-19 INCREASED FMAP - DHCS	\$0	(\$2,554,167,000)	(\$220,134,000)	(\$2,737,892,000)	(\$220,134,000)	(\$183,725,000)
247	179	COVID-19 UTILIZATION CHANGE	(\$395,693,000)	(\$146,780,000)	(\$947,400,000)	(\$377,752,700)	(\$551,707,000)	(\$230,972,700)
--	247	COVID-19 VACCINE ADMINISTRATION	\$0	\$0	\$31,650,000	\$10,761,000	\$31,650,000	\$10,761,000
246	--	COVID-19 ADDITIONAL IMPACTS	\$286,584,000	\$126,622,000	\$0	\$0	(\$286,584,000)	(\$126,622,000)
248	--	COVID-19 EMERGENCY FMAP - OTHER DEPTS	\$1,296,027,000	\$0	\$0	\$0	(\$1,296,027,000)	\$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 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>COVID-19 SUBTOTAL</b>	<b>\$8,104,678,000</b>	<b>(\$153,062,000)</b>	<b>\$5,204,607,700</b>	<b>(\$1,062,623,540)</b>	<b>(\$2,900,070,300)</b>	<b>(\$909,561,540)</b>
		<b>STATE ONLY CLAIMING</b>						
244	221	STATE ONLY CLAIMING ADJUSTMENTS	\$0	\$519,592,000	\$0	\$65,996,000	\$0	(\$453,596,000)
238	244	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	\$0	\$148,514,000	(\$3,169,000)	\$139,125,000	(\$3,169,000)	(\$9,389,000)
--	245	STATE ONLY CLAIMING ADJUSTMENTS - TCM	\$0	\$0	\$0	\$44,631,000	\$0	\$44,631,000
		<b>STATE ONLY CLAIMING SUBTOTAL</b>	<b>\$0</b>	<b>\$668,106,000</b>	<b>(\$3,169,000)</b>	<b>\$249,752,000</b>	<b>(\$3,169,000)</b>	<b>(\$418,354,000)</b>
		<b>OTHER DEPARTMENTS</b>						
172	180	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$5,130,000)	\$417,000	(\$20,248,000)	\$417,000	(\$15,118,000)	\$0
267	--	ADDITIONAL FEDERAL FUNDING TO OTHER DEPT.	\$438,643,000	\$0	\$0	\$0	(\$438,643,000)	\$0
		<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$433,513,000</b>	<b>\$417,000</b>	<b>(\$20,248,000)</b>	<b>\$417,000</b>	<b>(\$453,761,000)</b>	<b>\$0</b>
		<b>OTHER</b>						
178	187	CCI IHSS RECONCILIATION	\$100,000,000	\$0	\$142,263,000	\$0	\$42,263,000	\$0
181	188	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$95,060,000	\$0	\$102,878,000	\$0	\$7,818,000	\$0
189	190	PROP 56 - PROVIDER ACES TRAININGS	\$61,924,000	\$30,962,000	\$61,924,000	\$30,962,000	\$0	\$0
188	193	INFANT DEVELOPMENT PROGRAM	\$32,746,000	\$0	\$48,322,000	\$0	\$15,576,000	\$0
190	194	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$50,193,960	\$25,096,980	\$52,479,900	\$26,239,950	\$2,285,940	\$1,142,970
242	196	SELF-DETERMINATION PROGRAM - CDDS	\$17,139,000	\$0	\$8,365,000	\$0	(\$8,774,000)	\$0
191	197	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$15,797,000	\$6,928,000	\$16,891,000	\$7,731,000	\$1,094,000	\$803,000
199	199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$15,200,000	\$0	\$15,108,000	\$0	(\$92,000)	\$0
193	200	INDIAN HEALTH SERVICES	\$20,174,000	\$6,758,500	\$9,525,000	\$3,191,000	(\$10,649,000)	(\$3,567,500)
182	201	ARRA HITECH - PROVIDER PAYMENTS	\$15,268,000	\$0	\$8,651,000	\$0	(\$6,617,000)	\$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 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>OTHER</b>						
--	202	QAF WITHHOLD TRANSFER	\$0	\$0	\$7,816,000	(\$3,468,000)	\$7,816,000	(\$3,468,000)
--	203	CCS SAR EPC	\$0	\$0	\$6,166,000	\$3,222,240	\$6,166,000	\$3,222,240
208	204	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	(\$27,215,000)	(\$13,607,500)	\$168,175,000	\$84,087,500	\$195,390,000	\$97,695,000
194	205	WPCS WORKERS' COMPENSATION	\$3,324,000	\$1,662,000	\$3,324,000	\$1,662,000	\$0	\$0
236	206	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$1,576,000	\$350,550	\$1,780,000	\$462,300	\$204,000	\$111,750
205	209	AUDIT SETTLEMENTS	\$0	\$734,000	\$0	\$47,589,000	\$0	\$46,855,000
206	210	IMD ANCILLARY SERVICES	\$0	\$20,807,000	\$0	\$15,930,000	\$0	(\$4,877,000)
207	211	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$160,657,000)	\$0	(\$160,657,000)	\$0	\$0
202	212	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,824,254,400)	\$0	(\$1,898,984,800)	\$0	(\$74,730,400)
198	213	FUNDING ADJUST.—OTLICP	\$0	(\$109,194,740)	\$0	(\$105,944,100)	\$0	\$3,250,640
200	214	CMS DEFERRED CLAIMS	\$0	\$350,000,000	\$0	\$567,553,000	\$0	\$217,553,000
203	215	CLPP FUND	\$0	(\$916,000)	\$0	(\$916,000)	\$0	\$0
204	216	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$976,000,000)	\$0	(\$1,151,905,000)	\$0	(\$175,905,000)
233	217	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	\$0	\$10,370,000	\$0	\$10,370,000	\$0	\$0
201	218	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$13,000,000)	\$0	(\$12,500,000)	\$0	\$500,000
261	219	FUND 3156 TRANSFER TO THE GENERAL FUND	\$0	(\$100,000,000)	\$0	(\$100,000,000)	\$0	\$0
262	220	FUND 3311 TRANSFER TO THE GENERAL FUND	\$0	(\$36,552,000)	\$0	(\$20,000,000)	\$0	\$16,552,000
211	222	ASSISTED LIVING WAIVER EXPANSION	(\$56,144,000)	(\$28,072,000)	(\$55,933,000)	(\$27,966,500)	\$211,000	\$105,500
210	223	COUNTY SHARE OF OTLICP-CCS COSTS	(\$22,660,000)	(\$22,660,000)	(\$22,168,000)	(\$22,168,000)	\$492,000	\$492,000
192	--	OVERTIME FOR WPCS PROVIDERS	\$8,444,000	\$4,222,000	\$0	\$0	(\$8,444,000)	(\$4,222,000)
263	--	ELECTRONIC CIGARETTE PRODUCTS TAX	\$0	(\$9,600,000)	\$0	\$0	\$0	\$9,600,000

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

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>OTHER</b>						
265	--	RECONCILIATION	\$2,491,000	\$10,681,000	\$0	\$0	(\$2,491,000)	(\$10,681,000)
		<b>OTHER SUBTOTAL</b>	<b>\$333,317,960</b>	<b>(\$2,825,941,610)</b>	<b>\$575,566,900</b>	<b>(\$2,705,509,410)</b>	<b>\$242,248,940</b>	<b>\$120,432,200</b>
		<b>GRAND TOTAL</b>	<b>\$48,962,319,840</b>	<b>(\$448,473,850)</b>	<b>\$50,730,379,970</b>	<b>(\$1,311,011,420)</b>	<b>\$1,768,060,140</b>	<b>(\$862,537,570)</b>

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

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>PA-OAS</b>	<b>NEWLY</b>	<b>PA-ATD</b>	<b>PA-AFDC</b>	<b>LT-OAS</b>	<b>H-PE</b>
PHYSICIANS	\$7,851,030	\$172,285,240	\$74,261,410	\$48,789,750	\$2,430,540	\$57,898,460
OTHER MEDICAL	\$86,998,310	\$1,351,990,350	\$410,113,660	\$331,604,340	\$5,075,690	\$41,720,030
CO. & COMM. OUTPATIENT	\$3,489,640	\$174,745,710	\$110,701,120	\$25,878,310	\$618,150	\$52,891,710
PHARMACY	\$5,849,730	\$1,192,108,910	\$978,426,730	\$112,682,050	\$4,674,940	\$20,581,680
COUNTY INPATIENT	\$2,868,140	\$588,793,270	\$25,622,000	\$24,639,810	\$3,219,400	\$49,626,520
COMMUNITY INPATIENT	\$49,561,180	\$1,355,622,010	\$499,014,710	\$221,307,670	\$20,931,300	\$348,911,810
NURSING FACILITIES	\$192,918,320	\$190,122,220	\$500,503,050	\$4,833,020	\$1,439,085,290	\$1,297,220
ICF-DD	\$1,758,750	\$11,845,950	\$173,756,990	\$873,530	\$75,634,220	\$60
MEDICAL TRANSPORTATION	\$4,866,000	\$42,166,710	\$19,240,240	\$3,822,590	\$2,981,080	\$10,466,600
OTHER SERVICES	\$117,629,240	\$39,854,380	\$488,910,210	\$40,956,570	\$80,090,180	\$1,851,790
HOME HEALTH	\$3,283,070	\$2,313,260	\$149,627,760	\$7,942,990	\$44,780	\$196,570
<b>FFS SUBTOTAL</b>	<b>\$477,073,430</b>	<b>\$5,121,848,010</b>	<b>\$3,430,177,890</b>	<b>\$823,330,630</b>	<b>\$1,634,785,570</b>	<b>\$585,442,450</b>
DENTAL	\$110,397,390	\$337,351,700	\$113,634,980	\$142,270,860	\$17,803,840	\$0
MENTAL HEALTH	\$10,079,380	\$382,321,530	\$1,062,069,250	\$779,971,640	\$841,180	\$8,809,220
TWO PLAN MODEL	\$1,816,739,570	\$10,246,796,800	\$5,503,228,010	\$1,479,562,260	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$301,335,870	\$4,228,829,070	\$1,354,210,440	\$318,643,740	\$975,214,560	\$0
GEOGRAPHIC MANAGED CARE	\$225,052,030	\$1,610,580,500	\$1,040,341,000	\$215,366,050	\$0	\$0
PHP & OTHER MANAG. CARE	\$299,877,570	\$26,294,100	\$211,846,230	\$15,147,830	\$17,470,370	\$0
MEDICARE PAYMENTS	\$1,797,336,720	\$0	\$1,646,349,940	\$0	\$191,166,130	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$2,321,750	\$0	\$5,057,010	\$5,695,070	\$269,120	\$0
MISC. SERVICES	\$950,512,750	\$2,120	\$7,980,790,360	\$11,241,140	\$20	\$0
DRUG MEDI-CAL	\$13,268,420	\$161,255,080	\$52,362,690	\$43,144,460	\$1,313,590	\$40,900
REGIONAL MODEL	\$15,589,530	\$558,345,150	\$313,190,920	\$77,838,430	\$0	\$0
<b>NON-FFS SUBTOTAL</b>	<b>\$5,542,510,980</b>	<b>\$17,551,776,040</b>	<b>\$19,283,080,830</b>	<b>\$3,088,881,470</b>	<b>\$1,204,078,810</b>	<b>\$8,850,130</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$6,019,584,420</b>	<b>\$22,673,624,050</b>	<b>\$22,713,258,730</b>	<b>\$3,912,212,100</b>	<b>\$2,838,864,380</b>	<b>\$594,292,580</b>
<b>ELIGIBLES ***</b>	<b>425,800</b>	<b>4,166,900</b>	<b>917,300</b>	<b>1,073,800</b>	<b>50,200</b>	<b>36,500</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$14,137</b>	<b>\$5,441</b>	<b>\$24,761</b>	<b>\$3,643</b>	<b>\$56,551</b>	<b>\$16,282</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$1,178</b>	<b>\$453</b>	<b>\$2,063</b>	<b>\$304</b>	<b>\$4,713</b>	<b>\$1,357</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>LT-ATD</b>	<b>POV 250</b>	<b>MN-OAS</b>	<b>MN-ATD</b>	<b>MN-AFDC</b>	<b>MI-C</b>
PHYSICIANS	\$1,414,740	\$20,736,980	\$26,492,790	\$13,208,070	\$141,038,000	\$34,880,770
OTHER MEDICAL	\$1,867,390	\$215,462,040	\$204,052,280	\$103,267,620	\$1,115,250,900	\$104,608,650
CO. & COMM. OUTPATIENT	\$344,680	\$24,546,010	\$20,333,520	\$14,513,560	\$122,971,760	\$11,014,000
PHARMACY	\$5,099,980	\$103,909,390	\$37,891,670	\$78,934,390	\$402,907,160	\$56,679,520
COUNTY INPATIENT	\$1,563,660	\$1,138,370	\$60,974,510	\$15,655,600	\$141,396,120	\$10,698,980
COMMUNITY INPATIENT	\$12,252,470	\$84,256,450	\$163,947,680	\$60,441,840	\$812,927,230	\$77,622,650
NURSING FACILITIES	\$252,570,200	\$4,872,370	\$214,796,460	\$65,358,860	\$32,026,610	\$9,425,970
ICF-DD	\$196,001,810	\$325,460	\$2,094,790	\$14,034,730	\$1,742,730	\$2,630,040
MEDICAL TRANSPORTATION	\$1,004,300	\$164,520	\$11,390,300	\$8,872,970	\$9,418,250	\$2,848,300
OTHER SERVICES	\$10,774,060	\$20,861,460	\$132,087,760	\$121,706,100	\$78,318,180	\$18,914,460
HOME HEALTH	\$11,140	\$18,433,710	\$2,476,690	\$63,216,140	\$18,597,320	\$18,679,690
<b>FFS SUBTOTAL</b>	<b>\$482,904,420</b>	<b>\$494,706,760</b>	<b>\$876,538,450</b>	<b>\$559,209,890</b>	<b>\$2,876,594,260</b>	<b>\$348,003,040</b>
DENTAL	\$17,553,180	\$278,347,350	\$14,602,390	\$17,801,690	\$522,223,220	\$14,417,400
MENTAL HEALTH	\$1,980,590	\$84,040,140	\$15,946,970	\$111,900,730	\$604,077,720	\$78,293,010
TWO PLAN MODEL	\$0	\$723,872,390	\$2,369,436,520	\$877,361,930	\$4,058,138,990	\$30,247,650
COUNTY ORGANIZED HEALTH SYSTEMS	\$215,040,990	\$241,056,460	\$544,117,960	\$401,301,750	\$1,476,023,150	\$23,904,290
GEOGRAPHIC MANAGED CARE	\$0	\$116,215,230	\$306,276,790	\$178,818,010	\$690,108,930	\$3,561,780
PHP & OTHER MANAG. CARE	\$641,410	\$4,253,740	\$408,293,430	\$43,333,480	\$8,119,980	\$7,099,460
MEDICARE PAYMENTS	\$0	\$0	\$1,736,350,180	\$675,455,210	\$126,169,300	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$63,490	\$0	\$3,390,180	\$1,151,630	\$20,558,140	\$828,620
MISC. SERVICES	\$250	(\$54,945,170)	\$1,254,730,910	\$1,921,761,850	\$36,380,820	\$1,449,790
DRUG MEDI-CAL	\$303,810	\$32,167,000	\$18,175,770	\$12,516,890	\$116,619,270	\$4,829,860
REGIONAL MODEL	\$0	\$38,310,650	\$50,647,050	\$52,567,230	\$264,055,590	\$1,014,030
<b>NON-FFS SUBTOTAL</b>	<b>\$235,583,710</b>	<b>\$1,463,317,780</b>	<b>\$6,721,968,170</b>	<b>\$4,293,970,410</b>	<b>\$7,922,475,120</b>	<b>\$165,645,880</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$718,488,130</b>	<b>\$1,958,024,550</b>	<b>\$7,598,506,610</b>	<b>\$4,853,180,300</b>	<b>\$10,799,069,380</b>	<b>\$513,648,920</b>
<b>ELIGIBLES ***</b>	<b>11,400</b>	<b>960,300</b>	<b>674,300</b>	<b>240,600</b>	<b>3,708,300</b>	<b>146,300</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$63,025</b>	<b>\$2,039</b>	<b>\$11,269</b>	<b>\$20,171</b>	<b>\$2,912</b>	<b>\$3,511</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$5,252</b>	<b>\$170</b>	<b>\$939</b>	<b>\$1,681</b>	<b>\$243</b>	<b>\$293</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>MI-A</b>	<b>REFUGEE</b>	<b>OBRA</b>	<b>POV 185</b>	<b>POV 133</b>	<b>POV 100</b>
PHYSICIANS	\$301,120	\$64,730	\$104,340	\$100,885,360	\$15,298,370	\$7,143,630
OTHER MEDICAL	(\$5,120)	\$403,890	\$44,580	\$239,074,780	\$208,587,690	\$86,225,560
CO. & COMM. OUTPATIENT	\$107,430	\$66,600	\$20,300	\$22,410,960	\$13,022,200	\$11,249,030
PHARMACY	\$906,170	\$136,580	\$125,430	\$19,537,340	\$48,710,670	\$47,626,480
COUNTY INPATIENT	\$2,047,420	\$10,310	\$35,700	\$83,377,640	\$559,620	\$570,410
COMMUNITY INPATIENT	\$1,436,860	\$63,750	\$293,360	\$670,440,610	\$75,613,100	\$31,400,170
NURSING FACILITIES	\$21,131,760	\$0	\$4,579,340	\$1,600,280	\$11,047,750	\$1,658,060
ICF-DD	\$1,319,500	\$0	\$122,440	\$137,420	\$554,630	\$55,760
MEDICAL TRANSPORTATION	\$78,240	\$5,770	\$10,050	\$1,651,240	\$304,740	\$30,680
OTHER SERVICES	\$354,030	\$2,640	\$7,450	\$5,513,200	\$13,735,390	\$8,732,700
HOME HEALTH	(\$420)	\$0	\$0	\$3,492,750	\$9,755,440	\$2,691,280
<b>FFS SUBTOTAL</b>	<b>\$27,676,990</b>	<b>\$754,280</b>	<b>\$5,342,970</b>	<b>\$1,148,121,590</b>	<b>\$397,189,600</b>	<b>\$197,383,750</b>
DENTAL	\$16,014,850	\$544,160	\$0	\$13,312,480	\$110,691,480	\$55,674,620
MENTAL HEALTH	\$0	\$162,550	\$1,626,610	\$1,829,580	\$27,136,850	\$40,949,170
TWO PLAN MODEL	\$14,590	\$432,940	\$0	\$231,982,970	\$587,990,840	\$316,933,390
COUNTY ORGANIZED HEALTH SYSTEMS	\$249,900	\$64,780	\$18,980	\$103,874,190	\$191,565,180	\$110,329,160
GEOGRAPHIC MANAGED CARE	\$4,040	\$429,390	\$0	\$42,938,440	\$92,369,610	\$49,809,210
PHP & OTHER MANAG. CARE	\$7,147,020	\$0	\$0	\$7,456,820	\$7,898,400	\$7,839,450
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$34,650	\$0	\$550	\$2,001,120	\$0	\$2,366,070
MISC. SERVICES	\$6,860	\$0	\$0	\$220	\$7,976,510	\$4,331,560
DRUG MEDI-CAL	\$91,710	\$15,320	\$0	\$11,837,860	\$25,301,340	\$13,881,200
REGIONAL MODEL	\$0	\$4,320	\$0	\$15,289,380	\$29,923,410	\$15,299,310
<b>NON-FFS SUBTOTAL</b>	<b>\$23,563,620</b>	<b>\$1,653,460</b>	<b>\$1,646,130</b>	<b>\$430,523,060</b>	<b>\$1,080,853,620</b>	<b>\$617,413,130</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$51,240,610</b>	<b>\$2,407,740</b>	<b>\$6,989,110</b>	<b>\$1,578,644,640</b>	<b>\$1,478,043,220</b>	<b>\$814,796,890</b>
<b>ELIGIBLES ***</b>	<b>3,200</b>	<b>600</b>	<b>0</b>	<b>333,500</b>	<b>811,700</b>	<b>432,600</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$16,013</b>	<b>\$4,013</b>		<b>\$4,734</b>	<b>\$1,821</b>	<b>\$1,883</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$1,334</b>	<b>\$334</b>		<b>\$394</b>	<b>\$152</b>	<b>\$157</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>TOTAL</b>
PHYSICIANS	\$725,085,320
OTHER MEDICAL	\$4,506,342,640
CO. & COMM. OUTPATIENT	\$608,924,690
PHARMACY	\$3,116,788,810
COUNTY INPATIENT	\$1,012,797,470
COMMUNITY INPATIENT	\$4,486,044,890
NURSING FACILITIES	\$2,947,826,770
ICF-DD	\$482,888,830
MEDICAL TRANSPORTATION	\$119,322,570
OTHER SERVICES	\$1,180,299,810
HOME HEALTH	\$300,762,180
<b>FFS SUBTOTAL</b>	<b>\$19,487,083,990</b>
DENTAL	\$1,782,641,580
MENTAL HEALTH	\$3,212,036,130
TWO PLAN MODEL	\$28,242,738,850
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,485,780,460
GEOGRAPHIC MANAGED CARE	\$4,571,871,000
PHP & OTHER MANAG. CARE	\$1,072,719,270
MEDICARE PAYMENTS	\$6,172,827,470
STATE HOSP./DEVELOPMENTAL CNTRS.	\$43,737,410
MISC. SERVICES	\$12,114,240,000
DRUG MEDI-CAL	\$507,125,180
REGIONAL MODEL	\$1,432,075,020
<b>NON-FFS SUBTOTAL</b>	<b>\$69,637,792,360</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$89,124,876,350</b>
<b>ELIGIBLES ***</b>	<b>13,993,300</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$6,369</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$531</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

EXCLUDED POLICY CHANGES: 83

4	BREAST AND CERVICAL CANCER TREATMENT
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
7	CHILDREN'S HEALTH INSURANCE PROGRAM
8	DISABLED ADULT CHILDREN PROGRAM CLEANUP
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
10	MEDICARE PART B DISREGARD
14	NON-OTLICP CHIP
18	CS3 PROXY ADJUSTMENT
27	1% FMAP INCREASE FOR PREVENTIVE SERVICES
29	ACA DSH REDUCTION
32	FAMILY PACT PROGRAM
46	HEARING AID COVERAGE
50	LITIGATION SETTLEMENTS
51	FAMILY PACT DRUG REBATES
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
70	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
78	GLOBAL PAYMENT PROGRAM
79	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL
80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS
82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM
84	BTR - LIHP - MCE
85	MH/UCD—SAFETY NET CARE POOL
89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.
104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF
124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
134	HOSPITAL QAF - FFS PAYMENTS



**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

## EXCLUDED POLICY CHANGES: 83

135	HOSPITAL QAF - MANAGED CARE PAYMENTS
136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
139	PRIVATE HOSPITAL DSH REPLACEMENT
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
143	DSH PAYMENT
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
145	DPH PHYSICIAN & NON-PHYS. COST
146	FFP FOR LOCAL TRAUMA CENTERS
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
148	CAPITAL PROJECT DEBT REIMBURSEMENT
149	NDPH IGT SUPPLEMENTAL PAYMENTS
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
161	PROP 56 - MEDI-CAL FAMILY PLANNING
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
163	NDPH SUPPLEMENTAL PAYMENT
164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
166	PROPOSITION 56 FUNDS TRANSFER
167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS
168	IGT PAYMENTS FOR HOSPITAL SERVICES
169	IGT ADMIN. & PROCESSING FEE
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS
175	COVID-19 BASE RECOVERIES
176	COVID-19 ELIGIBILITY
190	PROP 56 - PROVIDER ACES TRAININGS

**FISCAL YEAR 2020-21 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

EXCLUDED POLICY CHANGES: 83

191	MEDI-CAL TCM PROGRAM
192	LAWSUITS/CLAIMS
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG
201	ARRA HITECH - PROVIDER PAYMENTS
209	AUDIT SETTLEMENTS
211	CIGARETTE AND TOBACCO SURTAX FUNDS
214	CMS DEFERRED CLAIMS
215	CLPP FUND
216	HOSPITAL QAF - CHILDREN'S HEALTH CARE
221	STATE ONLY CLAIMING ADJUSTMENTS
224	BASE RECOVERIES
225	CALAIM ECM-ILOS-PLAN INCENTIVES
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246	COVID-19 INCREASED FMAP EXTENSION - DHCS
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## MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2021-22

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>GENERAL FUNDS</u>	<u>OTHER STATE FUNDS</u>
<b>I. BASE ESTIMATES</b>				
A. B/Y FFS BASE	\$18,329,741,380	\$9,164,870,690	\$9,164,870,690	\$0
B. B/Y BASE POLICY CHANGES	\$51,033,902,000	\$33,445,780,750	\$17,449,460,250	\$138,661,000
C. BASE ADJUSTMENTS	(\$159,890,000)	(\$224,650,870)	\$64,760,870	\$0
<b>D. ADJUSTED BASE</b>	<b>\$69,203,753,390</b>	<b>\$42,386,000,570</b>	<b>\$26,679,091,820</b>	<b>\$138,661,000</b>
<b>II. REGULAR POLICY CHANGES</b>				
A. ELIGIBILITY	(\$74,040,880)	(\$970,633,920)	\$893,883,040	\$2,710,000
B. AFFORDABLE CARE ACT	\$4,033,834,000	\$4,792,394,980	(\$236,309,980)	(\$522,251,000)
C. BENEFITS	\$2,319,750,850	\$1,609,481,030	\$685,104,810	\$25,165,000
D. PHARMACY	(\$2,656,649,400)	(\$2,289,123,420)	(\$1,909,723,980)	\$1,542,198,000
E. DRUG MEDI-CAL	\$406,145,800	\$361,285,120	\$44,860,680	\$0
F. MENTAL HEALTH	\$816,862,000	\$19,968,500	\$796,693,500	\$200,000
G. WAIVER--MH/UCD & BTR	\$3,673,401,090	\$1,995,758,550	\$184,123,550	\$1,493,519,000
H. MANAGED CARE	\$9,068,889,160	\$4,916,129,690	\$508,653,160	\$3,644,106,300
I. PROVIDER RATES	\$743,775,000	\$837,434,940	(\$699,323,830)	\$605,663,900
J. SUPPLEMENTAL PMNTS.	\$13,781,421,460	\$8,973,355,130	\$497,398,320	\$4,310,668,000
K. COVID-19	\$15,039,522,010	\$12,819,678,100	\$2,369,972,910	(\$150,129,000)
L. STATE ONLY CLAIMING	\$139,232,000	(\$139,885,000)	\$279,117,000	\$0
M. OTHER DEPARTMENTS	(\$21,517,000)	(\$21,934,000)	\$417,000	\$0
N. OTHER	\$674,716,800	\$2,223,383,610	(\$2,471,901,800)	\$923,235,000
<b>O. TOTAL CHANGES</b>	<b>\$47,945,342,880</b>	<b>\$35,127,293,310</b>	<b>\$942,964,370</b>	<b>\$11,875,085,200</b>
<b>III. TOTAL MEDI-CAL ESTIMATE</b>	<b>\$117,149,096,270</b>	<b>\$77,513,293,890</b>	<b>\$27,622,056,190</b>	<b>\$12,013,746,200</b>

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>ELIGIBILITY</u></b>					
1	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$208,596,000	\$104,298,000	\$104,298,000	\$0
2	MEDI-CAL STATE INMATE PROGRAMS	\$47,603,000	\$47,603,000	\$0	\$0
3	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$117,712,500	\$37,957,000	\$79,755,500	\$0
4	BREAST AND CERVICAL CANCER TREATMENT	\$64,135,000	\$38,802,850	\$25,332,150	\$0
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$0	(\$489,600)	\$489,600	\$0
10	MEDICARE PART B DISREGARD	\$1,911,000	\$0	\$1,911,000	\$0
11	PROVISIONAL POSTPARTUM CARE EXTENSION	\$27,058,000	\$0	\$27,058,000	\$0
12	MEDI-CAL COUNTY INMATE PROGRAMS	\$14,997,450	\$14,379,510	\$617,940	\$0
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	\$0	(\$2,428,000)	\$2,428,000
14	NON-OTLIP CHIP	\$0	\$83,603,400	(\$83,603,400)	\$0
15	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	(\$1,007,093,250)	\$1,007,093,250	\$0
16	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$71,624,150	(\$71,624,150)	\$0
18	CS3 PROXY ADJUSTMENT	\$0	\$57,816,200	(\$57,816,200)	\$0
19	REFUGEE MEDICAL ASSISTANCE	\$0	\$0	(\$282,000)	\$282,000
21	CHIP PREMIUMS	(\$64,270,000)	(\$41,775,500)	(\$22,494,500)	\$0
22	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$491,783,830)	(\$377,359,680)	(\$114,424,150)	\$0
	<b>ELIGIBILITY SUBTOTAL</b>	<b>(\$74,040,880)</b>	<b>(\$970,633,920)</b>	<b>\$893,883,040</b>	<b>\$2,710,000</b>
<b><u>AFFORDABLE CARE ACT</u></b>					
23	COMMUNITY FIRST CHOICE OPTION	\$5,587,467,000	\$5,587,467,000	\$0	\$0
25	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$14,820,000	\$14,820,000	\$0	\$0
26	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	\$43,987,480	(\$43,987,480)	\$0
27	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$3,568,000	(\$3,568,000)	\$0
28	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$32,000)	(\$32,000)	\$0	\$0
29	ACA DSH REDUCTION	(\$1,568,421,000)	(\$857,415,500)	(\$188,754,500)	(\$522,251,000)
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$4,033,834,000</b>	<b>\$4,792,394,980</b>	<b>(\$236,309,980)</b>	<b>(\$522,251,000)</b>
<b><u>BENEFITS</u></b>					
30	BEHAVIORAL HEALTH TREATMENT	\$1,118,481,000	\$581,143,650	\$537,337,350	\$0
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$445,897,000	\$445,897,000	\$0	\$0
32	FAMILY PACT PROGRAM	\$379,437,000	\$289,051,000	\$90,386,000	\$0
33	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$113,749,000	\$113,749,000	\$0	\$0
34	LEA EXPANSION	\$60,489,000	\$60,489,000	\$0	\$0
35	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	\$28,569,300	\$18,251,070	\$10,318,240	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>BENEFITS</u></b>					
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,232,000	\$10,116,000	(\$10,116,000)	\$20,232,000
37	CCS DEMONSTRATION PROJECT	\$6,908,000	\$3,604,150	\$3,303,850	\$0
38	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$13,798,000	\$7,891,000	\$5,907,000	\$0
39	MSSP SUPPLEMENTAL PAYMENTS	\$4,933,000	\$4,933,000	(\$4,933,000)	\$4,933,000
40	OPTIONAL BENEFITS RESTORATION	\$1,543,420	\$986,010	\$557,420	\$0
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,300,000	\$0	\$1,300,000	\$0
42	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,729,000	\$1,107,300	\$621,700	\$0
43	MEDICAL INTERPRETERS PILOT PROJECT	\$2,000,000	\$0	\$2,000,000	\$0
44	CCT FUND TRANSFER TO CDSS	\$196,000	\$196,000	\$0	\$0
45	DIABETES PREVENTION PROGRAM	\$1,276,660	\$824,610	\$452,050	\$0
46	HEARING AID COVERAGE	\$8,830,000	\$0	\$8,830,000	\$0
233	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$10,941,050	\$7,143,870	\$3,797,180	\$0
238	CALAIM - ORGAN TRANSPLANT	\$4,656,000	\$3,300,850	\$1,355,150	\$0
239	REMOTE PATIENT MONITORING	\$94,785,420	\$60,797,530	\$33,987,890	\$0
	<b>BENEFITS SUBTOTAL</b>	<b>\$2,319,750,850</b>	<b>\$1,609,481,030</b>	<b>\$685,104,810</b>	<b>\$25,165,000</b>
<b><u>PHARMACY</u></b>					
48	MEDI-CAL DRUG REBATE FUND	\$0	\$0	(\$1,542,198,000)	\$1,542,198,000
49	BCCTP DRUG REBATES	(\$4,578,000)	(\$4,578,000)	\$0	\$0
51	FAMILY PACT DRUG REBATES	(\$11,432,000)	(\$11,432,000)	\$0	\$0
52	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	(\$13,400,100)	(\$8,437,470)	(\$4,962,630)	\$0
53	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	(\$34,463,300)	(\$22,124,140)	(\$12,339,160)	\$0
54	MEDICAL SUPPLY REBATES	(\$90,973,000)	(\$45,486,500)	(\$45,486,500)	\$0
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$37,818,000)	(\$24,277,450)	(\$13,540,550)	\$0
56	STATE SUPPLEMENTAL DRUG REBATES	(\$118,242,000)	(\$118,242,000)	\$0	\$0
57	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	(\$297,336,000)	(\$172,304,700)	(\$125,031,300)	\$0
58	FEDERAL DRUG REBATES	(\$1,577,341,000)	(\$1,577,341,000)	\$0	\$0
232	PHARMACY RETROACTIVE ADJUSTMENTS	(\$74,078,000)	(\$40,745,410)	(\$33,332,590)	\$0
236	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	(\$396,988,000)	(\$264,154,750)	(\$132,833,250)	\$0
	<b>PHARMACY SUBTOTAL</b>	<b>(\$2,656,649,400)</b>	<b>(\$2,289,123,420)</b>	<b>(\$1,909,723,980)</b>	<b>\$1,542,198,000</b>
<b><u>DRUG MEDI-CAL</u></b>					
59	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$404,190,000	\$359,543,300	\$44,646,700	\$0
63	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$1,595,600	\$1,458,130	\$137,470	\$0
64	DRUG MEDI-CAL MAT BENEFIT	\$360,200	\$283,690	\$76,510	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$406,145,800</b>	<b>\$361,285,120</b>	<b>\$44,860,680</b>	<b>\$0</b>
	<b><u>MENTAL HEALTH</u></b>				
69	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$21,862,000	\$10,771,500	\$11,090,500	\$0
71	PATHWAYS TO WELL-BEING	\$1,006,000	\$1,006,000	\$0	\$0
73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	\$0	(\$200,000)	\$200,000
75	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	(\$3,375,000)	\$3,375,000	\$0
76	CHART REVIEW	(\$396,000)	(\$396,000)	\$0	\$0
231	BH QUALITY IMPROVEMENT PROGRAM	\$21,750,000	\$0	\$21,750,000	\$0
240	MHP COSTS FOR FFPSA - QUAILIFIED INDIVIDUAL	\$21,356,000	\$10,678,000	\$10,678,000	\$0
241	MHP COSTS FOR FFPSA - AFTERCARE SERVICES	\$1,284,000	\$1,284,000	\$0	\$0
249	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$750,000,000	\$0	\$750,000,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$816,862,000</b>	<b>\$19,968,500</b>	<b>\$796,693,500</b>	<b>\$200,000</b>
	<b><u>WAIVER--MH/UCD &amp; BTR</u></b>				
78	GLOBAL PAYMENT PROGRAM	\$2,387,038,000	\$1,193,519,000	\$0	\$1,193,519,000
80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$600,000,000	\$300,000,000	\$0	\$300,000,000
81	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$150,630,090	\$75,315,050	\$75,315,050	\$0
82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$316,000	\$316,000	\$0	\$0
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	\$158,900,000	(\$158,900,000)	\$0
225	CALAIM ECM-ILOS-PLAN INCENTIVES	\$535,417,000	\$267,708,500	\$267,708,500	\$0
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$3,673,401,090</b>	<b>\$1,995,758,550</b>	<b>\$184,123,550</b>	<b>\$1,493,519,000</b>
	<b><u>MANAGED CARE</u></b>				
89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$2,528,944,000	\$1,601,131,550	\$927,812,450	\$0
90	CCI-MANAGED CARE PAYMENTS	\$2,976,619,150	\$1,488,309,580	\$1,488,309,580	\$0
91	MANAGED CARE PUBLIC HOSPITAL EPP	\$1,208,317,000	\$804,870,220	\$403,446,780	\$0
92	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,061,465,000	\$691,971,350	\$369,493,650	\$0
93	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$962,754,000	\$715,786,500	\$246,967,500	\$0
96	RETRO MC RATE ADJUSTMENTS	\$174,899,000	\$92,597,050	\$82,301,950	\$0
98	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$98,780,000	\$72,108,700	\$13,958,000	\$12,713,300
102	CCI-QUALITY WITHHOLD REPAYMENTS	\$16,822,000	\$8,411,000	\$8,411,000	\$0
105	CAPITATED RATE ADJUSTMENT FOR FY 2021-22	\$1,185,484,000	\$778,366,300	\$407,117,700	\$0
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	\$0	(\$1,598,111,000)	\$1,598,111,000
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	\$0	(\$919,347,000)	\$919,347,000

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>MANAGED CARE</u></b>					
108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	\$0	(\$1,113,935,000)	\$1,113,935,000
110	COORDINATED CARE INITIATIVE RISK MITIGATION	(\$111,260,000)	(\$55,630,000)	(\$55,630,000)	\$0
112	MANAGED CARE EFFICIENCIES	(\$481,443,000)	(\$325,894,250)	(\$155,548,750)	\$0
114	MANAGED CARE DRUG REBATES	(\$1,415,902,000)	(\$1,415,902,000)	\$0	\$0
228	CALAIM - MANAGED CARE SMHS CARVE-OUT	(\$4,773,000)	(\$2,482,700)	(\$2,290,300)	\$0
234	CALAIM - MSSP CARVE-OUT OF CCI	\$1,600,000	\$800,000	\$800,000	\$0
235	CALAIM - TRANSITIONING POPULATIONS	\$401,597,000	\$226,837,400	\$174,759,600	\$0
242	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$76,000,000	\$40,356,000	\$35,644,000	\$0
248	INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SRVS.	\$388,986,000	\$194,493,000	\$194,493,000	\$0
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$9,068,889,150</b>	<b>\$4,916,129,690</b>	<b>\$508,653,160</b>	<b>\$3,644,106,300</b>
<b><u>PROVIDER RATES</u></b>					
115	DPH INTERIM RATE GROWTH	\$255,811,390	\$127,905,690	\$127,905,690	\$0
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$193,539,650	\$130,558,940	(\$6,485,190)	\$69,465,900
117	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$170,610,380	\$105,041,920	\$65,568,460	\$0
118	DPH INTERIM & FINAL RECONS	(\$123,313,000)	(\$123,313,000)	\$0	\$0
119	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$11,249,000	\$11,249,000	\$0	\$0
120	AB 1629 ANNUAL RATE ADJUSTMENTS	\$181,832,860	\$90,916,430	\$90,916,430	\$0
121	PROP 56 - HOME HEALTH RATE INCREASE	\$0	\$0	\$0	\$0
122	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$44,908,000	\$27,649,200	\$17,258,800	\$0
123	LTC RATE ADJUSTMENT	\$49,133,030	\$24,566,520	\$24,566,520	\$0
124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$8,539,000	\$5,501,000	(\$408,000)	\$3,446,000
125	HOSPICE RATE INCREASES	\$15,537,590	\$7,768,800	\$7,768,800	\$0
126	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$0	\$0	\$0	\$0
127	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,776,000	\$1,388,000	\$1,388,000	\$0
128	DPH INTERIM RATE	\$0	\$461,715,700	(\$461,715,700)	\$0
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	\$0	(\$532,752,000)	\$532,752,000
130	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$2,426,820)	(\$1,302,220)	(\$1,124,600)	\$0
131	REDUCTION TO RADIOLOGY RATES	(\$11,298,120)	(\$5,649,060)	(\$5,649,060)	\$0
132	10% PROVIDER PAYMENT REDUCTION	(\$13,936,310)	(\$6,968,150)	(\$6,968,150)	\$0
133	LABORATORY RATE METHODOLOGY CHANGE	(\$39,187,650)	(\$19,593,830)	(\$19,593,830)	\$0
	<b>PROVIDER RATES SUBTOTAL</b>	<b>\$743,775,000</b>	<b>\$837,434,940</b>	<b>(\$699,323,830)</b>	<b>\$605,663,900</b>

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



## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>					
134	HOSPITAL QAF - FFS PAYMENTS	\$3,302,291,000	\$1,834,632,000	\$0	\$1,467,659,000
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$1,897,400,000	\$1,297,917,000	\$0	\$599,483,000
136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$3,278,824,000	\$2,211,320,000	\$0	\$1,067,504,000
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$416,860,000	\$220,013,000	\$0	\$196,847,000
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,209,298,710	\$804,601,300	\$404,697,410	\$0
139	PRIVATE HOSPITAL DSH REPLACEMENT	\$623,212,000	\$311,606,000	\$311,606,000	\$0
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$41,966,150	\$26,213,140	\$15,753,010	\$0
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$364,207,000	\$244,341,350	\$119,865,650	\$0
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$308,193,000	\$162,877,500	\$118,400,000	\$26,915,500
143	DSH PAYMENT	\$427,503,000	\$309,968,500	\$24,993,000	\$92,541,500
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$246,989,000	\$246,989,000	\$0	\$0
145	DPH PHYSICIAN & NON-PHYS. COST	\$349,662,000	\$349,662,000	\$0	\$0
146	FFP FOR LOCAL TRAUMA CENTERS	\$168,229,000	\$100,004,000	\$0	\$68,225,000
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$115,461,000	\$65,461,000	\$0	\$50,000,000
148	CAPITAL PROJECT DEBT REIMBURSEMENT	\$97,169,000	\$74,304,000	\$22,865,000	\$0
149	NDPH IGT SUPPLEMENTAL PAYMENTS	\$44,983,000	\$26,720,000	(\$1,933,000)	\$20,196,000
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$81,000,000	\$40,500,000	\$46,979,000	(\$6,479,000)
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$92,298,000	\$92,298,000	\$0	\$0
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$35,470,000	\$35,470,000	\$0	\$0
153	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$105,000,000	\$52,500,000	\$52,500,000	\$0
154	PROP 56 - DEVELOPMENTAL SCREENINGS	\$57,201,470	\$33,311,320	\$23,890,150	\$0
155	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$30,753,000	\$16,468,500	\$14,284,500	\$0
156	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$41,063,740	\$25,375,130	\$15,688,610	\$0
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$10,706,000	\$10,706,000	\$0	\$0
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$5,000,000	\$0
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$4,000,000	\$0
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$7,214,930	\$3,936,020	\$3,278,900	\$0
161	PROP 56 - MEDI-CAL FAMILY PLANNING	\$400,034,820	\$360,031,330	\$40,003,480	\$0
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$4,525,210	\$3,901,590	\$623,620	\$0
163	NDPH SUPPLEMENTAL PAYMENT	\$4,201,000	\$2,301,000	\$1,900,000	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>					
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$1,705,430	\$926,450	\$778,980	\$0
166	PROPOSITION 56 FUNDS TRANSFER	\$0	\$0	(\$717,883,000)	\$717,883,000
167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
169	IGT ADMIN. & PROCESSING FEE	\$0	\$0	(\$9,893,000)	\$9,893,000
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$0	\$0	\$0	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$13,781,421,460</b>	<b>\$8,973,355,130</b>	<b>\$497,398,320</b>	<b>\$4,310,668,000</b>
<b><u>COVID-19</u></b>					
172	COVID-19 CASELOAD IMPACT	\$13,531,559,000	\$9,195,473,390	\$4,336,085,610	\$0
173	COVID-19 BEHAVIORAL HEALTH	\$497,815,000	\$469,677,400	\$28,137,600	\$0
174	COVID-19 FFS REIMBURSEMENT RATES	\$251,076,000	\$125,538,000	\$125,538,000	\$0
175	COVID-19 BASE RECOVERIES	(\$34,000,000)	(\$19,684,700)	(\$14,315,300)	\$0
176	COVID-19 ELIGIBILITY	\$17,277,000	\$5,026,000	\$12,251,000	\$0
177	COVID-19 - SICK LEAVE BENEFITS	\$18,450,000	\$18,399,500	\$50,500	\$0
178	COVID-19 INCREASED FMAP - DHCS	(\$50,094,000)	\$732,826,000	(\$782,920,000)	\$0
179	COVID-19 UTILIZATION CHANGE	(\$22,141,000)	(\$13,215,500)	(\$8,925,500)	\$0
246	COVID-19 INCREASED FMAP EXTENSION - DHCS	\$513,836,000	\$2,097,247,000	(\$1,433,282,000)	(\$150,129,000)
247	COVID-19 VACCINE ADMINISTRATION	\$315,744,000	\$208,391,000	\$107,353,000	\$0
	<b>COVID-19 SUBTOTAL</b>	<b>\$15,039,522,000</b>	<b>\$12,819,678,090</b>	<b>\$2,369,972,910</b>	<b>(\$150,129,000)</b>
<b><u>STATE ONLY CLAIMING</u></b>					
221	STATE ONLY CLAIMING ADJUSTMENTS	\$145,571,000	(\$114,531,000)	\$260,102,000	\$0
244	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$6,339,000)	(\$21,396,000)	\$15,057,000	\$0
245	STATE ONLY CLAIMING ADJUSTMENTS - TCM	\$0	(\$3,958,000)	\$3,958,000	\$0
	<b>STATE ONLY CLAIMING SUBTOTAL</b>	<b>\$139,232,000</b>	<b>(\$139,885,000)</b>	<b>\$279,117,000</b>	<b>\$0</b>
<b><u>OTHER DEPARTMENTS</u></b>					
180	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$21,517,000)	(\$21,934,000)	\$417,000	\$0
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>(\$21,517,000)</b>	<b>(\$21,934,000)</b>	<b>\$417,000</b>	<b>\$0</b>
<b><u>OTHER</u></b>					
187	CCI IHSS RECONCILIATION	\$100,000,000	\$100,000,000	\$0	\$0
188	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$63,974,000	\$63,974,000	\$0	\$0
190	PROP 56 - PROVIDER ACES TRAININGS	\$41,712,000	\$20,856,000	\$20,856,000	\$0
193	INFANT DEVELOPMENT PROGRAM	\$35,974,000	\$35,974,000	\$0	\$0
194	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$65,722,980	\$32,861,490	\$32,861,490	\$0
196	SELF-DETERMINATION PROGRAM - CDDS	\$10,424,000	\$10,424,000	\$0	\$0

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

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b>OTHER</b>					
197	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$11,039,000	\$5,998,000	\$5,041,000	\$0
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$29,092,000	\$0	\$0	\$29,092,000
200	INDIAN HEALTH SERVICES	\$18,436,000	\$12,260,000	\$6,176,000	\$0
201	ARRA HITECH - PROVIDER PAYMENTS	\$5,101,000	\$5,101,000	\$0	\$0
202	QAF WITHHOLD TRANSFER	\$47,076,000	\$27,347,000	\$19,729,000	\$0
203	CCS SAR EPC	\$6,166,000	\$3,136,760	\$3,222,240	(\$193,000)
204	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$154,044,000	\$77,022,000	\$77,022,000	\$0
205	WPCS WORKERS' COMPENSATION	\$3,325,000	\$1,662,500	\$1,662,500	\$0
206	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$12,827,000	\$9,496,700	\$3,330,300	\$0
209	AUDIT SETTLEMENTS	\$0	(\$69,588,000)	\$69,588,000	\$0
210	IMD ANCILLARY SERVICES	\$0	(\$12,322,000)	\$12,322,000	\$0
211	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	(\$131,870,000)	\$131,870,000
212	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	\$1,948,043,200	(\$1,948,043,200)	\$0
213	FUNDING ADJUST.—OTLICP	\$0	\$90,361,050	(\$90,361,050)	\$0
214	CMS DEFERRED CLAIMS	\$0	(\$200,000,000)	\$200,000,000	\$0
215	CLPP FUND	\$0	\$0	(\$916,000)	\$916,000
216	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	(\$761,550,000)	\$761,550,000
218	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	\$13,000,000	(\$13,000,000)	\$0
222	ASSISTED LIVING WAIVER EXPANSION	(\$17,945,180)	(\$8,972,590)	(\$8,972,590)	\$0
223	COUNTY SHARE OF OTLICP-CCS COSTS	(\$25,748,000)	\$0	(\$25,748,000)	\$0
226	CALAIM - DENTAL PREVENTIVE SERVICES	\$59,384,000	\$29,692,000	\$29,692,000	\$0
227	CALAIM - DENTAL CARIES RISK ASSESSMENT	\$8,991,000	\$4,495,500	\$4,495,500	\$0
229	CALAIM - DENTAL SILVER DIAMINE FLUORIDE	\$1,637,000	\$818,500	\$818,500	\$0
230	CALAIM - DENTAL CONTINUITY OF CARE	\$43,485,000	\$21,742,500	\$21,742,500	\$0
<b>OTHER SUBTOTAL</b>		<b>\$674,716,800</b>	<b>\$2,223,383,610</b>	<b>(\$2,471,901,800)</b>	<b>\$923,235,000</b>
<b>GRAND TOTAL</b>		<b>\$47,945,342,870</b>	<b>\$35,127,293,300</b>	<b>\$942,964,370</b>	<b>\$11,875,085,200</b>

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

## MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2021-22

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b>PROFESSIONAL</b>	\$9,542,302,720	\$6,040,041,660	\$2,676,308,050	\$825,953,020
PHYSICIANS	\$1,363,859,720	\$981,942,650	\$327,572,560	\$54,344,520
OTHER MEDICAL	\$6,129,728,420	\$3,734,408,680	\$2,219,588,840	\$175,730,890
CO. & COMM. OUTPATIENT	\$2,048,714,580	\$1,323,690,330	\$129,146,650	\$595,877,600
<b>PHARMACY</b>	\$8,601,445,350	\$4,534,579,420	\$2,441,331,030	\$1,625,534,910
<b>HOSPITAL INPATIENT</b>	\$11,443,300,890	\$7,437,396,560	\$1,735,055,430	\$2,270,848,900
COUNTY INPATIENT	\$3,295,571,680	\$2,094,153,350	\$50,558,480	\$1,150,859,860
COMMUNITY INPATIENT	\$8,147,729,200	\$5,343,243,210	\$1,684,496,950	\$1,119,989,040
<b>LONG TERM CARE</b>	\$4,136,783,630	\$2,441,620,950	\$1,556,509,230	\$138,653,450
NURSING FACILITIES	\$3,609,663,390	\$2,138,330,610	\$1,355,088,450	\$116,244,330
ICF-DD	\$527,120,240	\$303,290,340	\$201,420,780	\$22,409,120
<b>OTHER SERVICES</b>	\$1,919,967,090	\$1,146,346,120	\$718,737,690	\$54,883,280
MEDICAL TRANSPORTATION	\$189,004,960	\$137,187,540	\$47,217,680	\$4,599,740
OTHER SERVICES	\$1,425,737,990	\$832,347,660	\$548,206,230	\$45,184,090
HOME HEALTH	\$305,224,140	\$176,810,920	\$123,313,770	\$5,099,450
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$35,643,799,680</b>	<b>\$21,599,984,700</b>	<b>\$9,127,941,420</b>	<b>\$4,915,873,560</b>
<b>MANAGED CARE</b>	\$55,678,309,730	\$36,537,741,940	\$12,340,452,230	\$6,800,115,560
TWO PLAN MODEL	\$33,399,711,560	\$21,952,534,580	\$7,343,425,060	\$4,103,751,920
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,320,167,570	\$8,760,801,870	\$2,886,877,130	\$1,672,488,570
GEOGRAPHIC MANAGED CARE	\$5,884,638,990	\$3,853,085,680	\$1,290,844,030	\$740,709,280
PHP & OTHER MANAG. CARE	\$1,193,731,530	\$697,112,660	\$483,455,020	\$13,163,850
REGIONAL MODEL	\$1,880,060,090	\$1,274,207,140	\$335,851,000	\$270,001,940
<b>DENTAL</b>	\$2,296,796,950	\$1,430,848,580	\$807,609,610	\$58,338,770
<b>MENTAL HEALTH</b>	\$3,971,063,840	\$3,649,383,450	\$141,160,690	\$180,519,700
<b>AUDITS/ LAWSUITS</b>	\$32,350,000	(\$253,413,000)	\$285,763,000	\$0
<b>EPSDT SCREENS</b>	\$0	\$0	\$0	\$0
<b>MEDICARE PAYMENTS</b>	\$7,301,129,740	\$2,848,551,240	\$4,476,243,630	(\$23,665,130)
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$42,963,300	\$42,591,440	\$503,360	(\$131,490)
<b>MISC. SERVICES</b>	\$12,095,947,740	\$11,454,278,060	\$558,949,960	\$82,719,710
<b>RECOVERIES</b>	(\$397,986,990)	(\$230,491,790)	(\$167,495,200)	\$0
<b>DRUG MEDI-CAL</b>	\$484,722,280	\$433,819,270	\$50,927,490	(\$24,470)
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$117,149,096,270</b>	<b>\$77,513,293,890</b>	<b>\$27,622,056,190</b>	<b>\$12,013,746,200</b>

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

<u>SERVICE CATEGORY</u>	<u>NOV. 2020 EST. FOR 2020-21</u>	<u>NOV. 2020 EST. FOR 2021-22</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
<b>PROFESSIONAL</b>	\$8,458,894,960	\$9,542,302,720	\$1,083,407,760	12.81%
PHYSICIANS	\$1,101,865,000	\$1,363,859,720	\$261,994,720	23.78%
OTHER MEDICAL	\$4,901,103,180	\$6,129,728,420	\$1,228,625,230	25.07%
CO. & COMM. OUTPATIENT	\$2,455,926,780	\$2,048,714,580	(\$407,212,200)	-16.58%
<b>PHARMACY</b>	\$3,151,081,290	\$8,601,445,350	\$5,450,364,060	172.97%
<b>HOSPITAL INPATIENT</b>	\$13,904,297,040	\$11,443,300,890	(\$2,460,996,150)	-17.70%
COUNTY INPATIENT	\$3,378,934,770	\$3,295,571,680	(\$83,363,090)	-2.47%
COMMUNITY INPATIENT	\$10,525,362,270	\$8,147,729,200	(\$2,377,633,060)	-22.59%
<b>LONG TERM CARE</b>	\$3,618,456,710	\$4,136,783,630	\$518,326,920	14.32%
NURSING FACILITIES	\$3,135,426,760	\$3,609,663,390	\$474,236,630	15.13%
ICF-DD	\$483,029,960	\$527,120,240	\$44,090,280	9.13%
<b>OTHER SERVICES</b>	\$1,675,366,550	\$1,919,967,090	\$244,600,530	14.60%
MEDICAL TRANSPORTATION	\$190,326,010	\$189,004,960	(\$1,321,050)	-0.69%
OTHER SERVICES	\$1,183,059,750	\$1,425,737,990	\$242,678,230	20.51%
HOME HEALTH	\$301,980,790	\$305,224,140	\$3,243,350	1.07%
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$30,808,096,560</b>	<b>\$35,643,799,680</b>	<b>\$4,835,703,120</b>	<b>15.70%</b>
<b>MANAGED CARE</b>	\$57,147,054,800	\$55,678,309,730	(\$1,468,745,070)	-2.57%
TWO PLAN MODEL	\$35,035,119,700	\$33,399,711,560	(\$1,635,408,140)	-4.67%
COUNTY ORGANIZED HEALTH SYSTEMS	\$13,242,607,730	\$13,320,167,570	\$77,559,840	0.59%
GEOGRAPHIC MANAGED CARE	\$5,934,016,110	\$5,884,638,990	(\$49,377,130)	-0.83%
PHP & OTHER MANAG. CARE	\$1,077,498,130	\$1,193,731,530	\$116,233,400	10.79%
REGIONAL MODEL	\$1,857,813,140	\$1,880,060,090	\$22,246,950	1.20%
<b>DENTAL</b>	\$1,786,389,910	\$2,296,796,950	\$510,407,040	28.57%
<b>MENTAL HEALTH</b>	\$3,222,810,700	\$3,971,063,840	\$748,253,150	23.22%
<b>AUDITS/ LAWSUITS</b>	\$16,800,010	\$32,350,000	\$15,549,990	92.56%
<b>MEDICARE PAYMENTS</b>	\$6,172,827,470	\$7,301,129,740	\$1,128,302,270	18.28%
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$43,737,400	\$42,963,300	(\$774,100)	-1.77%
<b>MISC. SERVICES</b>	\$13,302,358,000	\$12,095,947,740	(\$1,206,410,260)	-9.07%
<b>RECOVERIES</b>	(\$253,271,960)	(\$397,986,990)	(\$144,715,040)	57.14%
<b>DRUG MEDI-CAL</b>	\$507,200,110	\$484,722,280	(\$22,477,830)	-4.43%
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$112,754,003,000</b>	<b>\$117,149,096,270</b>	<b>\$4,395,093,270</b>	<b>3.90%</b>
<b>GENERAL FUNDS</b>	<b>\$21,344,400,370</b>	<b>\$27,622,056,190</b>	<b>\$6,277,655,820</b>	<b>29.41%</b>
<b>OTHER STATE FUNDS</b>	<b>\$16,346,737,820</b>	<b>\$12,013,746,200</b>	<b>(\$4,332,991,630)</b>	<b>-26.51%</b>

**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>ELIGIBILITY</u></b>							
1	FPL INCREASE FOR AGED AND DISABLED PERSONS	\$100,498,000	\$50,249,000	\$208,596,000	\$104,298,000	\$108,098,000	\$54,049,000
2	MEDI-CAL STATE INMATE PROGRAMS	\$70,059,000	\$0	\$47,603,000	\$0	(\$22,456,000)	\$0
3	UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION	\$265,377,000	\$182,915,000	\$323,031,000	\$218,868,000	\$57,654,000	\$35,953,000
4	BREAST AND CERVICAL CANCER TREATMENT	\$63,661,000	\$25,147,750	\$64,135,000	\$25,332,150	\$474,000	\$184,400
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT	\$14,938,000	\$26,286,680	\$0	\$489,600	(\$14,938,000)	(\$25,797,080)
8	DISABLED ADULT CHILDREN PROGRAM CLEANUP	\$3,232,000	\$5,847,000	\$0	\$0	(\$3,232,000)	(\$5,847,000)
10	MEDICARE PART B DISREGARD	\$1,115,000	\$1,115,000	\$1,911,000	\$1,911,000	\$796,000	\$796,000
11	PROVISIONAL POSTPARTUM CARE EXTENSION	\$0	\$0	\$27,058,000	\$27,058,000	\$27,058,000	\$27,058,000
12	MEDI-CAL COUNTY INMATE PROGRAMS	\$42,506,000	\$2,340,000	\$59,632,000	\$2,457,000	\$17,126,000	\$117,000
13	MEDI-CAL COUNTY INMATE REIMBURSEMENT	\$0	(\$2,270,000)	\$0	(\$2,428,000)	\$0	(\$158,000)
14	NON-OTLICP CHIP	\$0	(\$99,627,380)	\$0	(\$83,603,400)	\$0	\$16,023,980
15	NON-EMERGENCY FUNDING ADJUSTMENT	\$0	\$1,008,412,530	\$0	\$1,007,093,250	\$0	(\$1,319,280)
16	SCHIP FUNDING FOR PRENATAL CARE	\$0	(\$95,528,900)	\$0	(\$71,624,150)	\$0	\$23,904,750
17	CDCR RETRO REPAYMENT	\$0	\$410,000	\$0	\$0	\$0	(\$410,000)
18	CS3 PROXY ADJUSTMENT	\$0	(\$155,547,330)	\$0	(\$57,816,200)	\$0	\$97,731,130
19	REFUGEE MEDICAL ASSISTANCE	\$0	(\$376,000)	\$0	(\$282,000)	\$0	\$94,000
20	CCHIP DELIVERY SYSTEM	(\$3,936,000)	(\$1,264,440)	\$0	\$0	\$3,936,000	\$1,264,440
21	CHIP PREMIUMS	(\$64,198,000)	(\$20,623,660)	(\$64,270,000)	(\$22,494,500)	(\$72,000)	(\$1,870,840)
22	MINIMUM WAGE INCREASE - CASELOAD SAVINGS	(\$542,006,000)	(\$113,509,000)	(\$887,216,000)	(\$206,430,000)	(\$345,210,000)	(\$92,921,000)
	<b>ELIGIBILITY SUBTOTAL</b>	<b>(\$48,754,000)</b>	<b>\$813,976,240</b>	<b>(\$219,520,000)</b>	<b>\$942,828,750</b>	<b>(\$170,766,000)</b>	<b>\$128,852,510</b>
<b><u>AFFORDABLE CARE ACT</u></b>							
23	COMMUNITY FIRST CHOICE OPTION	\$5,620,436,000	\$0	\$5,587,467,000	\$0	(\$32,969,000)	\$0

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CURRENT YEAR COMPARED TO BUDGET YEAR  
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NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>AFFORDABLE CARE ACT</u></b>							
24	HEALTH INSURER FEE	\$284,312,000	\$97,410,090	\$0	\$0	(\$284,312,000)	(\$97,410,090)
25	HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS	\$22,231,000	\$0	\$14,820,000	\$0	(\$7,411,000)	\$0
26	HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.	\$0	(\$44,084,820)	\$0	(\$43,987,480)	\$0	\$97,340
27	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	(\$5,250,000)	\$0	(\$3,568,000)	\$0	\$1,682,000
28	PAYMENTS TO PRIMARY CARE PHYSICIANS	(\$32,000)	\$0	(\$32,000)	\$0	\$0	\$0
29	ACA DSH REDUCTION	(\$640,068,000)	(\$78,878,000)	(\$1,568,421,000)	(\$188,754,500)	(\$928,353,000)	(\$109,876,500)
237	ACA OPTIONAL EXPANSION MLR RISK CORRIDOR	\$0	\$0	\$0	\$0	\$0	\$0
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$5,286,879,000</b>	<b>(\$30,802,730)</b>	<b>\$4,033,834,000</b>	<b>(\$236,309,980)</b>	<b>(\$1,253,045,000)</b>	<b>(\$205,507,250)</b>
<b><u>BENEFITS</u></b>							
30	BEHAVIORAL HEALTH TREATMENT	\$936,977,000	\$392,132,820	\$1,118,481,000	\$537,337,350	\$181,504,000	\$145,204,530
31	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$568,296,000	\$0	\$445,897,000	\$0	(\$122,399,000)	\$0
32	FAMILY PACT PROGRAM	\$354,323,000	\$84,403,500	\$379,437,000	\$90,386,000	\$25,114,000	\$5,982,500
33	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$106,617,000	\$0	\$113,749,000	\$0	\$7,132,000	\$0
34	LEA EXPANSION	\$64,911,000	\$0	\$60,489,000	\$0	(\$4,422,000)	\$0
35	RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS	\$34,948,780	\$12,622,280	\$35,481,000	\$12,814,500	\$532,220	\$192,220
36	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$20,232,000	(\$10,743,000)	\$20,232,000	(\$10,116,000)	\$0	\$627,000
37	CCS DEMONSTRATION PROJECT	\$11,306,000	\$5,347,420	\$6,908,000	\$3,303,850	(\$4,398,000)	(\$2,043,570)
38	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$10,020,000	\$2,272,000	\$13,798,000	\$5,907,000	\$3,778,000	\$3,635,000
39	MSSP SUPPLEMENTAL PAYMENTS	\$4,933,000	(\$4,627,000)	\$4,933,000	(\$4,933,000)	\$0	(\$306,000)
40	OPTIONAL BENEFITS RESTORATION	\$17,445,420	\$6,300,530	\$17,519,000	\$6,327,100	\$73,580	\$26,570
41	MEDICALLY TAILORED MEALS PILOT PROGRAM	\$1,600,000	\$1,600,000	\$1,300,000	\$1,300,000	(\$300,000)	(\$300,000)

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CURRENT YEAR COMPARED TO BUDGET YEAR  
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NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>BENEFITS</u></b>							
42	EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES	\$1,566,290	\$563,160	\$1,729,000	\$621,700	\$162,710	\$58,540
43	MEDICAL INTERPRETERS PILOT PROJECT	\$1,000,000	\$1,000,000	\$2,000,000	\$2,000,000	\$1,000,000	\$1,000,000
44	CCT FUND TRANSFER TO CDSS	\$267,000	\$0	\$196,000	\$0	(\$71,000)	\$0
45	DIABETES PREVENTION PROGRAM	\$202,830	\$72,020	\$1,276,660	\$452,050	\$1,073,820	\$380,030
46	HEARING AID COVERAGE	\$0	\$0	\$8,830,000	\$8,830,000	\$8,830,000	\$8,830,000
233	CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT	\$0	\$0	\$10,941,050	\$3,797,180	\$10,941,050	\$3,797,180
238	CALAIM - ORGAN TRANSPLANT	\$0	\$0	\$4,656,000	\$1,355,150	\$4,656,000	\$1,355,150
239	REMOTE PATIENT MONITORING	\$0	\$0	\$94,785,420	\$33,987,890	\$94,785,420	\$33,987,890
	<b>BENEFITS SUBTOTAL</b>	<b>\$2,134,645,330</b>	<b>\$490,943,730</b>	<b>\$2,342,638,120</b>	<b>\$693,370,760</b>	<b>\$207,992,790</b>	<b>\$202,427,030</b>
<b><u>PHARMACY</u></b>							
48	MEDI-CAL DRUG REBATE FUND	\$0	(\$1,490,899,000)	\$0	(\$1,542,198,000)	\$0	(\$51,299,000)
49	BCCTP DRUG REBATES	(\$4,682,000)	\$0	(\$4,578,000)	\$0	\$104,000	\$0
50	LITIGATION SETTLEMENTS	(\$19,201,000)	(\$19,201,000)	\$0	\$0	\$19,201,000	\$19,201,000
51	FAMILY PACT DRUG REBATES	(\$10,497,000)	\$0	(\$11,432,000)	\$0	(\$935,000)	\$0
52	OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS	(\$20,958,000)	(\$7,761,650)	(\$21,000,000)	(\$7,777,200)	(\$42,000)	(\$15,550)
53	BLOOD FACTOR REIMBURSEMENT METHODOLOGY	(\$35,907,150)	(\$12,804,110)	(\$37,797,000)	(\$13,532,750)	(\$1,889,850)	(\$728,640)
54	MEDICAL SUPPLY REBATES	(\$22,271,000)	(\$11,135,500)	(\$90,973,000)	(\$45,486,500)	(\$68,702,000)	(\$34,351,000)
55	MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS	(\$7,619,000)	(\$2,420,900)	(\$37,818,000)	(\$13,540,550)	(\$30,199,000)	(\$11,119,650)
56	STATE SUPPLEMENTAL DRUG REBATES	(\$119,571,000)	\$0	(\$118,242,000)	\$0	\$1,329,000	\$0
57	MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS	\$174,437,000	\$49,267,750	(\$297,336,000)	(\$125,031,300)	(\$471,773,000)	(\$174,299,050)
58	FEDERAL DRUG REBATES	(\$1,570,146,000)	\$0	(\$1,577,341,000)	\$0	(\$7,195,000)	\$0
232	PHARMACY RETROACTIVE ADJUSTMENTS	(\$120,732,000)	(\$25,693,460)	(\$74,078,000)	(\$33,332,590)	\$46,654,000	(\$7,639,130)
236	MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES	\$0	\$0	(\$396,988,000)	(\$132,833,250)	(\$396,988,000)	(\$132,833,250)

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CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b>PHARMACY SUBTOTAL</b>	<b>(\$1,757,147,150)</b>	<b>(\$1,520,647,870)</b>	<b>(\$2,667,583,000)</b>	<b>(\$1,913,732,140)</b>	<b>(\$910,435,850)</b>	<b>(\$393,084,270)</b>
	<b><u>DRUG MEDI-CAL</u></b>						
59	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER	\$419,478,000	\$41,639,150	\$404,190,000	\$44,646,700	(\$15,288,000)	\$3,007,550
63	DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT	\$758,250	\$63,150	\$1,595,600	\$137,470	\$837,350	\$74,320
64	DRUG MEDI-CAL MAT BENEFIT	\$348,250	\$60,020	\$360,200	\$76,510	\$11,950	\$16,480
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$46,000	(\$14,000)	\$0	\$0	(\$46,000)	\$14,000
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$420,630,500</b>	<b>\$41,748,320</b>	<b>\$406,145,800</b>	<b>\$44,860,680</b>	<b>(\$14,484,700)</b>	<b>\$3,112,350</b>
	<b><u>MENTAL HEALTH</u></b>						
69	MHP COSTS FOR CONTINUUM OF CARE REFORM	\$23,862,000	\$11,627,500	\$21,862,000	\$11,090,500	(\$2,000,000)	(\$537,000)
70	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	\$9,861,000	\$0	\$0	\$0	(\$9,861,000)	\$0
71	PATHWAYS TO WELL-BEING	\$961,000	\$0	\$1,006,000	\$0	\$45,000	\$0
72	LATE CLAIMS FOR SMHS	\$30,000	\$30,000	\$0	\$0	(\$30,000)	(\$30,000)
73	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	\$0	(\$200,000)	\$0	(\$200,000)	\$0	\$0
75	SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS	\$0	\$0	\$0	\$3,375,000	\$0	\$3,375,000
76	CHART REVIEW	(\$41,000)	\$0	(\$396,000)	\$0	(\$355,000)	\$0
77	INTERIM AND FINAL COST SETTLEMENTS - SMHS	(\$61,870,000)	\$1,103,000	\$0	\$0	\$61,870,000	(\$1,103,000)
231	BH QUALITY IMPROVEMENT PROGRAM	\$0	\$0	\$21,750,000	\$21,750,000	\$21,750,000	\$21,750,000
240	MHP COSTS FOR FFPSA - QUAILIFIED INDIVIDUAL	\$0	\$0	\$21,356,000	\$10,678,000	\$21,356,000	\$10,678,000
241	MHP COSTS FOR FFPSA - AFTERCARE SERVICES	\$0	\$0	\$1,284,000	\$0	\$1,284,000	\$0
249	BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE	\$0	\$0	\$750,000,000	\$750,000,000	\$750,000,000	\$750,000,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>(\$27,197,000)</b>	<b>\$12,560,500</b>	<b>\$816,862,000</b>	<b>\$796,693,500</b>	<b>\$844,059,000</b>	<b>\$784,133,000</b>

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		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>							
78	GLOBAL PAYMENT PROGRAM	\$2,209,581,000	\$0	\$2,387,038,000	\$0	\$177,457,000	\$0
79	PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL	\$1,039,219,000	\$0	\$0	\$0	(\$1,039,219,000)	\$0
80	MEDI-CAL 2020 WHOLE PERSON CARE PILOTS	\$1,038,646,000	\$0	\$600,000,000	\$0	(\$438,646,000)	\$0
81	MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE	\$242,033,000	\$106,009,500	\$205,358,000	\$102,679,000	(\$36,675,000)	(\$3,330,500)
82	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	\$324,000	\$0	\$316,000	\$0	(\$8,000)	\$0
83	MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM	\$0	(\$94,542,000)	\$0	(\$158,900,000)	\$0	(\$64,358,000)
84	BTR - LIHP - MCE	\$0	\$0	\$0	\$0	\$0	\$0
85	MH/UCD—SAFETY NET CARE POOL	(\$26,021,000)	\$0	\$0	\$0	\$26,021,000	\$0
225	CALAIM ECM-ILOS-PLAN INCENTIVES	\$0	\$0	\$535,417,000	\$267,708,500	\$535,417,000	\$267,708,500
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$4,503,782,000</b>	<b>\$11,467,500</b>	<b>\$3,728,129,000</b>	<b>\$211,487,500</b>	<b>(\$775,653,000)</b>	<b>\$200,020,000</b>
<b><u>MANAGED CARE</u></b>							
89	2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.	\$3,176,921,000	\$1,142,755,720	\$2,528,944,000	\$927,812,450	(\$647,977,000)	(\$214,943,260)
90	CCI-MANAGED CARE PAYMENTS	\$8,489,560,000	\$4,244,780,000	\$8,798,756,000	\$4,399,378,000	\$309,196,000	\$154,598,000
91	MANAGED CARE PUBLIC HOSPITAL EPP	\$2,517,179,000	\$697,155,340	\$1,208,317,000	\$403,446,780	(\$1,308,862,000)	(\$293,708,560)
92	MANAGED CARE HEALTH CARE FINANCING PROGRAM	\$1,928,567,000	\$656,872,360	\$1,061,465,000	\$369,493,650	(\$867,102,000)	(\$287,378,710)
93	MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL	\$1,324,714,000	\$315,840,480	\$962,754,000	\$246,967,500	(\$361,960,000)	(\$68,872,980)
96	RETRO MC RATE ADJUSTMENTS	\$403,089,000	\$224,118,380	\$174,899,000	\$82,301,950	(\$228,190,000)	(\$141,816,440)
97	EXTENDED FILE CORRECTION	\$300,000,000	\$335,205,360	\$0	\$0	(\$300,000,000)	(\$335,205,360)
98	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS	\$138,589,000	\$0	\$98,780,000	\$13,958,000	(\$39,809,000)	\$13,958,000
101	SAN MATEO HEALTH PLAN REIMBURSEMENT	\$30,000,000	\$30,000,000	\$0	\$0	(\$30,000,000)	(\$30,000,000)
102	CCI-QUALITY WITHHOLD REPAYMENTS	\$18,830,000	\$9,415,000	\$16,822,000	\$8,411,000	(\$2,008,000)	(\$1,004,000)

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		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b>MANAGED CARE</b>							
105	CAPITATED RATE ADJUSTMENT FOR FY 2021-22	\$0	\$0	\$1,185,484,000	\$407,117,700	\$1,185,484,000	\$407,117,700
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS	\$0	(\$1,760,119,000)	\$0	(\$1,598,111,000)	\$0	\$162,008,000
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ	\$0	(\$1,009,538,000)	\$0	(\$919,347,000)	\$0	\$90,191,000
108	MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND	\$0	(\$1,852,689,000)	\$0	(\$1,113,935,000)	\$0	\$738,754,000
110	COORDINATED CARE INITIATIVE RISK MITIGATION	\$0	\$0	(\$111,260,000)	(\$55,630,000)	(\$111,260,000)	(\$55,630,000)
111	RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS	(\$1,166,000)	(\$457,650)	\$0	\$0	\$1,166,000	\$457,650
112	MANAGED CARE EFFICIENCIES	(\$199,574,000)	(\$64,469,950)	(\$481,443,000)	(\$155,548,750)	(\$281,869,000)	(\$91,078,800)
113	ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020	(\$603,348,000)	(\$186,307,300)	\$0	\$0	\$603,348,000	\$186,307,300
114	MANAGED CARE DRUG REBATES	(\$1,504,915,000)	\$0	(\$1,415,902,000)	\$0	\$89,013,000	\$0
228	CALAIM - MANAGED CARE SMHS CARVE-OUT	\$0	\$0	(\$4,773,000)	(\$2,290,300)	(\$4,773,000)	(\$2,290,300)
234	CALAIM - MSSP CARVE-OUT OF CCI	\$0	\$0	\$1,600,000	\$800,000	\$1,600,000	\$800,000
235	CALAIM - TRANSITIONING POPULATIONS	\$0	\$0	\$401,597,000	\$174,759,600	\$401,597,000	\$174,759,600
242	PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM	\$57,000,000	\$24,966,000	\$76,000,000	\$35,644,000	\$19,000,000	\$10,678,000
248	INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SRVS.	\$0	\$0	\$388,986,000	\$194,493,000	\$388,986,000	\$194,493,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$16,075,446,000</b>	<b>\$2,807,527,740</b>	<b>\$14,891,026,000</b>	<b>\$3,419,721,580</b>	<b>(\$1,184,420,000)</b>	<b>\$612,193,850</b>
<b>PROVIDER RATES</b>							
115	DPH INTERIM RATE GROWTH	\$192,578,850	\$96,289,420	\$257,252,000	\$128,626,000	\$64,673,150	\$32,336,580
116	GROUND EMERGENCY MEDICAL TRANSPORTATION QAF	\$226,313,000	(\$8,233,000)	\$223,616,000	(\$7,493,000)	(\$2,697,000)	\$740,000
117	RATE INCREASE FOR FQHCS/RHCS/CBRCS	\$157,132,330	\$60,388,530	\$170,610,380	\$65,568,460	\$13,478,060	\$5,179,930
118	DPH INTERIM & FINAL RECONS	\$136,116,000	\$0	(\$123,313,000)	\$0	(\$259,429,000)	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>PROVIDER RATES</u></b>							
119	DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST	\$134,994,000	\$0	\$11,249,000	\$0	(\$123,745,000)	\$0
120	AB 1629 ANNUAL RATE ADJUSTMENTS	\$299,266,150	\$149,633,070	\$390,199,260	\$195,099,630	\$90,933,120	\$45,466,560
121	PROP 56 - HOME HEALTH RATE INCREASE	\$167,320,000	\$77,151,580	\$92,754,000	\$43,338,200	(\$74,566,000)	(\$33,813,380)
122	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$44,610,000	\$17,144,200	\$44,908,000	\$17,258,800	\$298,000	\$114,600
123	LTC RATE ADJUSTMENT	\$56,836,720	\$28,418,360	\$85,582,710	\$42,791,350	\$28,745,990	\$14,373,000
124	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	\$13,972,000	(\$2,210,000)	\$8,539,000	(\$408,000)	(\$5,433,000)	\$1,802,000
125	HOSPICE RATE INCREASES	\$9,260,220	\$4,630,110	\$15,537,590	\$7,768,800	\$6,277,370	\$3,138,680
126	PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE	\$17,353,000	\$7,741,120	\$14,246,000	\$6,655,550	(\$3,107,000)	(\$1,085,580)
127	GDSP NEWBORN SCREENING PROGRAM FEE INCREASE	\$2,301,300	\$1,150,650	\$2,776,000	\$1,388,000	\$474,700	\$237,350
128	DPH INTERIM RATE	\$0	(\$436,092,100)	\$0	(\$461,715,700)	\$0	(\$25,623,600)
129	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	\$0	(\$628,556,000)	\$0	(\$532,752,000)	\$0	\$95,804,000
130	DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT	(\$2,464,000)	(\$1,114,380)	(\$2,942,670)	(\$1,363,640)	(\$478,670)	(\$249,270)
131	REDUCTION TO RADIOLOGY RATES	(\$4,027,600)	(\$2,013,800)	(\$12,410,060)	(\$6,205,030)	(\$8,382,470)	(\$4,191,230)
132	10% PROVIDER PAYMENT REDUCTION	(\$171,841,000)	(\$85,920,500)	(\$171,841,000)	(\$85,920,500)	\$0	\$0
133	LABORATORY RATE METHODOLOGY CHANGE	(\$29,641,130)	(\$14,820,560)	(\$39,187,650)	(\$19,593,830)	(\$9,546,520)	(\$4,773,260)
243	HOME HEALTH & PDHC RECOUPMENTS	(\$51,392,000)	(\$25,030,160)	\$0	\$0	\$51,392,000	\$25,030,160
	<b>PROVIDER RATES SUBTOTAL</b>	<b>\$1,198,687,840</b>	<b>(\$761,443,440)</b>	<b>\$967,575,560</b>	<b>(\$606,956,910)</b>	<b>(\$231,112,270)</b>	<b>\$154,486,540</b>
<b><u>SUPPLEMENTAL PMNTS.</u></b>							
134	HOSPITAL QAF - FFS PAYMENTS	\$5,179,786,000	\$0	\$3,302,291,000	\$0	(\$1,877,495,000)	\$0
135	HOSPITAL QAF - MANAGED CARE PAYMENTS	\$2,846,100,000	\$0	\$1,897,400,000	\$0	(\$948,700,000)	\$0
136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS	\$2,326,556,000	\$0	\$3,278,824,000	\$0	\$952,268,000	\$0

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**COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>							
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS	\$1,287,506,000	\$0	\$416,860,000	\$0	(\$870,646,000)	\$0
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS	\$1,276,175,000	\$400,453,780	\$1,275,228,000	\$426,760,950	(\$947,000)	\$26,307,160
139	PRIVATE HOSPITAL DSH REPLACEMENT	\$608,040,000	\$266,230,000	\$623,212,000	\$311,606,000	\$15,172,000	\$45,376,000
140	PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES	\$518,839,000	\$180,707,180	\$514,291,000	\$193,051,600	(\$4,548,000)	\$12,344,420
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM	\$364,513,000	\$112,546,900	\$364,207,000	\$119,865,650	(\$306,000)	\$7,318,750
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT	\$429,933,000	\$126,275,000	\$308,193,000	\$118,400,000	(\$121,740,000)	(\$7,875,000)
143	DSH PAYMENT	\$327,845,000	\$19,641,000	\$427,503,000	\$24,993,000	\$99,658,000	\$5,352,000
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	\$291,729,000	\$0	\$246,989,000	\$0	(\$44,740,000)	\$0
145	DPH PHYSICIAN & NON-PHYS. COST	\$268,004,000	\$0	\$349,662,000	\$0	\$81,658,000	\$0
146	FFP FOR LOCAL TRAUMA CENTERS	\$136,157,000	\$0	\$168,229,000	\$0	\$32,072,000	\$0
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS	\$121,860,000	\$4,659,270	\$115,461,000	\$0	(\$6,399,000)	(\$4,659,270)
148	CAPITAL PROJECT DEBT REIMBURSEMENT	\$97,776,000	\$22,722,500	\$97,169,000	\$22,865,000	(\$607,000)	\$142,500
149	NDPH IGT SUPPLEMENTAL PAYMENTS	\$54,971,000	(\$7,432,000)	\$44,983,000	(\$1,933,000)	(\$9,988,000)	\$5,499,000
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	\$81,000,000	\$46,979,000	\$81,000,000	\$46,979,000	\$0	\$0
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS	\$71,812,000	\$0	\$92,298,000	\$0	\$20,486,000	\$0
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$55,960,000	\$0	\$35,470,000	\$0	(\$20,490,000)	\$0
153	NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS	\$26,250,000	\$11,497,000	\$105,000,000	\$52,500,000	\$78,750,000	\$41,003,000
154	PROP 56 - DEVELOPMENTAL SCREENINGS	\$53,222,710	\$20,921,360	\$61,960,000	\$25,877,550	\$8,737,290	\$4,956,190
155	PROP 56 - CBAS SUPPLEMENTAL PAYMENTS	\$38,648,000	\$16,928,000	\$30,753,000	\$14,284,500	(\$7,895,000)	(\$2,643,500)
156	PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS	\$41,972,150	\$14,868,140	\$47,682,000	\$18,217,150	\$5,709,850	\$3,349,010
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	\$14,857,000	\$0	\$10,706,000	\$0	(\$4,151,000)	\$0

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CURRENT YEAR COMPARED TO BUDGET YEAR  
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NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>							
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$4,380,000	\$10,000,000	\$5,000,000	\$0	\$620,000
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$3,504,000	\$8,000,000	\$4,000,000	\$0	\$496,000
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS	\$25,988,000	\$11,076,500	\$25,925,000	\$11,781,900	(\$63,000)	\$705,400
161	PROP 56 - MEDI-CAL FAMILY PLANNING	\$436,844,000	\$43,684,400	\$431,072,000	\$43,107,200	(\$5,772,000)	(\$577,200)
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS	\$154,170,000	\$21,476,000	\$163,957,000	\$22,595,000	\$9,787,000	\$1,119,000
163	NDPH SUPPLEMENTAL PAYMENT	\$4,256,000	\$1,900,000	\$4,201,000	\$1,900,000	(\$55,000)	\$0
164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS	\$4,000,000	\$1,752,000	\$0	\$0	(\$4,000,000)	(\$1,752,000)
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS	\$9,155,000	\$3,831,400	\$8,943,000	\$4,084,850	(\$212,000)	\$253,450
166	PROPOSITION 56 FUNDS TRANSFER	\$0	(\$975,709,000)	\$0	(\$717,883,000)	\$0	\$257,826,000
167	PROP 56 - NEMT SUPPLEMENTAL PAYMENTS	\$7,925,000	\$3,664,100	\$7,925,000	\$3,892,450	\$0	\$228,340
168	IGT PAYMENTS FOR HOSPITAL SERVICES	\$0	\$10,077,000	\$0	\$0	\$0	(\$10,077,000)
169	IGT ADMIN. & PROCESSING FEE	\$0	(\$27,989,000)	\$0	(\$9,893,000)	\$0	\$18,096,000
170	PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS	\$6,800,000	\$2,978,000	\$6,800,000	\$3,189,000	\$0	\$211,000
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$17,186,649,860</b>	<b>\$341,622,530</b>	<b>\$14,562,194,000</b>	<b>\$745,241,800</b>	<b>(\$2,624,455,860)</b>	<b>\$403,619,270</b>
<b><u>COVID-19</u></b>							
172	COVID-19 CASELOAD IMPACT	\$5,428,893,000	\$1,742,310,580	\$13,531,559,000	\$4,336,085,610	\$8,102,666,000	\$2,593,775,030
173	COVID-19 BEHAVIORAL HEALTH	\$287,307,000	\$16,677,240	\$497,815,000	\$28,137,600	\$210,508,000	\$11,460,360
174	COVID-19 FFS REIMBURSEMENT RATES	\$334,768,000	\$167,384,000	\$251,076,000	\$125,538,000	(\$83,692,000)	(\$41,846,000)
175	COVID-19 BASE RECOVERIES	\$216,304,000	\$91,073,700	(\$34,000,000)	(\$14,315,300)	(\$250,304,000)	(\$105,389,000)
176	COVID-19 ELIGIBILITY	\$36,319,700	\$24,713,650	\$17,277,000	\$12,251,000	(\$19,042,700)	(\$12,462,650)
177	COVID-19 - SICK LEAVE BENEFITS	\$36,900,000	\$101,000	\$18,450,000	\$50,500	(\$18,450,000)	(\$50,500)
178	COVID-19 INCREASED FMAP - DHCS	(\$220,134,000)	(\$2,737,892,000)	(\$50,094,000)	(\$782,920,000)	\$170,040,000	\$1,954,972,000

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CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>COVID-19</u></b>							
179	COVID-19 UTILIZATION CHANGE	(\$947,400,000)	(\$377,752,700)	(\$22,141,000)	(\$8,925,500)	\$925,259,000	\$368,827,200
246	COVID-19 INCREASED FMAP EXTENSION - DHCS	\$0	\$0	\$513,836,000	(\$1,433,282,000)	\$513,836,000	(\$1,433,282,000)
247	COVID-19 VACCINE ADMINISTRATION	\$31,650,000	\$10,761,000	\$315,744,000	\$107,353,000	\$284,094,000	\$96,592,000
	<b>COVID-19 SUBTOTAL</b>	<b>\$5,204,607,700</b>	<b>(\$1,062,623,540)</b>	<b>\$15,039,522,000</b>	<b>\$2,369,972,910</b>	<b>\$9,834,914,300</b>	<b>\$3,432,596,440</b>
<b><u>STATE ONLY CLAIMING</u></b>							
221	STATE ONLY CLAIMING ADJUSTMENTS	\$0	\$65,996,000	\$145,571,000	\$260,102,000	\$145,571,000	\$194,106,000
244	STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC	(\$3,169,000)	\$139,125,000	(\$6,339,000)	\$15,057,000	(\$3,170,000)	(\$124,068,000)
245	STATE ONLY CLAIMING ADJUSTMENTS - TCM	\$0	\$44,631,000	\$0	\$3,958,000	\$0	(\$40,673,000)
	<b>STATE ONLY CLAIMING SUBTOTAL</b>	<b>(\$3,169,000)</b>	<b>\$249,752,000</b>	<b>\$139,232,000</b>	<b>\$279,117,000</b>	<b>\$142,401,000</b>	<b>\$29,365,000</b>
<b><u>OTHER DEPARTMENTS</u></b>							
180	ELECTRONIC VISIT VERIFICATION FED PENALTIES	(\$20,248,000)	\$417,000	(\$21,517,000)	\$417,000	(\$1,269,000)	\$0
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>(\$20,248,000)</b>	<b>\$417,000</b>	<b>(\$21,517,000)</b>	<b>\$417,000</b>	<b>(\$1,269,000)</b>	<b>\$0</b>
<b><u>OTHER</u></b>							
187	CCI IHSS RECONCILIATION	\$142,263,000	\$0	\$100,000,000	\$0	(\$42,263,000)	\$0
188	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	\$102,878,000	\$0	\$63,974,000	\$0	(\$38,904,000)	\$0
190	PROP 56 - PROVIDER ACES TRAININGS	\$61,924,000	\$30,962,000	\$41,712,000	\$20,856,000	(\$20,212,000)	(\$10,106,000)
193	INFANT DEVELOPMENT PROGRAM	\$48,322,000	\$0	\$35,974,000	\$0	(\$12,348,000)	\$0
194	MINIMUM WAGE INCREASE FOR HCBS WAIVERS	\$52,479,900	\$26,239,950	\$65,722,980	\$32,861,490	\$13,243,080	\$6,621,540
196	SELF-DETERMINATION PROGRAM - CDDS	\$8,365,000	\$0	\$10,424,000	\$0	\$2,059,000	\$0
197	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$16,891,000	\$7,731,000	\$11,039,000	\$5,041,000	(\$5,852,000)	(\$2,690,000)
199	PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG	\$15,108,000	\$0	\$29,092,000	\$0	\$13,984,000	\$0

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		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b>OTHER</b>						
200	INDIAN HEALTH SERVICES	\$9,525,000	\$3,191,000	\$18,436,000	\$6,176,000	\$8,911,000	\$2,985,000
201	ARRA HITECH - PROVIDER PAYMENTS	\$8,651,000	\$0	\$5,101,000	\$0	(\$3,550,000)	\$0
202	QAF WITHHOLD TRANSFER	\$7,816,000	(\$3,468,000)	\$47,076,000	\$19,729,000	\$39,260,000	\$23,197,000
203	CCS SAR EPC	\$6,166,000	\$3,222,240	\$6,166,000	\$3,222,240	\$0	\$0
204	HOME & COMMUNITY-BASED ALTERNATIVES WAIVER	\$168,175,000	\$84,087,500	\$154,044,000	\$77,022,000	(\$14,131,000)	(\$7,065,500)
205	WPCS WORKERS' COMPENSATION	\$3,324,000	\$1,662,000	\$3,325,000	\$1,662,500	\$1,000	\$500
206	TRIBAL FEDERALLY QUALIFIED HEALTH CENTER	\$1,780,000	\$462,300	\$12,827,000	\$3,330,300	\$11,047,000	\$2,868,000
209	AUDIT SETTLEMENTS	\$0	\$47,589,000	\$0	\$69,588,000	\$0	\$21,999,000
210	IMD ANCILLARY SERVICES	\$0	\$15,930,000	\$0	\$12,322,000	\$0	(\$3,608,000)
211	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	(\$160,657,000)	\$0	(\$131,870,000)	\$0	\$28,787,000
212	FUNDING ADJUST.—ACA OPT. EXPANSION	\$0	(\$1,898,984,800)	\$0	(\$1,948,043,200)	\$0	(\$49,058,400)
213	FUNDING ADJUST.—OTLIPC	\$0	(\$105,944,100)	\$0	(\$90,361,050)	\$0	\$15,583,060
214	CMS DEFERRED CLAIMS	\$0	\$567,553,000	\$0	\$200,000,000	\$0	(\$367,553,000)
215	CLPP FUND	\$0	(\$916,000)	\$0	(\$916,000)	\$0	\$0
216	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	(\$1,151,905,000)	\$0	(\$761,550,000)	\$0	\$390,355,000
217	REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS	\$0	\$10,370,000	\$0	\$0	\$0	(\$10,370,000)
218	INDIAN HEALTH SERVICES FUNDING SHIFT	\$0	(\$12,500,000)	\$0	(\$13,000,000)	\$0	(\$500,000)
219	FUND 3156 TRANSFER TO THE GENERAL FUND	\$0	(\$100,000,000)	\$0	\$0	\$0	\$100,000,000
220	FUND 3311 TRANSFER TO THE GENERAL FUND	\$0	(\$20,000,000)	\$0	\$0	\$0	\$20,000,000
222	ASSISTED LIVING WAIVER EXPANSION	(\$55,933,000)	(\$27,966,500)	(\$58,075,000)	(\$29,037,500)	(\$2,142,000)	(\$1,071,000)
223	COUNTY SHARE OF OTLIPC-CCS COSTS	(\$22,168,000)	(\$22,168,000)	(\$25,748,000)	(\$25,748,000)	(\$3,580,000)	(\$3,580,000)
226	CALAIM - DENTAL PREVENTIVE SERVICES	\$0	\$0	\$59,384,000	\$29,692,000	\$59,384,000	\$29,692,000
227	CALAIM - DENTAL CARIES RISK ASSESSMENT	\$0	\$0	\$8,991,000	\$4,495,500	\$8,991,000	\$4,495,500
229	CALAIM - DENTAL SILVER DIAMINE FLUORIDE	\$0	\$0	\$1,637,000	\$818,500	\$1,637,000	\$818,500

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 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b>OTHER</b>						
230	CALAIM - DENTAL CONTINUITY OF CARE	\$0	\$0	\$43,485,000	\$21,742,500	\$43,485,000	\$21,742,500
	<b>OTHER SUBTOTAL</b>	<b>\$575,566,900</b>	<b>(\$2,705,509,410)</b>	<b>\$634,586,980</b>	<b>(\$2,491,966,720)</b>	<b>\$59,020,080</b>	<b>\$213,542,690</b>
	<b>GRAND TOTAL</b>	<b><u>\$50,730,379,970</u></b>	<b><u>(\$1,311,011,420)</u></b>	<b><u>\$54,653,125,460</u></b>	<b><u>\$4,254,745,740</u></b>	<b><u>\$3,922,745,490</u></b>	<b><u>\$5,565,757,160</u></b>

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

**FISCAL YEAR 2021-22 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>PA-OAS</b>	<b>NEWLY</b>	<b>PA-ATD</b>	<b>PA-AFDC</b>	<b>LT-OAS</b>	<b>H-PE</b>
PHYSICIANS	\$8,961,380	\$214,652,270	\$83,121,690	\$60,927,910	\$2,872,300	\$59,472,280
OTHER MEDICAL	\$104,800,960	\$1,702,485,800	\$490,236,610	\$403,126,730	\$6,914,320	\$44,690,950
CO. & COMM. OUTPATIENT	\$4,285,320	\$213,504,950	\$123,698,270	\$31,869,370	\$763,480	\$54,625,090
PHARMACY	\$18,642,900	\$3,342,619,920	\$2,522,257,830	\$306,453,290	\$11,717,760	\$21,481,530
COUNTY INPATIENT	\$2,654,320	\$666,087,010	\$21,100,040	\$19,643,030	\$2,737,750	\$53,434,600
COMMUNITY INPATIENT	\$52,235,180	\$1,562,843,890	\$499,891,210	\$240,735,910	\$24,357,240	\$361,432,030
NURSING FACILITIES	\$206,582,190	\$225,566,040	\$528,936,110	\$4,353,170	\$1,691,946,810	\$1,356,340
ICF-DD	\$1,750,250	\$13,445,710	\$169,625,600	\$829,200	\$90,766,450	\$70
MEDICAL TRANSPORTATION	\$5,312,760	\$52,227,400	\$21,453,030	\$4,812,870	\$3,647,740	\$11,021,440
OTHER SERVICES	\$125,384,830	\$61,949,090	\$533,735,930	\$52,448,290	\$96,507,540	\$1,914,320
HOME HEALTH	\$3,371,950	\$2,574,780	\$140,241,120	\$7,696,500	\$52,550	\$200,050
<b>FFS SUBTOTAL</b>	<b>\$533,982,050</b>	<b>\$8,057,956,850</b>	<b>\$5,134,297,420</b>	<b>\$1,132,896,260</b>	<b>\$1,932,283,950</b>	<b>\$609,628,700</b>
DENTAL	\$122,343,550	\$423,856,550	\$138,936,920	\$168,124,510	\$20,995,510	\$0
MENTAL HEALTH	\$11,697,290	\$490,551,350	\$1,228,833,360	\$947,583,440	\$1,078,470	\$9,831,080
TWO PLAN MODEL	\$1,579,751,470	\$9,766,142,140	\$4,719,209,030	\$1,340,308,350	\$0	\$0
COUNTY ORGANIZED HEALTH SYSTEMS	\$307,628,390	\$3,757,055,870	\$1,366,262,250	\$346,829,670	\$982,091,860	\$0
GEOGRAPHIC MANAGED CARE	\$203,936,730	\$1,678,108,590	\$927,886,790	\$204,271,910	\$0	\$0
PHP & OTHER MANAG. CARE	\$305,495,470	\$28,125,620	\$215,049,590	\$15,412,960	\$21,872,540	\$0
MEDICARE PAYMENTS	\$1,979,634,180	\$0	\$1,805,492,610	\$0	\$237,311,900	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$2,040,810	\$0	\$4,426,470	\$5,287,150	\$266,760	\$0
MISC. SERVICES	\$948,621,130	\$1,298,760	\$7,884,293,510	\$8,378,730	\$250	\$0
DRUG MEDI-CAL	\$12,735,160	\$153,721,790	\$48,810,350	\$41,145,890	\$1,265,710	\$35,980
REGIONAL MODEL	\$13,990,820	\$588,524,250	\$275,314,690	\$74,269,380	\$0	\$0
<b>NON-FFS SUBTOTAL</b>	<b>\$5,487,875,000</b>	<b>\$16,887,384,920</b>	<b>\$18,614,515,570</b>	<b>\$3,151,611,990</b>	<b>\$1,264,883,000</b>	<b>\$9,867,070</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$6,021,857,050</b>	<b>\$24,945,341,770</b>	<b>\$23,748,812,990</b>	<b>\$4,284,508,260</b>	<b>\$3,197,166,950</b>	<b>\$619,495,770</b>
<b>ELIGIBLES ***</b>	<b>431,100</b>	<b>4,777,600</b>	<b>924,300</b>	<b>1,110,500</b>	<b>56,200</b>	<b>36,800</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$13,969</b>	<b>\$5,221</b>	<b>\$25,694</b>	<b>\$3,858</b>	<b>\$56,889</b>	<b>\$16,834</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$1,164</b>	<b>\$435</b>	<b>\$2,141</b>	<b>\$322</b>	<b>\$4,741</b>	<b>\$1,403</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2021-22 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>LT-ATD</b>	<b>POV 250</b>	<b>MN-OAS</b>	<b>MN-ATD</b>	<b>MN-AFDC</b>	<b>MI-C</b>
PHYSICIANS	\$1,863,620	\$26,698,580	\$33,673,570	\$16,837,030	\$180,817,970	\$38,188,690
OTHER MEDICAL	\$3,845,650	\$281,119,020	\$268,089,640	\$139,480,020	\$1,432,327,560	\$123,278,840
CO. & COMM. OUTPATIENT	\$497,120	\$30,008,530	\$26,338,170	\$18,881,030	\$153,723,520	\$12,379,100
PHARMACY	\$13,332,210	\$225,899,550	\$105,579,900	\$202,766,040	\$1,137,201,600	\$156,133,290
COUNTY INPATIENT	\$1,416,590	\$3,319,180	\$50,714,610	\$14,583,200	\$124,979,300	\$8,065,690
COMMUNITY INPATIENT	\$13,779,060	\$95,221,870	\$181,415,050	\$74,257,770	\$942,922,850	\$78,971,650
NURSING FACILITIES	\$297,100,910	\$4,119,640	\$251,575,430	\$79,703,770	\$35,579,250	\$9,192,270
ICF-DD	\$220,746,820	\$188,310	\$2,382,270	\$16,045,290	\$1,641,230	\$2,510,740
MEDICAL TRANSPORTATION	\$1,258,300	\$881,230	\$14,398,910	\$11,223,700	\$12,976,150	\$3,097,960
OTHER SERVICES	\$13,443,770	\$31,621,370	\$162,884,100	\$155,571,710	\$109,641,620	\$22,349,410
HOME HEALTH	\$2,710	\$18,887,180	\$2,825,510	\$70,398,570	\$20,185,270	\$17,322,680
<b>FFS SUBTOTAL</b>	<b>\$567,286,760</b>	<b>\$717,964,460</b>	<b>\$1,099,877,170</b>	<b>\$799,748,110</b>	<b>\$4,151,996,320</b>	<b>\$471,490,330</b>
DENTAL	\$20,954,450	\$316,682,570	\$21,950,900	\$26,286,620	\$667,826,540	\$19,310,140
MENTAL HEALTH	\$2,539,160	\$102,559,700	\$20,449,870	\$150,004,980	\$791,385,910	\$89,520,180
TWO PLAN MODEL	\$0	\$661,857,050	\$2,387,615,650	\$884,598,930	\$4,006,436,810	\$26,214,510
COUNTY ORGANIZED HEALTH SYSTEMS	\$216,428,470	\$270,010,650	\$641,614,690	\$478,664,510	\$1,730,979,750	\$24,788,030
GEOGRAPHIC MANAGED CARE	\$0	\$111,643,080	\$326,950,750	\$189,102,890	\$712,692,900	\$3,192,840
PHP & OTHER MANAG. CARE	\$803,920	\$4,154,500	\$485,065,210	\$53,976,030	\$8,729,370	\$6,259,170
MEDICARE PAYMENTS	\$0	\$0	\$2,153,345,560	\$883,753,650	\$160,594,840	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$62,920	\$0	\$3,324,560	\$1,193,070	\$20,898,570	\$720,130
MISC. SERVICES	\$510	(\$55,847,110)	\$1,252,233,870	\$1,896,618,220	\$27,118,190	\$1,077,700
DRUG MEDI-CAL	\$292,660	\$30,987,670	\$17,451,460	\$11,984,340	\$112,322,820	\$4,630,390
REGIONAL MODEL	\$0	\$37,122,600	\$54,688,330	\$57,524,790	\$274,881,970	\$912,450
<b>NON-FFS SUBTOTAL</b>	<b>\$241,082,080</b>	<b>\$1,479,170,700</b>	<b>\$7,364,690,830</b>	<b>\$4,633,708,040</b>	<b>\$8,513,867,670</b>	<b>\$176,625,550</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$808,368,840</b>	<b>\$2,197,135,160</b>	<b>\$8,464,568,000</b>	<b>\$5,433,456,160</b>	<b>\$12,665,863,990</b>	<b>\$648,115,880</b>
<b>ELIGIBLES ***</b>	<b>12,700</b>	<b>1,037,800</b>	<b>774,600</b>	<b>276,400</b>	<b>4,234,900</b>	<b>146,400</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$63,651</b>	<b>\$2,117</b>	<b>\$10,928</b>	<b>\$19,658</b>	<b>\$2,991</b>	<b>\$4,427</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$5,304</b>	<b>\$176</b>	<b>\$911</b>	<b>\$1,638</b>	<b>\$249</b>	<b>\$369</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2021-22 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>MI-A</b>	<b>REFUGEE</b>	<b>OBRA</b>	<b>POV 185</b>	<b>POV 133</b>	<b>POV 100</b>
PHYSICIANS	\$348,730	\$68,930	\$104,410	\$118,142,250	\$21,705,630	\$9,930,340
OTHER MEDICAL	\$582,550	\$405,250	\$45,110	\$293,059,060	\$286,040,300	\$115,795,000
CO. & COMM. OUTPATIENT	\$128,490	\$71,030	\$19,810	\$27,376,410	\$17,832,970	\$14,351,680
PHARMACY	\$2,617,300	\$451,080	\$302,540	\$63,419,350	\$168,007,850	\$126,313,880
COUNTY INPATIENT	\$1,495,880	\$310	\$22,230	\$67,087,900	\$2,421,630	\$1,145,190
COMMUNITY INPATIENT	\$1,387,430	\$69,450	\$266,280	\$733,003,210	\$97,671,350	\$38,582,540
NURSING FACILITIES	\$22,555,020	\$0	\$4,788,550	\$1,112,700	\$11,569,360	\$1,483,130
ICF-DD	\$1,305,460	\$0	\$117,000	\$59,720	\$497,380	\$1,670
MEDICAL TRANSPORTATION	\$94,240	\$7,210	\$10,590	\$2,256,760	\$1,058,800	\$272,700
OTHER SERVICES	\$489,260	\$3,580	\$7,500	\$10,882,750	\$22,887,700	\$13,578,600
HOME HEALTH	\$340	\$0	\$0	\$4,069,740	\$10,427,450	\$2,887,830
<b>FFS SUBTOTAL</b>	<b>\$31,004,690</b>	<b>\$1,076,840</b>	<b>\$5,684,010</b>	<b>\$1,320,469,840</b>	<b>\$640,120,420</b>	<b>\$324,342,560</b>
DENTAL	\$17,491,180	\$548,880	\$0	\$22,473,490	\$144,787,390	\$71,751,670
MENTAL HEALTH	\$0	\$174,730	\$1,748,150	\$2,291,870	\$34,979,130	\$52,613,810
TWO PLAN MODEL	\$13,450	\$404,190	\$0	\$210,005,760	\$568,715,290	\$305,672,110
COUNTY ORGANIZED HEALTH SYSTEMS	\$268,520	\$71,000	\$22,150	\$115,146,870	\$220,773,970	\$127,217,250
GEOGRAPHIC MANAGED CARE	\$4,580	\$390,510	\$0	\$41,060,500	\$93,633,710	\$50,352,490
PHP & OTHER MANAG. CARE	\$6,397,880	\$0	\$0	\$7,427,060	\$8,324,420	\$8,216,810
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$30,390	\$0	\$470	\$1,892,290	\$0	\$2,369,650
MISC. SERVICES	\$5,757,780	\$0	\$0	\$130,810	\$5,945,640	\$3,230,770
DRUG MEDI-CAL	\$88,370	\$14,820	\$0	\$11,397,390	\$24,379,230	\$13,371,020
REGIONAL MODEL	\$0	\$3,920	\$0	\$14,693,120	\$30,566,980	\$15,622,900
<b>NON-FFS SUBTOTAL</b>	<b>\$30,052,160</b>	<b>\$1,608,030</b>	<b>\$1,770,780</b>	<b>\$426,519,160</b>	<b>\$1,132,105,750</b>	<b>\$650,418,470</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$61,056,840</b>	<b>\$2,684,880</b>	<b>\$7,454,790</b>	<b>\$1,746,988,990</b>	<b>\$1,772,226,170</b>	<b>\$974,761,030</b>
<b>ELIGIBLES ***</b>	<b>3,300</b>	<b>700</b>	<b>0</b>	<b>361,900</b>	<b>923,700</b>	<b>489,900</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$18,502</b>	<b>\$3,836</b>		<b>\$4,827</b>	<b>\$1,919</b>	<b>\$1,990</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$1,542</b>	<b>\$320</b>		<b>\$402</b>	<b>\$160</b>	<b>\$166</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2021-22 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>TOTAL</b>
PHYSICIANS	\$878,387,570
OTHER MEDICAL	\$5,696,323,370
CO. & COMM. OUTPATIENT	\$730,354,330
PHARMACY	\$8,425,197,830
COUNTY INPATIENT	\$1,040,908,460
COMMUNITY INPATIENT	\$4,999,043,970
NURSING FACILITIES	\$3,377,520,690
ICF-DD	\$521,913,150
MEDICAL TRANSPORTATION	\$146,011,790
OTHER SERVICES	\$1,415,301,380
HOME HEALTH	\$301,144,220
<b>FFS SUBTOTAL</b>	<b>\$27,532,106,750</b>
DENTAL	\$2,204,320,860
MENTAL HEALTH	\$3,937,842,480
TWO PLAN MODEL	\$26,456,944,750
COUNTY ORGANIZED HEALTH SYSTEMS	\$10,585,853,900
GEOGRAPHIC MANAGED CARE	\$4,543,228,270
PHP & OTHER MANAG. CARE	\$1,175,310,550
MEDICARE PAYMENTS	\$7,220,132,750
STATE HOSP./DEVELOPMENTAL CNTRS.	\$42,513,250
MISC. SERVICES	\$11,978,858,740
DRUG MEDI-CAL	\$484,635,050
REGIONAL MODEL	\$1,438,116,180
<b>NON-FFS SUBTOTAL</b>	<b>\$70,067,756,760</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$97,599,863,510</b>
<b>ELIGIBLES ***</b>	<b>15,598,800</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$6,257</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$521</b>

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

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

Refer to page following for listing of excluded policy changes.

**FISCAL YEAR 2021-22 COST PER ELIGIBLE BASED ON NOVEMBER 2020 ESTIMATE**

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5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
6	MEDICARE OPTIONAL EXPANSION ADJUSTMENT
7	CHILDREN'S HEALTH INSURANCE PROGRAM
8	DISABLED ADULT CHILDREN PROGRAM CLEANUP
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
10	MEDICARE PART B DISREGARD
14	NON-OTLICP CHIP
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104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
106	2020 MCO ENROLLMENT TAX MANAGED CARE PLANS
107	2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ
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## EXCLUDED POLICY CHANGES: 83

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136	MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS
137	GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS
138	PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS
139	PRIVATE HOSPITAL DSH REPLACEMENT
141	PROP 56 - VALUE-BASED PAYMENT PROGRAM
142	PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
143	DSH PAYMENT
144	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
145	DPH PHYSICIAN & NON-PHYS. COST
146	FFP FOR LOCAL TRAUMA CENTERS
147	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS
148	CAPITAL PROJECT DEBT REIMBURSEMENT
149	NDPH IGT SUPPLEMENTAL PAYMENTS
150	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
151	CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS
152	GEMT SUPPLEMENTAL PAYMENT PROGRAM
157	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
158	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
159	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
160	PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS
161	PROP 56 - MEDI-CAL FAMILY PLANNING
162	PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS
163	NDPH SUPPLEMENTAL PAYMENT
164	PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS
165	PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS
166	PROPOSITION 56 FUNDS TRANSFER
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209	AUDIT SETTLEMENTS
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AVERAGE MONTHLY CASELOAD IN FEE-FOR-SERVICE .....	E
<b>CASELOAD GRAPHS .....</b>	<b>CL 1-5</b>
STATEWIDE ELIGIBLES: ALL AID CATEGORIES .....	CL 1
STATEWIDE ELIGIBLES: FAMILIES AND CHILDREN .....	CL 2
STATEWIDE ELIGIBLES: SENIORS .....	CL 3
STATEWIDE ELIGIBLES: PERSONS WITH DISABILITIES .....	CL 4
STATEWIDE ELIGIBLES: ACA OPTIONAL EXPANSION .....	CL 5
<b>MEDI-CAL AID CATEGORY DEFINITIONS .....</b>	<b>CL 6</b>

**Estimated Average Monthly Certified Eligibles  
November 2020 Estimate  
Fiscal Years 2019-2020, 2020-2021 & 2021-22**

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

	<b>2019-2020</b>	<b>2020-2021</b>	<b>2021-2022</b>	<b>19-20 To 20-21 % Change</b>	<b>20-21 To 21-22 % Change</b>
<b>Public Assistance</b>	<b>2,348,400</b>	<b>2,389,400</b>	<b>2,465,900</b>	<b>1.75%</b>	<b>3.20%</b>
Seniors	420,900	425,800	431,100	1.16%	1.24%
Persons with Disabilities	915,400	917,300	924,300	0.21%	0.76%
Families <sup>1</sup>	1,012,100	1,046,300	1,110,500	3.38%	6.14%
<b>Long Term</b>	<b>54,300</b>	<b>61,600</b>	<b>68,900</b>	<b>13.44%</b>	<b>11.85%</b>
Seniors	44,100	50,200	56,200	13.83%	11.95%
Persons with Disabilities	10,200	11,400	12,700	11.76%	11.40%
<b>Medically Needy</b>	<b>4,037,600</b>	<b>4,608,600</b>	<b>5,271,300</b>	<b>14.14%</b>	<b>14.38%</b>
Seniors	534,500	665,500	765,800	24.51%	15.07%
Persons with Disabilities	191,200	234,800	270,600	22.80%	15.25%
Families <sup>1</sup>	3,311,900	3,708,300	4,234,900	11.97%	14.20%
<b>Medically Indigent</b>	<b>152,800</b>	<b>149,500</b>	<b>149,700</b>	<b>-2.16%</b>	<b>0.13%</b>
Children	149,000	146,300	146,400	-1.81%	0.07%
Adults	3,800	3,200	3,300	-15.79%	3.13%
<b>Other</b>	<b>6,099,200</b>	<b>6,761,700</b>	<b>7,648,000</b>	<b>10.86%</b>	<b>13.11%</b>
Refugees	700	600	700	-14.29%	16.67%
OBRA <sup>2</sup>	300	0	0	-100.00%	n/a
185% Poverty <sup>3</sup>	333,300	333,500	361,900	0.06%	8.52%
133% Poverty	730,000	811,700	923,700	11.19%	13.80%
100% Poverty	391,000	432,600	489,900	10.64%	13.25%
Opt. Targeted Low Income Children	906,800	960,300	1,037,800	5.90%	8.07%
ACA Optional Expansion	3,684,600	4,166,900	4,777,600	13.09%	14.66%
Hospital PE	32,800	36,500	36,800	11.28%	0.82%
Medi-Cal Access Program	5,500	5,000	5,000	n/a	n/a
QMB	14,200	14,600	14,600	2.82%	0.00%
<b>GRAND TOTAL <sup>4</sup></b>	<b>12,692,300</b>	<b>13,970,800</b>	<b>15,603,800</b>	<b>10.07%</b>	<b>11.69%</b>
<b>Seniors</b>	<b>999,500</b>	<b>1,141,500</b>	<b>1,253,100</b>	<b>14.21%</b>	<b>9.78%</b>
<b>Persons with Disabilities</b>	<b>1,116,800</b>	<b>1,163,500</b>	<b>1,207,600</b>	<b>4.18%</b>	<b>3.79%</b>
<b>Families and Children <sup>5</sup></b>	<b>6,834,100</b>	<b>7,439,000</b>	<b>8,305,100</b>	<b>8.85%</b>	<b>11.64%</b>
<b>ACA Optional Expansion</b>	<b>3,684,600</b>	<b>4,166,900</b>	<b>4,777,600</b>	<b>13.09%</b>	<b>14.66%</b>

**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.**

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

<sup>2</sup> 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.

<sup>3</sup> Includes the following presumptive eligibility for pregnant women program eligibles:

	<u>2019-2020</u>	<u>2020-2021</u>	<u>2021-2022</u>
Presumptive Eligibility	36,600	37,000	37,000

<sup>4</sup> The following Medi-Cal special program eligibles (average monthly during FY 2016-17 shown in parenthesis) are not included above: BCCTP (6,794), Tuberculosis (81), Dialysis (154), TPN (2). Family PACT eligibles are also not included above.

<sup>5</sup> 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>	<b>Caseload Change</b>		
		<b>Average Monthly Eligibles not in the Base Estimate</b>		
		<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>
<b>PC 2 Medi-Cal State Inmates</b>	LT Seniors	7	10	10
	MN Seniors	35	35	35
	MN Persons with Disabilities	7	7	7
	MI Children	3	4	4
	185% Poverty	2	2	2
	ACA Optional Expansion	261	243	243
	<b>Total</b>	<b>315</b>	<b>302</b>	<b>302</b>
	<b>PC 5 Medi-Cal Access Program Mothers 213-322%</b>	MCAP Mothers	4,676	4,132
<b>Total</b>		<b>4,676</b>	<b>4,132</b>	<b>4,132</b>
<b>PC 9 Medi-Cal Access Program Infants 266-322%</b>	MCAP Infants	869	909	909
	<b>Total</b>	<b>869</b>	<b>909</b>	<b>909</b>
<b>PC 172 COVID-19 Caseload Impact</b>	PA Seniors		5,101	10,212
	PA Persons with Disabilities		6,613	13,239
	PA Families		40,522	107,077
	LT Seniors		5,855	11,723
	LT Persons with Disabilities		1,308	2,619
	MN Seniors		76,154	152,466
	MN Persons with Disabilities		30,537	66,961
	MN Families		456,257	1,005,433
	MI Children		312	624
	MI Adults		31	62
	185% Poverty		18,521	45,350
	133% Poverty		96,959	214,252
	100% Poverty		48,096	107,021
	OTLICP		55,689	135,311
	ACA Optional Expansion		535,646	1,175,751
<b>Total</b>		<b>1,377,600</b>	<b>3,048,100</b>	
<b>PC 22 Minimum Wage Increase - Caseload Savings</b>	MN Families	(1,467)	(6,894)	(18,179)
	MI Children	(67)	(271)	(713)
	185% Poverty	(150)	(698)	(1,841)
	133% Poverty	(326)	(1,512)	(3,986)
	100% Poverty	(172)	(825)	(2,175)
	OTLICP	(395)	(1,915)	(5,049)
	ACA Optional Expansion	(1,644)	(6,807)	(17,949)
	<b>Total</b>	<b>(4,221)</b>	<b>(18,922)</b>	<b>(49,892)</b>
<b>PC 3 Undocumented Young Adults Full Scope Expansion</b>	MN Families	7,794	8,715	13,187
	185% Poverty	6,919	7,737	11,706
	ACA Optional Expansion	416	465	703
		<b>15,129</b>	<b>16,917</b>	<b>25,596</b>
<b>PC 1 FPL Increase for Aged And Disabled Persons</b>	MN Seniors		30,123	30,425
	MN Persons with Disabilities		9,365	9,458
		<b>39,488</b>	<b>39,883</b>	
<b>Total by Aid Category</b>	<b>Budget Aid Category</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>
	PA Seniors	0	5,101	10,212
	PA Persons with Disabilities	0	6,613	13,239
	PA Families	0	40,522	107,077
	LT Seniors	7	5,865	11,733
	LT Persons with Disabilities	0	1,308	2,619
	MN Seniors	35	106,312	182,926
	MN Persons with Disabilities	7	39,909	76,426
	MN Families	6,327	458,078	1,000,441
	MI Children	(64)	45	(85)
	MI Adults	0	31	62
	Undocumented Persons	0	0	0
	185% Poverty	6,771	25,562	55,218
	133% Poverty	(326)	95,447	210,266
	100% Poverty	(172)	47,271	104,846
	OTLICP	(395)	53,774	130,262
	ACA Optional Expansion	(967)	529,547	1,158,748
	MCAP Infants	869	909	909
	MCAP Mothers	4,676	4,132	4,132
	<b>Total</b>	<b>16,768</b>	<b>1,420,426</b>	<b>3,069,030</b>

**Comparison of Average Monthly Certified Eligibles  
November 2020 Estimate  
Fiscal Year 2020-21**

*(With Estimated Impact of Eligibility Policy Changes)*

	Appropriation 2020-2021	Nov 2020 2020-2021	Appropriation to Nov % Change
<b>Public Assistance</b>	<b>2,541,500</b>	<b>2,389,400</b>	<b>-5.98%</b>
Seniors	421,800	425,800	0.95%
Persons with Disabilities	914,800	917,300	0.27%
Families	1,204,900	1,046,300	-13.16%
<b>Long Term</b>	<b>54,600</b>	<b>61,600</b>	<b>12.82%</b>
Seniors	44,400	50,200	13.06%
Persons with Disabilities	10,200	11,400	11.76%
<b>Medically Needy</b>	<b>4,775,900</b>	<b>4,608,600</b>	<b>-3.50%</b>
Seniors	556,800	665,500	19.52%
Persons with Disabilities	318,400	234,800	-26.26%
Families	3,900,700	3,708,300	-4.93%
<b>Medically Indigent</b>	<b>155,800</b>	<b>149,500</b>	<b>-4.04%</b>
Children	152,700	146,300	-4.19%
Adults	3,100	3,200	3.23%
<b>Other</b>	<b>6,713,800</b>	<b>6,761,700</b>	<b>0.71%</b>
Refugees	500	600	20.00%
OBRA	300	0	-100.00%
185% Poverty	394,400	333,500	-15.44%
133% Poverty	855,200	811,700	-5.09%
100% Poverty	466,300	432,600	-7.23%
Opt. Targeted Low Income Children	1,083,500	960,300	-11.37%
ACA Optional Expansion	3,850,900	4,166,900	8.21%
Hospital PE	43,100	36,500	-15.31%
Medi-Cal Access Program	5,700	5,000	-12.28%
QMB	13,900	14,600	5.04%
<b>GRAND TOTAL</b>	<b>14,241,600</b>	<b>13,970,800</b>	<b>-1.90%</b>
<b>Seniors</b>	1,023,000	1,141,500	11.58%
<b>Persons with Disabilities</b>	1,243,400	1,163,500	-6.43%
<b>Families and Children</b>	8,057,700	7,439,000	-7.68%
<b>ACA Optional Expansion</b>	3,850,900	4,166,900	8.21%

**Estimated Average Monthly Certified Eligibles  
November 2020 Estimate  
Fiscal Years 2019-2020, 2020-2021 & 2021-22**

<b>Managed Care<sup>1</sup></b> <i>(With Estimated Impact of Eligibility Policy Changes)<sup>***</sup></i>					
	<b>2019-2020</b>	<b>2020-2021</b>	<b>2021-2022</b>	<b>19-20 To 20-21 % Change</b>	<b>20-21 To 21-22 % Change</b>
<b>Public Assistance</b>	<b>2,031,193</b>	<b>2,072,046</b>	<b>2,142,282</b>	<b>2.01%</b>	<b>3.39%</b>
Seniors	322,021	328,810	336,332	2.11%	2.29%
Persons with Disabilities	790,490	795,107	801,803	0.58%	0.84%
Families	918,683	948,129	1,004,147	3.21%	5.91%
<b>Long Term</b>	<b>30,713</b>	<b>37,756</b>	<b>44,652</b>	<b>22.93%</b>	<b>18.26%</b>
Seniors	25,284	31,167	36,821	23.27%	18.14%
Persons with Disabilities	5,430	6,589	7,831	21.36%	18.85%
<b>Medically Needy</b>	<b>3,153,408</b>	<b>3,710,805</b>	<b>4,323,180</b>	<b>17.68%</b>	<b>16.50%</b>
Seniors	387,362	507,950	597,034	31.13%	17.54%
Persons with Disabilities	136,343	178,100	211,527	30.63%	18.77%
Families	2,629,702	3,024,756	3,514,619	15.02%	16.20%
<b>Medically Indigent</b>	<b>47,072</b>	<b>48,405</b>	<b>48,854</b>	<b>2.83%</b>	<b>0.93%</b>
Children	47,014	48,306	48,725	2.75%	0.87%
Adults	58	99	129	70.80%	29.72%
<b>Other</b>	<b>5,144,527</b>	<b>5,794,746</b>	<b>6,614,245</b>	<b>12.64%</b>	<b>14.14%</b>
Refugees	417	474	507	13.68%	6.89%
OBRA	0	8	9	n/a	9.09%
185% Poverty	192,063	203,166	229,754	5.78%	13.09%
133% Poverty	689,213	767,812	871,516	11.40%	13.51%
100% Poverty	375,677	417,504	470,634	11.13%	12.73%
Opt. Targeted Low Income Children	848,433	899,808	970,147	6.06%	7.82%
ACA Optional Expansion	3,033,416	3,501,179	4,066,884	15.42%	16.16%
Medi-Cal Access Program	5,308	4,795	4,795	-9.67%	0.00%
<b>GRAND TOTAL <sup>1</sup></b>	<b>10,406,913</b>	<b>11,663,759</b>	<b>13,173,214</b>	<b>12.08%</b>	<b>12.94%</b>
<b>Percent of Statewide</b>	<b>81.99%</b>	<b>83.49%</b>	<b>84.42%</b>		
<b>Seniors</b>	734,667	867,926	970,188	18.14%	11.78%
<b>Persons with Disabilities</b>	932,262	979,796	1,021,161	5.10%	4.22%
<b>Families and Children</b>	5,700,785	6,309,481	7,109,541	10.68%	12.68%
<b>ACA Optional Expansion</b>	3,033,416	3,501,179	4,066,884	15.42%	16.16%

<sup>\*\*\*</sup> See Attached Chart reflecting impact of Policy Changes.

<sup>1</sup> Eligibles enrolled or estimated to be enrolled in a medical Managed Care plan.

**Estimated Average Monthly Certified Eligibles  
November 2020 Estimate  
Fiscal Years 2019-2020, 2020-2021 & 2021-22**

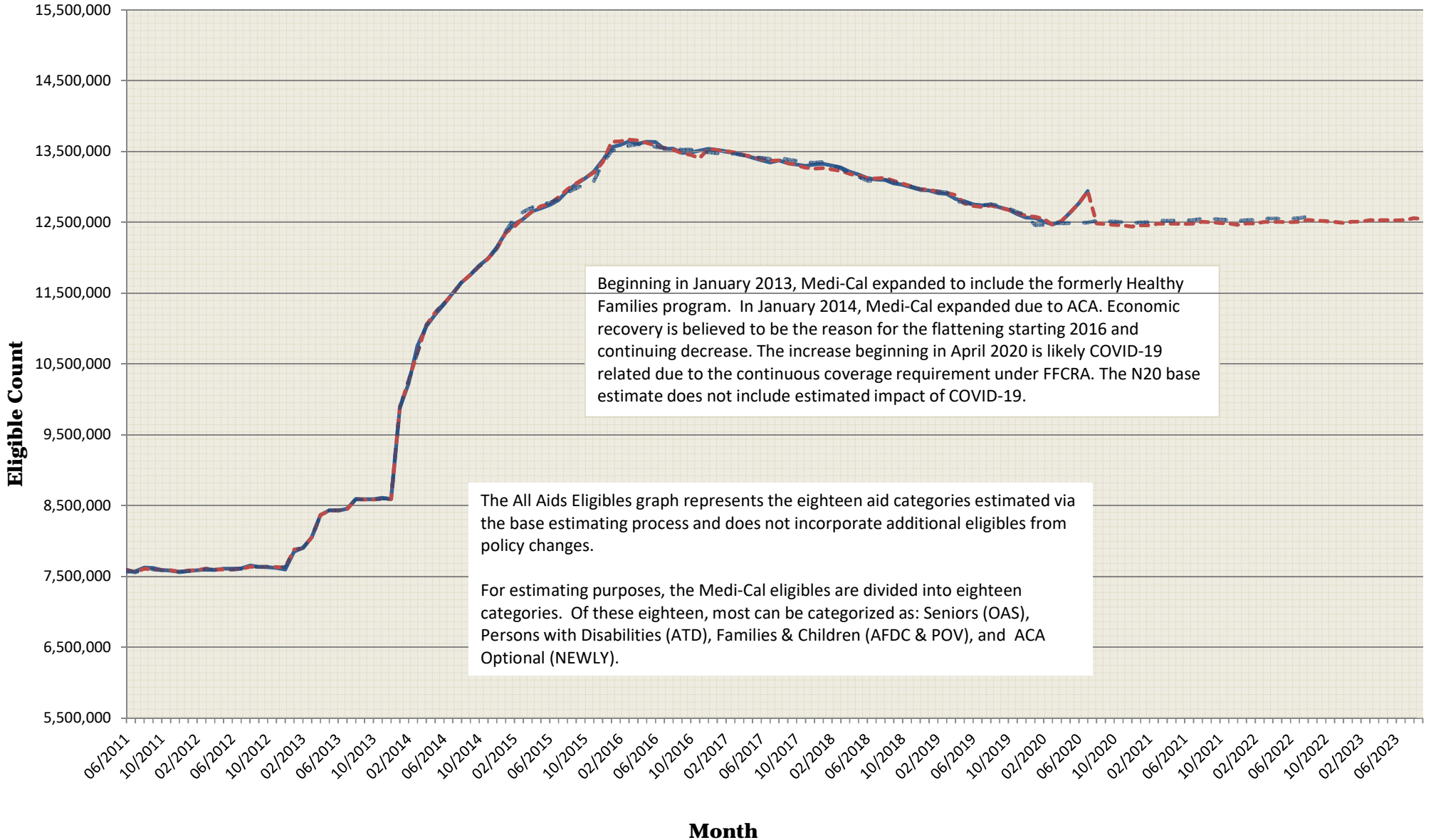
<b>Fee-For-Service</b> <i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	<b>2019-2020</b>	<b>2020-2021</b>	<b>2021-2022</b>	<b>19-20 To 20-21 % Change</b>	<b>20-21 To 21-22 % Change</b>
<b>Public Assistance</b>	<b>317,207</b>	<b>317,354</b>	<b>323,618</b>	<b>0.05%</b>	<b>1.97%</b>
Seniors	98,879	96,990	94,768	-1.91%	-2.29%
Persons with Disabilities	124,910	122,193	122,497	-2.18%	0.25%
Families	93,417	98,171	106,353	5.09%	8.33%
<b>Long Term</b>	<b>23,587</b>	<b>23,844</b>	<b>24,248</b>	<b>1.09%</b>	<b>1.69%</b>
Seniors	18,816	19,033	19,379	1.15%	1.82%
Persons with Disabilities	4,771	4,811	4,869	0.85%	1.21%
<b>Medically Needy</b>	<b>884,192</b>	<b>897,795</b>	<b>948,120</b>	<b>1.54%</b>	<b>5.61%</b>
Seniors	147,138	157,550	168,766	7.08%	7.12%
Persons with Disabilities	54,857	56,700	59,073	3.36%	4.18%
Families	682,198	683,544	720,281	0.20%	5.37%
<b>Medically Indigent</b>	<b>105,728</b>	<b>101,095</b>	<b>100,846</b>	<b>-4.38%</b>	<b>-0.25%</b>
Children	101,986	97,994	97,675	-3.91%	-0.33%
Adults	3,742	3,101	3,171	-17.13%	2.27%
<b>Other</b>	<b>954,673</b>	<b>966,954</b>	<b>1,033,755</b>	<b>1.29%</b>	<b>6.91%</b>
Refugees	283	126	193	-55.56%	53.56%
OBRA	300	(8)	(9)	-102.69%	9.09%
185% Poverty	141,237	130,334	132,146	-7.72%	1.39%
133% Poverty	40,787	43,888	52,184	7.60%	18.90%
100% Poverty	15,323	15,096	19,266	-1.48%	27.62%
Opt. Targeted Low Income Children	58,367	60,492	67,653	3.64%	11.84%
ACA Optional Expansion	651,184	665,721	710,716	2.23%	6.76%
Hospital PE	32,800	36,500	36,800	11.28%	0.82%
Medi-Cal Access Program	192	206	206	6.80%	0.00%
QMB	14,200	14,600	14,600	2.82%	0.00%
<b>GRAND TOTAL</b>	<b>2,285,387</b>	<b>2,307,041</b>	<b>2,430,586</b>	<b>0.95%</b>	<b>5.36%</b>
<b>Percent of Statewide</b>	<b>18.01%</b>	<b>16.51%</b>	<b>15.58%</b>		
<b>Seniors</b>	264,833	273,574	282,912	3.30%	3.41%
<b>Persons with Disabilities</b>	184,538	183,704	186,439	-0.45%	1.49%
<b>Families and Children</b>	1,133,315	1,129,519	1,195,559	-0.33%	5.85%
<b>ACA Optional Expansion</b>	651,184	665,721	710,716	2.23%	6.76%

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

# Statewide Expanded Eligible for Aid Category: All Aids

Certified Average Monthly Eligible Count by Month

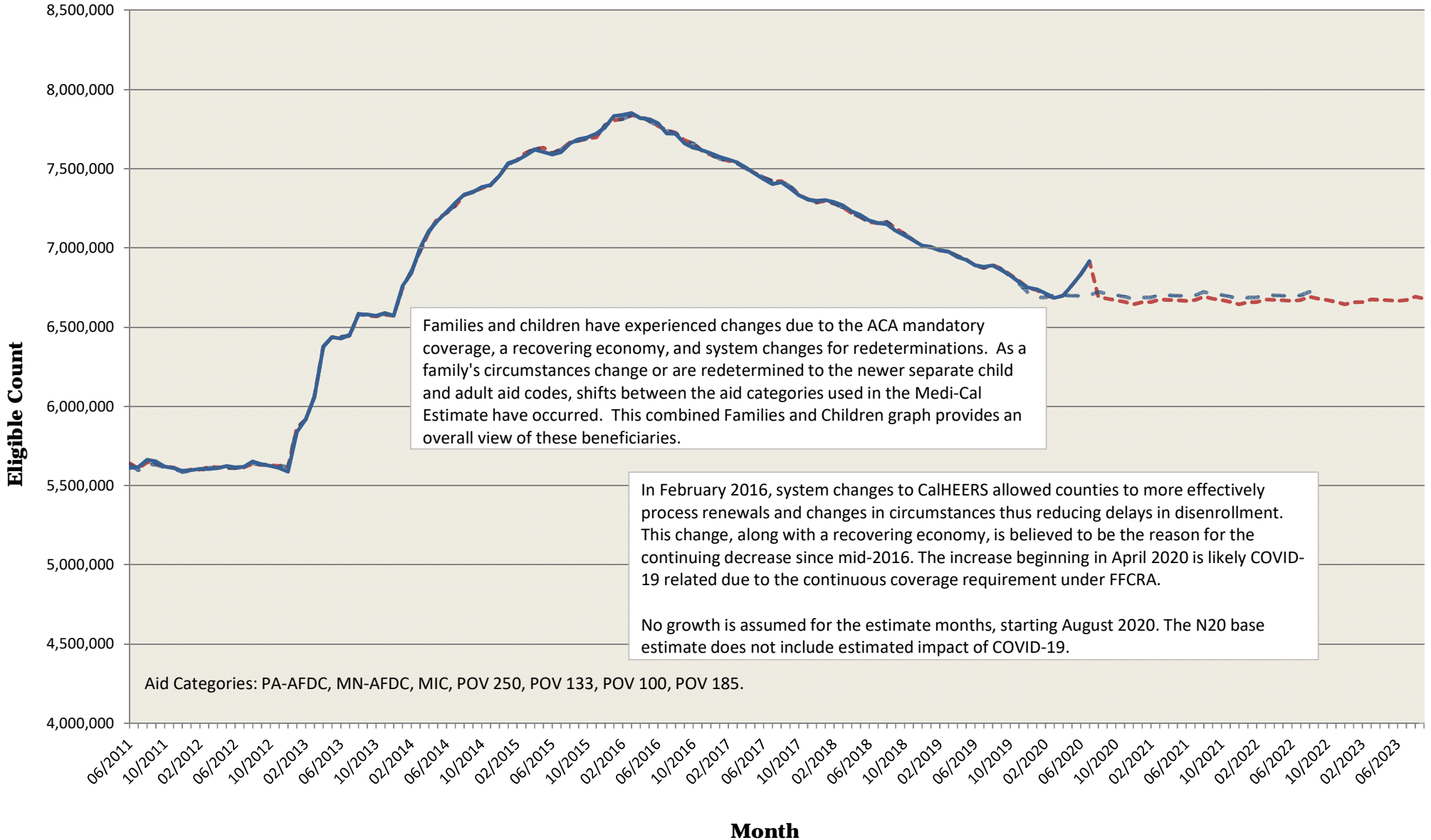
--- N20  
 - - - M20  
 — Actuals



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

Certified Average Monthly Eligible Count by Month

--- N20  
--- M20  
— Actuals

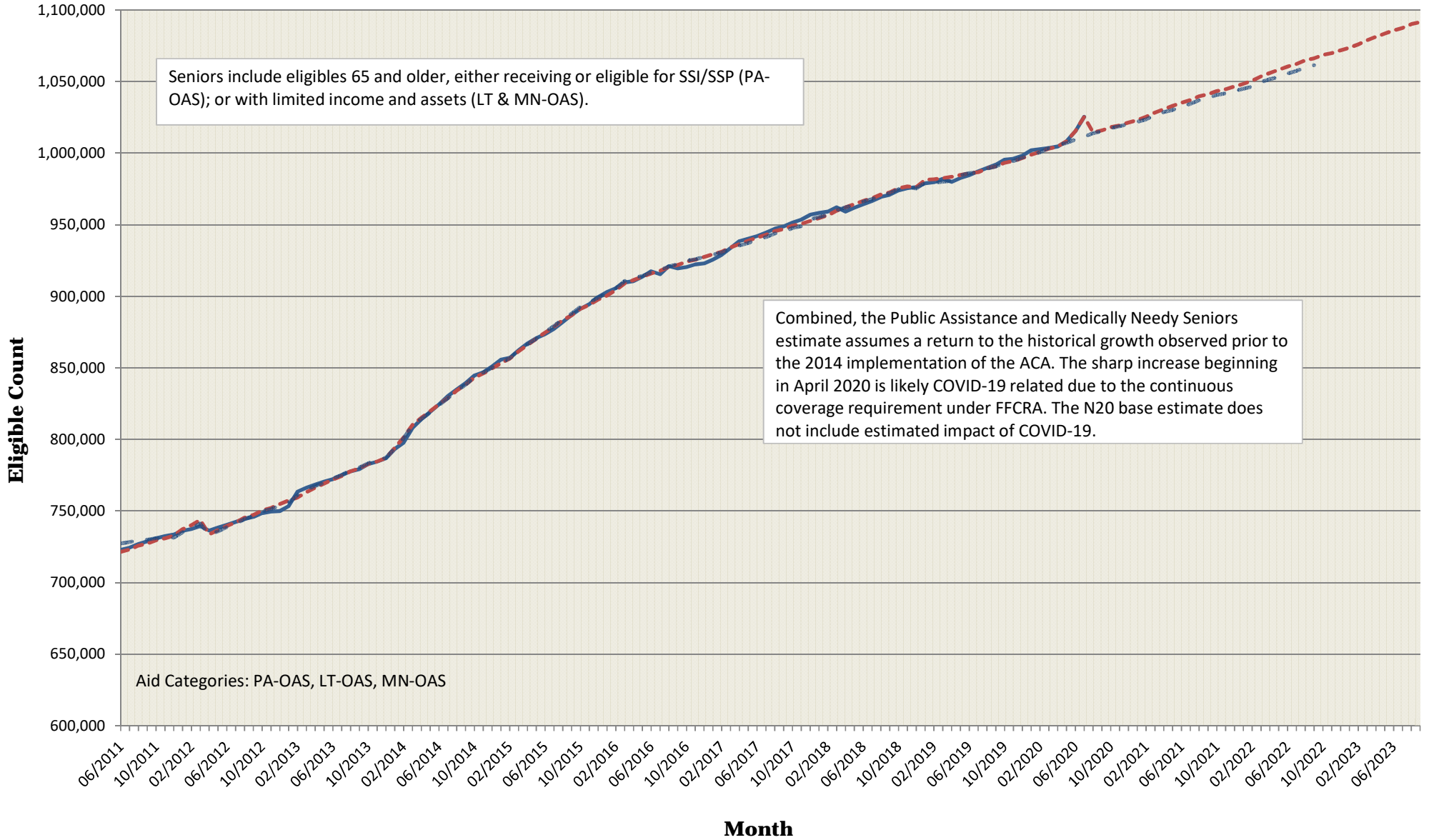




# Statewide Expanded Eligible for Aid Category: Seniors

Certified Average Monthly Eligible Count by Month

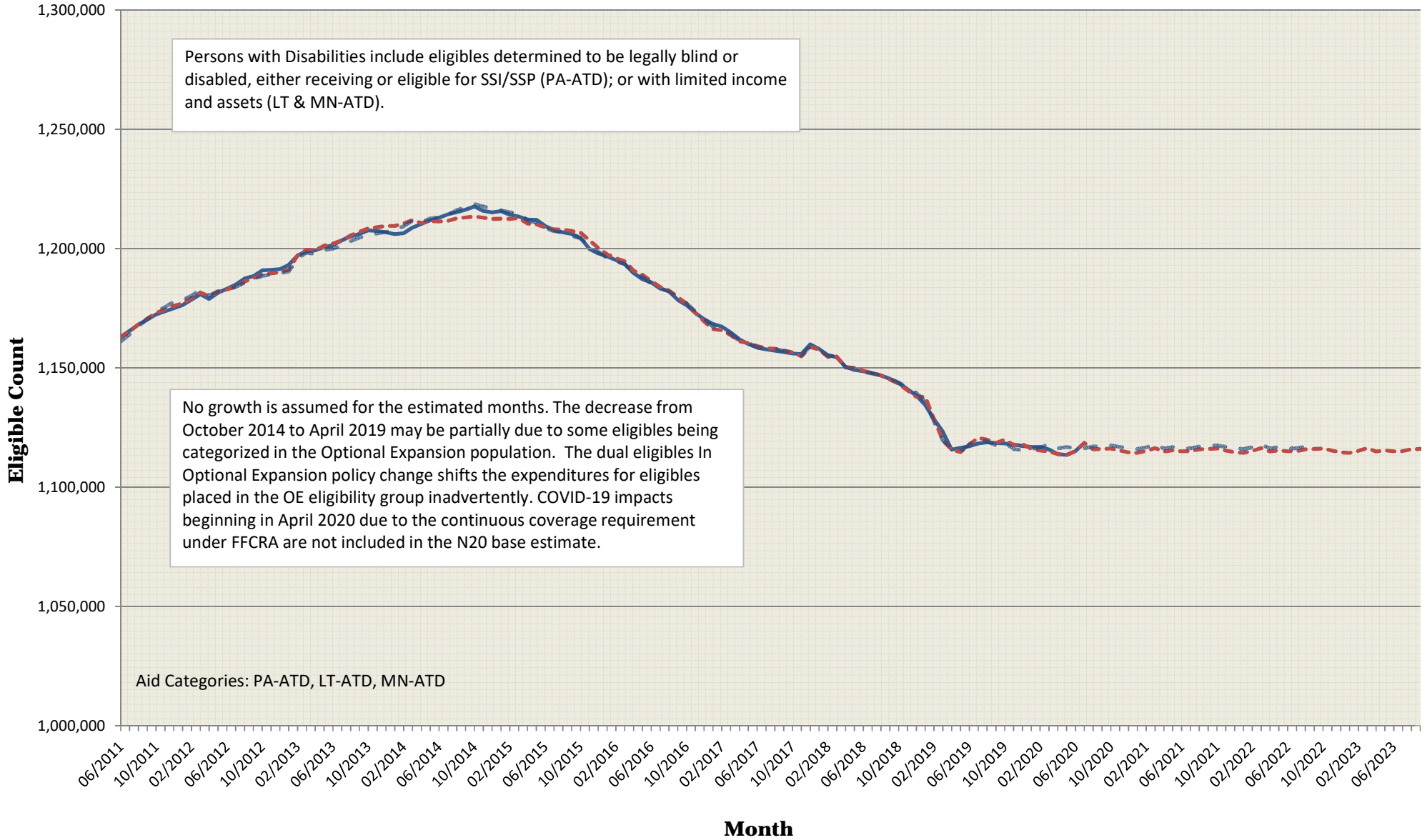
- - - N20  
- - - M20 Estimate  
— Actuals



# Statewide Expanded Eligible for Aid Category: Persons with Disabilities

Certified Average Monthly Eligible Count by Month

--- N20  
 --- M20  
 — Actuals



# Statewide Expanded Eligible: ACA Optional Expansion (NEWLY)

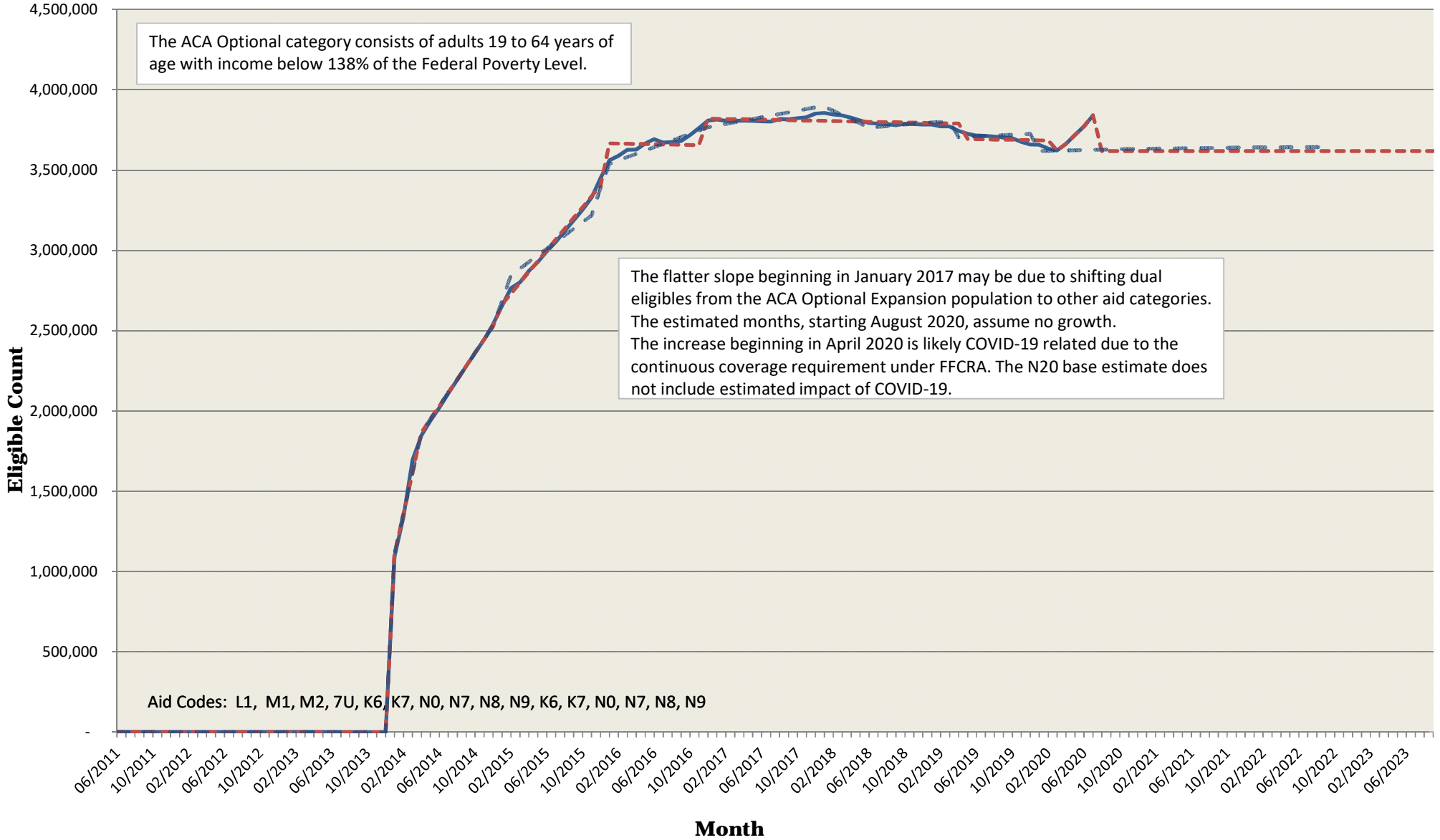
Certified Average Monthly Eligible Count by Month

--- N20  
 - - - M20  
 — Actuals

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 2020, assume no growth. The increase beginning in April 2020 is likely COVID-19 related due to the continuous coverage requirement under FFCRA. The N20 base estimate does not include estimated impact of COVID-19.

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



**MEDI-CAL AID CATEGORY DEFINITIONS**

<b>Aid Category</b>	<b>Aid Codes</b>
Seniors	10, 16, 1E, 13, D2, D3 J5, J6, 14, 17, 1H, 1U, 1X, 1Y, C1, C2
Disabled	20, 26, 2E, 36, 60, 66, 6A, 6C, 6E, 6N, 6P, 23, 63, D4, D5, D6, D7, J7, J8, 24, 27, 2H, 64, 67, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G, C3, C4, C7, C8, K8, K9, L6, L7
Families and Children (Including Pregnant Women)	2S, 2T, 2U, 30, 32, 33, 35, 38, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 40, 42, 43, 49, 4F, 4G, 4H, 4N, 4S, 4T, 4W, 5L, K1, R1, 34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 6J, 6R, 7J, 7K, 7S, 7W, C5, C6, M3, M4, P5, P6, 7A, 7C, 8R, 8T, M5, M6, 72, 74, 8N, 8P, P7, P8, 44, 47, 48, 5F, 69, 76, 7F, 7G, 8U, 8V, D8, D9, M0, M7, M8, M9, P0, P9, 5C, 5D, 8X, E6, H1, H2, H3, H4, H5, T0, T1, T2, T3, T4, T5, T6, T7, T8, T9, 03, 04, 06, 07, 2A, 2P, 2R, 45, 46, 4A, 4L, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 82, 83, 8E, 8W, C9, D1, G5, G6, G7, G8
Newly	7U, K6, K7, L1, M1, M2, N0, N7, N8, N9
HP-E	4E, H0, H6, H7, H8, H9, P1, P2, P3, P4, 7D
All Others	53, 81, 86, 87, 8L, F3, F4, G3, G4, J1, J2, J3, J4, 01, 02, 08, 0A, 55, 58

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*The Fee-For-Service (FFS) Base section provides a detailed overview of projected FFS benefits expenditures by service category and base aid category.*

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**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 the most recent 36 months of 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 2020 FFS Base Estimate**

Fiscal Year		November 2020 Estimate Total Expenditure	
<b>PY</b>	FY 2019-20	\$17,054,572,700	--
<b>CY</b>	FY 2020-21	\$17,772,825,400	4.2%
<b>BY</b>	FY 2021-22	\$18,329,726,300	3.1%

Fiscal Year	FFS Base Expenditure		
	May-20	Nov-20	% Chng
FY 2019-20	\$17,432,458,800	\$17,054,572,700	-2.2%
FY 2020-21	\$17,897,434,100	\$17,772,825,400	-0.7%

Overall, the November 2020 FFS Base is estimated at \$17.8 billion for FY 2020-21 and \$18.3 billion for FY 2021-22. Compared to the May 2020 Estimate, the FFS Base total expenditures decreased by 2.2% for FY 2019-20 and remained relatively unchanged for FY 2020-21.

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

## Items Impacting FFS Base Estimate

**Overall Decreases Relative to Previous Estimates:** The total FFS expenditure decrease in 2019-20 and 2020-21 is attributable mainly to fewer people using services. This is assumed to be caused by the COVID-19 pandemic and related stay-at-home orders. This impact is seen in almost all service categories, but is most noticeable in Other Medical, Other Services, and Pharmacy. Except for July 2020 which is actual data, estimated total expenditures for the current year are assumed to have no COVID impact because this impact is estimated in a separate policy change.

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

**HIPAA 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.

**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 had 251 processing days, CY has 253 processing days and BY has 255 processing days. This increases costs marginally for CY and BY.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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	
2018-19 *	1	2,036,100	3.29	\$240.56	\$790.39	\$4,827,950,200
2018-19 *	2	1,908,320	3.03	\$242.90	\$736.56	\$4,216,771,000
2018-19 *	3	1,932,850	3.09	\$238.08	\$735.39	\$4,264,201,300
2018-19 *	4	1,811,770	2.99	\$236.60	\$708.35	\$3,850,128,500
2018-19 *	TOTAL	1,922,260	3.10	\$239.61	\$743.87	\$17,159,051,000
2019-20 *	1	2,089,650	3.33	\$241.29	\$803.16	\$5,034,956,100
2019-20 *	2	1,947,270	3.03	\$238.18	\$722.12	\$4,218,498,600
2019-20 *	3	1,989,190	3.01	\$240.94	\$725.25	\$4,327,999,600
2019-20 *	4	1,398,150	3.16	\$262.41	\$828.03	\$3,473,118,400
2019-20 *	TOTAL	1,856,070	3.13	\$244.42	\$765.71	\$17,054,572,700
2020-21 **	1	1,947,140	3.28	\$259.43	\$850.36	\$4,967,295,600
2020-21 **	2	2,043,490	3.09	\$248.74	\$768.50	\$4,711,305,300
2020-21 **	3	1,880,200	2.94	\$246.84	\$726.28	\$4,096,680,000
2020-21 **	4	1,843,850	2.97	\$243.40	\$722.68	\$3,997,544,500
2020-21 **	TOTAL	1,928,670	3.07	\$249.94	\$767.92	\$17,772,825,400
2021-22 **	1	2,174,130	3.31	\$252.69	\$836.18	\$5,453,873,700
2021-22 **	2	1,957,160	3.02	\$251.76	\$759.32	\$4,458,337,200
2021-22 **	3	1,968,130	3.03	\$250.17	\$758.88	\$4,480,727,900
2021-22 **	4	1,827,960	2.92	\$245.97	\$717.88	\$3,936,787,400
2021-22 **	TOTAL	1,981,840	3.08	\$250.38	\$770.74	\$18,329,726,300

\* ACTUAL

\*\* ESTIMATED

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



## Physicians Fee-for-Service Base Estimate

**Analyst:** Cari Porter

**Background:** The Physicians category include services billed by physicians (M.D or D.O) & physician groups.

Fiscal Year		Users		Utilization (Claims per User)		Rate (Cost per Unit)		Total Expenditure	
<b>PY</b>	FY 2019-20	296,900	--	2.41	--	\$80.95	--	\$693,667,000	--
<b>CY</b>	FY 2020-21	296,560	-0.1%	2.43	1.0%	\$84.34	4.2%	\$729,360,600	5.1%
<b>BY</b>	FY 2021-22	305,240	2.9%	2.43	-0.1%	\$84.28	-0.1%	\$749,174,200	2.7%

**Users:** Users are estimated to remain relatively unchanged for CY and increase by 2.9% in BY.

**Utilization:** Claims per user are estimated to increase by 1.0% in CY and remain relatively stable in BY.

**Rate:** The rate increase of 4.2% from PY to CY is partially due to the Radiology Retroactive Rate adjustments which occurred mainly in July 2019. The adjustments lowered the rate in PY and are not assumed to occur in CY. Rate in BY remains relatively unchanged.

**Total Expenditure:** CY is estimated to increase by 5.1% mainly due to the increase in Rate and the slight increase in Utilization. BY is estimated to increase by 2.7% due to the increase in Users.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$710,314,000	\$693,667,000	-2.3%
FY 2020-21	\$729,499,200	\$729,360,600	0.0%

Compared to the May 2020 Estimate, the November 2020 Estimate is lower by 2.3% for FY 2019-20 due primarily to the decrease in Users correlated to the COVID-19 public health emergency and partially offset with an increase in rates due to Radiological Rate adjustments. The estimate is relatively unchanged for FY 2020-21 with the decrease in users offset by an increase in the rate.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	341,200	2.41	\$79.51	\$191.69	\$196,211,000
2018-19 *	2	318,750	2.37	\$82.80	\$195.96	\$187,387,800
2018-19 *	3	330,340	2.32	\$79.17	\$183.45	\$181,806,700
2018-19 *	4	286,170	2.28	\$80.32	\$183.33	\$157,386,700
2018-19 *	TOTAL	319,120	2.35	\$80.43	\$188.75	\$722,792,200
2019-20 *	1	343,510	2.48	\$76.78	\$190.33	\$196,138,600
2019-20 *	2	297,060	2.39	\$82.97	\$198.01	\$176,466,700
2019-20 *	3	322,880	2.35	\$81.71	\$192.22	\$186,197,300
2019-20 *	4	224,150	2.39	\$83.85	\$200.56	\$134,864,300
2019-20 *	TOTAL	296,900	2.41	\$80.95	\$194.70	\$693,667,000
2020-21 **	1	301,230	2.58	\$85.93	\$221.32	\$200,005,100
2020-21 **	2	310,910	2.45	\$85.33	\$209.49	\$195,401,400
2020-21 **	3	298,400	2.32	\$82.93	\$192.30	\$172,150,200
2020-21 **	4	275,690	2.36	\$82.77	\$195.63	\$161,803,900
2020-21 **	TOTAL	296,560	2.43	\$84.34	\$204.95	\$729,360,600
2021-22 **	1	338,000	2.57	\$85.81	\$220.22	\$223,296,600
2021-22 **	2	296,280	2.41	\$85.33	\$205.69	\$182,823,400
2021-22 **	3	313,960	2.38	\$83.00	\$197.36	\$185,893,000
2021-22 **	4	272,750	2.33	\$82.53	\$192.07	\$157,161,300
2021-22 **	TOTAL	305,240	2.43	\$84.28	\$204.53	\$749,174,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

## Other Medical Fee-for-Service Base Estimate

**Analyst:** Cari Porter

**Background:** Other Medical includes clinics and specialist service providers. Payments to Federally Qualified Health Care Centers and Rural Health Centers (FQHC/RHC) are approximately 85% 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 Expenditures	
<b>PY</b>	FY 2019-20	1,150,140	--	1.57	--	\$173.32	--	\$3,751,919,700	--
<b>CY</b>	FY 2020-21	1,220,800	6.1%	1.57	0.3%	\$176.54	1.9%	\$4,069,596,800	8.5%
<b>BY</b>	FY 2021-22	1,259,710	3.2%	1.57	-0.2%	\$176.91	0.2%	\$4,199,975,500	3.2%

**Users:** Users are estimated to increase by 6.1% in CY and 3.2% in BY due to a return to pre-COVID-19 pandemic levels and modest increases in FQHC users. Users decreased in PY and July 2020 due to the COVID-19 public health emergency. Future impacts related to COVID-19 are estimated through a separate policy change.

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

**Rate:** Rate is estimated to increase by 1.9% in CY due 2019 FQHC rate increases. Rate increases were partially offset by Clinical Laboratories retroactive savings. The BY rate is estimated to remain relatively unchanged. Future rate increases for FQHC, CBRC, and Indian Health are estimated through policy changes.

**Total Expenditure:** CY is estimated to increase by 8.5% primarily due to the increase in Users along with a smaller impact from the increase in Rates. BY is estimated to increase by 3.2% due to the increase in Users.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$3,972,850,700	\$3,751,919,700	-5.6%
FY 2020-21	\$4,082,774,200	\$4,069,596,800	-0.3%

Compared to the May 2020 2019 Estimate, the November 2020 Estimate is lower by 5.6% for FY 2019-20 and 0.3% for 2020-21 due to the decrease in users caused by the COVID-19 public health emergency.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**OTHER MEDICAL**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	1,285,960	1.62	\$164.34	\$266.17	\$1,026,856,800
2018-19 *	2	1,174,050	1.55	\$166.09	\$257.84	\$908,143,500
2018-19 *	3	1,186,890	1.56	\$168.63	\$262.81	\$935,782,700
2018-19 *	4	1,117,640	1.56	\$170.38	\$265.25	\$889,364,400
2018-19 *	TOTAL	1,191,130	1.57	\$167.23	\$263.06	\$3,760,147,400
2019-20 *	1	1,331,970	1.62	\$170.79	\$276.63	\$1,105,399,200
2019-20 *	2	1,216,610	1.55	\$173.53	\$268.56	\$980,200,200
2019-20 *	3	1,241,600	1.55	\$178.36	\$276.38	\$1,029,475,900
2019-20 *	4	810,400	1.54	\$169.64	\$261.95	\$636,844,500
2019-20 *	TOTAL	1,150,140	1.57	\$173.32	\$271.84	\$3,751,919,700
2020-21 **	1	1,255,430	1.65	\$174.69	\$288.36	\$1,086,049,400
2020-21 **	2	1,297,280	1.57	\$178.20	\$280.41	\$1,091,300,000
2020-21 **	3	1,167,570	1.53	\$177.49	\$271.57	\$951,235,600
2020-21 **	4	1,162,900	1.53	\$175.82	\$269.73	\$941,011,900
2020-21 **	TOTAL	1,220,800	1.57	\$176.54	\$277.80	\$4,069,596,800
2021-22 **	1	1,422,230	1.65	\$176.22	\$290.51	\$1,239,501,300
2021-22 **	2	1,233,520	1.55	\$178.20	\$275.53	\$1,019,613,500
2021-22 **	3	1,231,790	1.56	\$177.46	\$277.06	\$1,023,843,400
2021-22 **	4	1,151,290	1.51	\$175.81	\$265.50	\$917,017,100
2021-22 **	TOTAL	1,259,710	1.57	\$176.91	\$277.84	\$4,199,975,500

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

## County & Community Outpatient Fee-for-Service Base Estimate

**Analyst:** My-Ai Bui

**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 Expenditures	
<b>PY</b>	FY 2019-20	188,360	--	1.54	--	\$159.44	--	\$555,561,800	--
<b>CY</b>	FY 2020-21	191,240	1.5%	1.54	0.0%	\$165.10	3.5%	\$585,062,700	5.3%
<b>BY</b>	FY 2021-22	197,320	3.2%	1.55	0.6%	\$164.07	-0.6%	\$600,871,600	2.7%

**Users:** Users are estimated to increase by 1.5% in CY and 3.2% in BY because PY actuals reflect reduced utilization under the COVID-19 pandemic and the estimated months for CY and BY assume no COVID-19 impact. Additional COVID-19 impact after July 2020 is budgeted in a separate policy change.

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

**Rate:** Rate is estimated to increase by 3.5% in CY and remain unchanged for BY.

**Total Expenditure:** CY is estimated to increase by 5.3% due primarily assuming estimated users remain at pre-COVID level. BY is estimated to increase by 2.7% due to increase in users.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$572,149,000	\$555,561,800	-2.9%
FY 2020-21	\$592,075,800	\$585,062,700	-1.2%

Compared to the May 2020 2019 Estimate, total expenditures decrease by 2.9% and 1.2% for FY 2019-20 and FY 2020-21, respectively. This is mainly due to fewer people using services during the COVID-19 pandemic.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**CO. & COMM. OUTPATIENT**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	226,560	1.56	\$156.86	\$244.24	\$166,006,900
2018-19 *	2	216,300	1.52	\$141.81	\$215.34	\$139,736,100
2018-19 *	3	204,770	1.51	\$155.83	\$235.22	\$144,496,100
2018-19 *	4	183,890	1.51	\$149.05	\$224.42	\$123,806,800
2018-19 *	TOTAL	207,880	1.52	\$151.00	\$230.12	\$574,045,800
2019-20 *	1	224,390	1.57	\$151.30	\$238.01	\$160,222,400
2019-20 *	2	200,690	1.54	\$153.81	\$237.44	\$142,952,500
2019-20 *	3	196,710	1.52	\$157.22	\$239.51	\$141,346,200
2019-20 *	4	131,640	1.51	\$185.99	\$281.17	\$111,040,700
2019-20 *	TOTAL	188,360	1.54	\$159.44	\$245.79	\$555,561,800
2020-21 **	1	197,030	1.59	\$175.07	\$279.02	\$164,927,300
2020-21 **	2	204,210	1.57	\$162.05	\$253.65	\$155,389,600
2020-21 **	3	185,880	1.50	\$165.07	\$247.49	\$138,012,200
2020-21 **	4	177,820	1.51	\$157.10	\$237.57	\$126,733,600
2020-21 **	TOTAL	191,240	1.54	\$165.10	\$254.95	\$585,062,700
2021-22 **	1	222,790	1.61	\$170.97	\$274.48	\$183,459,200
2021-22 **	2	196,220	1.54	\$161.92	\$249.69	\$146,978,600
2021-22 **	3	194,220	1.53	\$164.99	\$252.08	\$146,876,800
2021-22 **	4	176,060	1.50	\$156.14	\$233.93	\$123,557,100
2021-22 **	TOTAL	197,320	1.55	\$164.07	\$253.76	\$600,871,600

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

## Pharmacy Fee-for-Service Base Estimate

**Analyst:** Alvin Bautista

**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 2019-20	431,940	--	2.81	--	\$226.33	--	\$3,296,938,500	--
CY	FY 2020-21	432,520	0.1%	2.82	0.4%	\$244.58	8.1%	\$3,575,843,600	8.5%
BY	FY 2021-22	438,170	1.3%	2.83	0.4%	\$259.19	6.0%	\$3,853,444,500	7.8%

**Users:** Users are projected to remain steady from PY through BY.

**Utilization:** Utilization is projected to remain steady from PY through BY at 2.8 prescriptions per user.

**Rate:** Rate increased by 8.1% from PY to CY because April and May 2020 actual rates were higher than expected. The BY is estimated to increase by 6.0%, consistent with the historical rate growth.

**Total Expenditure:** Total expenditure is estimated to increase by 8.5% in CY due to rates higher than expected. Expenditures estimated to increase by 7.8% in BY due to the historical rate growth and a slight increase in users.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$3,323,985,500	\$3,296,938,500	-0.8%
FY 2020-21	\$3,593,690,500	\$3,575,843,600	-0.5%

Compared to the May 2020 Estimate, the November 2020 Estimate is lower by 0.8% and 0.5% for FY 2019-20 and FY 2020-21, respectively. This is mainly due to a slight decrease in users.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	470,970	2.98	\$255.77	\$762.61	\$1,077,495,000
2018-19 *	2	444,370	2.75	\$255.03	\$702.53	\$936,547,500
2018-19 *	3	453,030	2.76	\$249.55	\$689.40	\$936,961,800
2018-19 *	4	393,800	2.67	\$240.49	\$642.94	\$759,565,000
2018-19 *	TOTAL	440,540	2.80	\$250.75	\$701.89	\$3,710,569,300
2019-20 *	1	469,700	3.01	\$225.32	\$677.96	\$955,309,600
2019-20 *	2	443,160	2.75	\$219.14	\$603.01	\$801,689,600
2019-20 *	3	448,050	2.74	\$221.69	\$608.37	\$817,729,300
2019-20 *	4	366,870	2.71	\$242.31	\$656.19	\$722,210,000
2019-20 *	TOTAL	431,940	2.81	\$226.33	\$636.07	\$3,296,938,500
2020-21 **	1	452,780	3.04	\$243.19	\$738.81	\$1,003,556,000
2020-21 **	2	453,910	2.85	\$241.30	\$687.25	\$935,842,200
2020-21 **	3	423,190	2.67	\$242.90	\$648.48	\$823,298,200
2020-21 **	4	400,220	2.69	\$252.08	\$677.26	\$813,147,100
2020-21 **	TOTAL	432,520	2.82	\$244.58	\$688.95	\$3,575,843,600
2021-22 **	1	478,130	3.09	\$258.69	\$800.48	\$1,148,198,500
2021-22 **	2	438,060	2.76	\$255.50	\$704.50	\$925,841,800
2021-22 **	3	439,330	2.78	\$257.59	\$717.10	\$945,138,200
2021-22 **	4	397,160	2.63	\$266.01	\$700.19	\$834,266,000
2021-22 **	TOTAL	438,170	2.83	\$259.19	\$732.87	\$3,853,444,500

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of prescriptions



## County Inpatient Fee-for-Service Base Estimate

**Analyst:** Adriana Oprea

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

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
<b>PY</b>	FY 2019-20	4,000	--	4.69	--	\$3,361.70	--	\$756,439,300	--
<b>CY</b>	FY 2020-21	3,880	-3.0%	4.86	3.6%	\$3,495.24	4.0%	\$790,229,100	4.5%
<b>BY</b>	FY 2021-22	3,990	2.8%	4.82	-0.8%	\$3,490.53	-0.1%	\$805,272,200	1.9%

**Users:** Users are estimated to decrease by -3.0% from PY to CY. This is mainly due to low actual users in July attributable to COVID-19 pandemic. The BY estimate assumes a return to the pre-COVID level. The ongoing COVID-19 impact is estimated in a separate policy change.

**Utilization:** Utilization, or the number of days stay per user, is expected to increase by 3.6%, in CY, correlating to the COVID-19 pandemic. The Utilization from CY to BY is estimated to decrease slightly due to potential diminished COVID-19 impact.

**Rate:** Rate, or the cost per day, is estimated to increase by 3.9% from PY to CY, mainly due to the FY 2019-20 DPH interim rate increase of 6.74% implemented in July 2019. CY incorporates a full year impact of the rate increase and is fully incorporated in the base. Future rate increases are budgeted in a separate policy change.

**Total Expenditures:** Total expenditures are estimated to increase by 4.4% in CY due to estimated increases in Utilization and Rate, partially offset by a decrease in users. Total expenditures are estimate to increase by 1.9% in BY due to users returning to the pre-COVID user level in the base estimate.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$821,474,600	\$756,439,300	-7.9%
FY 2020-21	\$870,000,800	\$789,728,400	-9.2%

Compared to the May 2020 estimate, the November 2020 estimate is lower by 7.9% in FY 2019-20 and 9.2% in FY 2020-21. This is attributable to fewer days per user than assumed in the M20 Estimate.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**COUNTY INPATIENT**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	4,700	5.26	\$2,947.41	\$15,513.77	\$218,759,600
2018-19 *	2	4,320	4.93	\$3,128.12	\$15,427.86	\$199,852,500
2018-19 *	3	4,360	4.79	\$3,238.62	\$15,517.60	\$203,109,900
2018-19 *	4	11,900	1.61	\$3,217.29	\$5,175.34	\$184,827,100
2018-19 *	TOTAL	6,320	3.40	\$3,122.86	\$10,632.49	\$806,549,100
2019-20 *	1	4,540	4.92	\$3,222.64	\$15,865.90	\$216,046,000
2019-20 *	2	4,140	4.40	\$3,462.91	\$15,237.05	\$189,137,500
2019-20 *	3	4,450	4.82	\$3,436.91	\$16,571.72	\$221,199,300
2019-20 *	4	2,870	4.53	\$3,334.87	\$15,091.26	\$130,056,500
2019-20 *	TOTAL	4,000	4.69	\$3,361.70	\$15,760.46	\$756,439,300
2020-21 **	1	4,130	5.00	\$3,477.23	\$17,398.77	\$215,446,600
2020-21 **	2	4,100	4.80	\$3,513.23	\$16,849.61	\$207,382,700
2020-21 **	3	3,970	4.79	\$3,505.46	\$16,806.79	\$199,937,300
2020-21 **	4	3,320	4.82	\$3,484.24	\$16,794.06	\$167,462,600
2020-21 **	TOTAL	3,880	4.86	\$3,495.24	\$16,972.83	\$790,229,100
2021-22 **	1	4,610	4.91	\$3,475.62	\$17,057.23	\$235,851,700
2021-22 **	2	3,880	4.77	\$3,507.38	\$16,739.68	\$194,954,500
2021-22 **	3	4,200	4.81	\$3,496.55	\$16,811.18	\$211,926,000
2021-22 **	4	3,260	4.77	\$3,484.34	\$16,622.15	\$162,540,000
2021-22 **	TOTAL	3,990	4.82	\$3,490.53	\$16,826.25	\$805,272,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

## Community Inpatient Fee-for-Service Base Estimate

**Analyst:** Adriana Oprea

**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 some of the Designated Public Hospitals (DPHs).

Fiscal Year		Users		Utilization (Days per User)		Rate (Cost per Day)		Total Expenditure	
<b>PY</b>	FY 2019-20	26,590	--	4.99	--	\$2,390.87	--	\$3,810,386,500	--
<b>CY</b>	FY 2020-21	26,370	-0.8%	5.00	0.2%	\$2,420.30	1.2%	\$3,833,187,400	0.6%
<b>BY</b>	FY 2021-22	26,830	1.7%	4.97	-0.6%	\$2,428.32	0.3%	\$3,884,715,900	1.3%

**Users:** Users are estimated to decrease by -0.8% from PY to CY. This is mainly due to low actual users in July attributable to the COVID-19 pandemic. The BY estimate assumes a return to the pre-COVID level. The Ongoing COVID-19 impact is estimated in a separate policy change.

**Utilization:** Utilization is estimated to remain relatively stable from PY to CY and CY to BY.

**Rate:** Rate is estimated to increase by 1.2% from PY to CY due to DPH rate increase that was implemented in July 2020. The rate increase for the remainder of CY is estimated in the policy change. BY remains relatively stable.

**Total Expenditures:** Total expenditures are estimated to remain stable from PY to CY and increase by 1.3% in BY due to an increase in Users.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$3,880,422,600	\$3,810,386,500	-1.8%
FY 2020-21	\$3,922,166,800	\$3,833,187,400	-2.3%

Compared to the May 2020 Estimate, expenditures in the November 2020 Estimate are lower by 1.8% in FY 2019-20 and by 2.5% in FY 2020-21. These changes are attributable to fewer days per user.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**COMMUNITY INPATIENT**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	30,520	4.96	\$2,360.61	\$11,702.66	\$1,071,554,300
2018-19 *	2	27,120	4.89	\$2,353.25	\$11,510.31	\$936,317,700
2018-19 *	3	27,580	4.92	\$2,313.40	\$11,371.75	\$940,830,100
2018-19 *	4	26,300	4.59	\$2,400.69	\$11,015.90	\$869,154,300
2018-19 *	TOTAL	27,880	4.84	\$2,355.91	\$11,412.09	\$3,817,856,400
2019-20 *	1	31,110	5.09	\$2,384.60	\$12,136.41	\$1,132,545,300
2019-20 *	2	26,510	4.99	\$2,366.52	\$11,800.56	\$938,628,600
2019-20 *	3	26,680	4.86	\$2,377.75	\$11,567.64	\$925,989,600
2019-20 *	4	22,050	5.03	\$2,444.20	\$12,292.32	\$813,223,100
2019-20 *	TOTAL	26,590	4.99	\$2,390.87	\$11,942.31	\$3,810,386,500
2020-21 **	1	28,530	5.23	\$2,434.54	\$12,740.36	\$1,090,578,300
2020-21 **	2	27,920	5.00	\$2,405.07	\$12,031.52	\$1,007,651,800
2020-21 **	3	24,580	4.92	\$2,403.88	\$11,816.88	\$871,322,800
2020-21 **	4	24,470	4.83	\$2,437.09	\$11,765.66	\$863,634,500
2020-21 **	TOTAL	26,370	5.00	\$2,420.30	\$12,111.57	\$3,833,187,400
2021-22 **	1	30,680	5.12	\$2,420.93	\$12,392.50	\$1,140,456,500
2021-22 **	2	26,110	5.00	\$2,422.83	\$12,116.74	\$949,097,200
2021-22 **	3	26,420	4.93	\$2,419.92	\$11,928.87	\$945,570,400
2021-22 **	4	24,100	4.79	\$2,454.05	\$11,751.41	\$849,591,700
2021-22 **	TOTAL	26,830	4.97	\$2,428.32	\$12,067.27	\$3,884,715,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

## Nursing Facility Fee-for-Service Base Estimate

**Analyst:** My-Ai Bui

**Background:** Nursing Facilities consist 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 Claim)		Total Expenditures	
<b>PY</b>	FY 2019-20	26,420	--	32.68	--	\$246.81	--	\$2,556,626,800	--
<b>CY</b>	FY 2020-21	25,820	-2.3%	32.55	-0.4%	\$245.94	-0.4%	\$2,481,018,800	-3.0%
<b>BY</b>	FY 2021-22	25,900	0.3%	32.69	0.4%	\$244.15	-0.7%	\$2,481,018,900	0.0%

**Users:** Users are estimated to decrease by 2.3% from PY to CY and to remain relatively unchanged from CY to BY.

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

**Rate:** The rate remains relatively unchanged. Any future rate increases will be budgeted in a separate policy changes.

**Total Expenditure:** CY is estimated to decrease by 3.0% due primarily to the decrease in users along with a smaller impact from the decrease in rates. BY is estimated to remain unchanged.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$2,503,537,400	\$2,556,626,800	2.1%
FY 2020-21	\$2,461,424,100	\$2,481,018,800	0.8%

Compared to May 2020, the FY 2019-20 total expenditure increase of 2.1% is because of a one-time retroactive payment and rate increase. FY 2020-21 is relatively unchanged.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**NURSING FACILITIES**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	28,030	35.45	\$225.98	\$8,010.39	\$673,545,500
2018-19 *	2	27,020	31.82	\$224.92	\$7,157.63	\$580,297,300
2018-19 *	3	25,870	31.72	\$231.04	\$7,328.50	\$568,743,200
2018-19 *	4	23,260	30.67	\$230.47	\$7,069.37	\$493,322,200
2018-19 *	TOTAL	26,050	32.52	\$227.88	\$7,409.77	\$2,315,908,200
2019-20 *	1	28,510	37.42	\$246.34	\$9,216.76	\$788,355,700
2019-20 *	2	27,070	30.95	\$231.64	\$7,168.72	\$582,193,600
2019-20 *	3	25,890	31.53	\$245.14	\$7,730.01	\$600,327,800
2019-20 *	4	24,200	30.25	\$266.71	\$8,067.07	\$585,749,600
2019-20 *	TOTAL	26,420	32.68	\$246.81	\$8,064.56	\$2,556,626,800
2020-21 **	1	27,180	36.15	\$250.56	\$9,057.86	\$738,684,700
2020-21 **	2	26,930	34.02	\$242.28	\$8,243.63	\$665,896,000
2020-21 **	3	25,090	29.45	\$245.69	\$7,234.56	\$544,439,000
2020-21 **	4	24,100	30.09	\$244.54	\$7,358.97	\$531,999,000
2020-21 **	TOTAL	25,820	32.55	\$245.94	\$8,006.47	\$2,481,018,800
2021-22 **	1	27,580	37.58	\$244.83	\$9,199.90	\$761,086,100
2021-22 **	2	26,510	31.88	\$242.69	\$7,736.72	\$615,313,000
2021-22 **	3	25,500	31.68	\$245.29	\$7,770.60	\$594,458,200
2021-22 **	4	24,010	29.07	\$243.60	\$7,081.30	\$510,161,500
2021-22 **	TOTAL	25,900	32.69	\$244.15	\$7,982.59	\$2,481,018,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

## ICF/DD Fee-for-Service Base Estimate

**Analyst:** Alvin Bautista

**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	
<b>PY</b>	FY 2019-20	4,680	--	31.47	--	\$234.16	--	\$413,521,900	--
<b>CY</b>	FY 2020-21	4,610	-1.5%	31.10	-1.2%	\$236.12	0.8%	\$406,722,800	-1.6%
<b>BY</b>	FY 2021-22	4,670	1.3%	31.35	0.8%	\$233.83	-1.0%	\$411,119,200	1.1%

**Users:** Users are estimated to remain relatively level from PY to BY.

**Utilization:** Utilization is estimated to remain relatively level from PY to BY.

**Rate:** Rates are estimated to increase by 0.8% from PY to CY due to a one-time retroactive payment for the rate increase that was implemented in January 2020. Rates are estimated to decrease by 1.0% from CY to BY because of the one-time retroactive payment in CY.

**Total Expenditure:** Total expenditures are estimated to remain relatively stable.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$412,939,500	\$413,521,900	0.1%
FY 2020-21	\$420,603,700	\$406,722,800	-3.3%

Compared to the May 2020 Estimate, the November 2020 Estimate total expenditures are higher by 0.1% for FY 2019-20 and lower by 3.3% for 2020-21. The decrease in FY 2020-21 is due to actual days per user ultimately coming in a little lower than estimated in May 2020 and reducing the future estimate.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	4,870	35.81	\$221.62	\$7,935.19	\$115,830,000
2018-19 *	2	4,810	32.09	\$222.28	\$7,133.03	\$102,901,100
2018-19 *	3	4,790	31.04	\$228.06	\$7,078.17	\$101,685,000
2018-19 *	4	4,550	27.62	\$223.57	\$6,175.08	\$84,326,800
2018-19 *	TOTAL	4,750	31.71	\$223.78	\$7,095.15	\$404,743,000
2019-20 *	1	4,800	36.37	\$224.63	\$8,168.93	\$117,681,600
2019-20 *	2	4,730	31.28	\$232.83	\$7,283.12	\$103,245,500
2019-20 *	3	4,700	30.91	\$232.51	\$7,187.50	\$101,430,100
2019-20 *	4	4,470	27.00	\$251.53	\$6,791.18	\$91,164,800
2019-20 *	TOTAL	4,680	31.47	\$234.16	\$7,368.79	\$413,521,900
2020-21 **	1	4,640	35.62	\$241.47	\$8,600.05	\$119,805,700
2020-21 **	2	4,650	33.25	\$233.35	\$7,757.83	\$108,272,800
2020-21 **	3	4,630	28.65	\$233.90	\$6,700.58	\$93,105,100
2020-21 **	4	4,530	26.80	\$234.77	\$6,290.96	\$85,539,200
2020-21 **	TOTAL	4,610	31.10	\$236.12	\$7,344.26	\$406,722,800
2021-22 **	1	4,730	37.21	\$233.80	\$8,700.45	\$123,551,300
2021-22 **	2	4,680	30.94	\$233.33	\$7,218.74	\$101,286,300
2021-22 **	3	4,700	31.01	\$233.57	\$7,243.70	\$102,240,600
2021-22 **	4	4,580	26.07	\$234.77	\$6,121.16	\$84,040,900
2021-22 **	TOTAL	4,670	31.35	\$233.83	\$7,331.52	\$411,119,200

\* 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 Unit)		Total Expenditure	
<b>PY</b>	FY 2019-20	24,090	--	2.76	--	\$161.97	--	\$129,061,100	--
<b>CY</b>	FY-2020-21	25,310	5.1%	2.70	-2.2%	\$142.08	-12.3%	\$116,507,900	-9.7%
<b>BY</b>	FY 2021-22	26,110	3.2%	2.72	0.7%	\$141.43	-0.5%	\$120,532,900	3.5%

**Users:** Users are estimated to increase by 5.1% in CY and 3.2% in BY due to a return to pre-COVID-19 pandemic levels with a modest growth population. Users decreased in PY and July 2020 due to the COVID-19 pandemic. Ongoing impacts related to COVID-19 are estimated in a separate policy change.

**Utilization:** Utilization is estimated to decrease by 2.2% in CY. This is mainly due to low actual utilization in 2019-20 and July 2020 attributable to COVID-19 pandemic. The BY estimate assumes a return to the pre-COVID-19 level. Ongoing COVID-19 impacts are estimated in a separate policy change.

**Rate:** The CY rate is projected to decrease by 12.3% is due to a low actual rate in July, primarily caused by a decrease in more expensive air transportation likely attributable to the COVID-19 pandemic. The estimates for CY and BY assume a return to the pre-COVID level. Ongoing COVID-19 impacts are estimated in policy change.

**Total Expenditure:** Total expenditure is estimated to decrease by 9.7% in CY due to low utilization and rate in 2019-20 and July 2020. Total expenditures in BY are estimated to increase by 3.5%, with no assumed COVID-19 impact. Ongoing COVID-19 impacts are estimated in a separate policy change.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$127,386,000	\$129,061,100	1.3%
FY 2020-21	\$109,388,600	\$116,507,900	6.5%

Compared to the May 2020 Estimate, the November 2020 Estimate is higher by 1.3% in 2019-20 and by 6.5% in 2020-21. This increase is attributable to the Proposition 56 Non-Emergency Medical Transportation (NEMT) Supplemental Payment rate increase that was implemented on March 2020.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**MEDICAL TRANSPORTATION**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	26,920	3.02	\$85.69	\$259.12	\$20,922,400
2018-19 *	2	22,510	2.96	\$83.50	\$247.16	\$16,692,400
2018-19 *	3	22,830	2.93	\$82.08	\$240.20	\$16,453,600
2018-19 *	4	21,300	2.85	\$77.97	\$222.43	\$14,211,100
2018-19 *	TOTAL	23,390	2.95	\$82.58	\$243.27	\$68,279,600
2019-20 *	1	26,150	2.92	\$183.08	\$534.17	\$41,908,000
2019-20 *	2	27,540	2.63	\$164.98	\$434.08	\$35,866,600
2019-20 *	3	23,170	2.79	\$129.92	\$362.89	\$25,226,900
2019-20 *	4	19,510	2.67	\$166.65	\$445.24	\$26,059,600
2019-20 *	TOTAL	24,090	2.76	\$161.97	\$446.38	\$129,061,100
2020-21 **	1	26,020	2.78	\$144.75	\$401.74	\$31,357,900
2020-21 **	2	28,070	2.72	\$143.96	\$391.73	\$32,991,900
2020-21 **	3	23,830	2.65	\$141.51	\$374.42	\$26,770,200
2020-21 **	4	23,300	2.65	\$137.21	\$363.23	\$25,387,900
2020-21 **	TOTAL	25,310	2.70	\$142.08	\$383.67	\$116,507,900
2021-22 **	1	29,230	2.87	\$142.69	\$409.60	\$35,912,800
2021-22 **	2	27,030	2.66	\$144.61	\$384.58	\$31,180,000
2021-22 **	3	24,980	2.72	\$140.36	\$381.71	\$28,604,000
2021-22 **	4	23,210	2.60	\$137.08	\$356.69	\$24,836,100
2021-22 **	TOTAL	26,110	2.72	\$141.43	\$384.70	\$120,532,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

## Other Services Fee-for-Service Base Estimate

**Analyst:** Ken Jansma

**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	
<b>PY</b>	FY 2019-20	174,970	--	3.10	--	\$126.61	--	\$824,132,000	--
<b>CY</b>	FY 2020-21	201,520	15.2%	2.71	-12.6%	\$140.72	11.1%	\$921,348,700	11.8%
<b>BY</b>	FY 2021-22	213,300	5.9%	2.81	3.7%	\$133.13	-5.4%	\$956,947,500	3.9%

**Users:** Users are estimated to increase by 15.2% in CY mainly due to including in the estimate the impact of the restoration of adult optical and optical lab services seen thus far in the actual data from its implementation in January 2020 through July 2020. The BY is estimated to increase primarily due to the full year impact of that same change.

**Utilization:** Utilization is estimated to decrease by 12.6% in CY primarily due to the same reason as the users. The increase in adult optical users, with only about one claim per user, brings down the average number of claims per user. In the BY, the full-year impact of that same drop in claims per user is offset by increased claims per user for provider types having a higher average claims per user.

**Rate:** The rate is estimated to increase by 11.1% in CY primarily due to increases in the Waiver Services which have a much higher than average cost per claim. BY is estimated to decrease due to the changing mix of claims among the provider types in this category which have a wide difference in cost per claim.

**Total Expenditure:** Total expenditures are estimated to increase in CY, mainly related to only one month of COVID-19 impact rather than two months in PY and higher costs for increases in Waiver Services renewal and expansion, adult optical, minimum wage increases for HCBS, and a Hospice rate increase. BY increases due to increased users and utilization.

### Reason for Change from Prior Estimate:

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$840,297,700	\$824,132,000	-1.9%
FY 2020-21	\$849,651,000	\$921,348,700	8.4%

Compared to the May 2020 Estimate, the Nov 2020 Estimate, decreased by 1.9% in FY 2019-20 and increased by 8.4% in FY 2020-21. The decrease in PY is mainly due to a drop in Users and Utilization caused by COVID-19 in May and June 2020. The increase in the CY is primarily due to increased costs now in the base for Waiver Services renewal and expansion, adult optical, minimum wage increases for HCBS, and a Hospice rate increase.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**OTHER SERVICES**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	171,750	3.36	\$117.46	\$394.67	\$203,350,500
2018-19 *	2	157,690	2.54	\$132.38	\$335.93	\$158,917,700
2018-19 *	3	173,980	3.34	\$99.20	\$331.07	\$172,797,500
2018-19 *	4	183,020	3.51	\$98.03	\$343.88	\$188,813,700
2018-19 *	TOTAL	171,610	3.20	\$109.68	\$351.52	\$723,879,400
2019-20 *	1	177,610	3.69	\$122.14	\$451.14	\$240,386,400
2019-20 *	2	190,340	2.91	\$123.03	\$357.44	\$204,105,400
2019-20 *	3	207,230	2.78	\$123.70	\$343.81	\$213,740,200
2019-20 *	4	124,700	3.09	\$143.73	\$443.47	\$165,900,000
2019-20 *	TOTAL	174,970	3.10	\$126.61	\$392.51	\$824,132,000
2020-21 **	1	170,340	2.53	\$188.52	\$476.14	\$243,309,800
2020-21 **	2	223,840	2.53	\$141.53	\$358.73	\$240,896,100
2020-21 **	3	201,140	2.74	\$129.29	\$354.38	\$213,834,700
2020-21 **	4	210,780	3.01	\$117.50	\$353.14	\$223,308,200
2020-21 **	TOTAL	201,520	2.71	\$140.72	\$380.99	\$921,348,700
2021-22 **	1	219,340	2.94	\$147.17	\$432.27	\$284,438,800
2021-22 **	2	213,780	2.52	\$139.67	\$352.15	\$225,851,200
2021-22 **	3	211,110	2.78	\$129.86	\$361.23	\$228,781,800
2021-22 **	4	208,950	2.99	\$116.10	\$347.57	\$217,875,700
2021-22 **	TOTAL	213,300	2.81	\$133.13	\$373.87	\$956,947,500

\* 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	
<b>PY</b>	FY 2019-20	4,020	--	5.39	--	\$1,025.45	--	\$266,318,200	--
<b>CY</b>	FY-2020-21	4,020	0.0%	5.30	-1.7%	\$1,032.10	0.6%	\$263,947,000	-0.9%
<b>BY</b>	FY 2021-22	4,030	0.2%	5.31	0.2%	\$1,038.29	0.6%	\$266,654,000	1.0%

**Users:** Users are estimated to remain relatively stable in CY and in BY.

**Utilization:** PY utilization actuals were slightly higher than estimated. CY and BY estimates are assumed to return to the normal trend.

**Rate:** Rate is projected to grow only slightly in both CY and BY.

**Total Expenditure:** CY expenditure estimates decrease slightly due to lower utilization. BY expenditure estimates increase by 1.0% due to a combination of users, utilization, and rate.

### Reason for Change from Prior Estimate

Fiscal Year	Total Expenditure		
	M20	N20	% Chng
FY 2019-20	\$267,101,800	\$266,318,200	-0.3%
FY 2020-21	\$266,159,600	\$263,947,000	-0.8%

Compared to the May 2020 Estimate, the November 2020 Estimate is lower by 0.3% in 2019-20 and 0.8% in 2020-21 because of slightly lower users and units per user.

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 BASE ESTIMATES)**

**HOME HEALTH**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNIT PER USER	COST PER UNIT	COST PER USER	
2018-19 *	1	4,090	6.18	\$757.76	\$4,682.99	\$57,418,100
2018-19 *	2	4,030	5.51	\$749.76	\$4,132.41	\$49,977,300
2018-19 *	3	3,880	5.47	\$965.10	\$5,282.85	\$61,534,600
2018-19 *	4	3,570	5.51	\$1,443.85	\$7,961.05	\$85,350,400
2018-19 *	TOTAL	3,890	5.68	\$958.45	\$5,442.18	\$254,280,500
2019-20 *	1	4,120	6.30	\$1,040.40	\$6,550.42	\$80,963,200
2019-20 *	2	4,050	5.24	\$1,006.15	\$5,268.96	\$64,012,500
2019-20 *	3	3,980	5.34	\$1,024.52	\$5,468.91	\$65,337,000
2019-20 *	4	3,910	4.64	\$1,027.70	\$4,768.85	\$56,005,400
2019-20 *	TOTAL	4,020	5.39	\$1,025.45	\$5,525.27	\$266,318,200
2020-21 **	1	4,230	5.69	\$1,017.92	\$5,795.81	\$73,574,900
2020-21 **	2	4,060	5.61	\$1,030.45	\$5,775.69	\$70,280,700
2020-21 **	3	3,950	4.99	\$1,057.16	\$5,275.74	\$62,574,700
2020-21 **	4	3,850	4.85	\$1,025.93	\$4,979.30	\$57,516,700
2020-21 **	TOTAL	4,020	5.30	\$1,032.10	\$5,467.58	\$263,947,000
2021-22 **	1	4,280	5.85	\$1,041.02	\$6,087.30	\$78,120,900
2021-22 **	2	3,990	5.31	\$1,029.35	\$5,463.28	\$65,397,500
2021-22 **	3	4,020	5.29	\$1,057.05	\$5,588.89	\$67,395,400
2021-22 **	4	3,840	4.73	\$1,022.99	\$4,842.10	\$55,740,200
2021-22 **	TOTAL	4,030	5.31	\$1,038.29	\$5,512.32	\$266,654,000

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	63,530	3.76	\$168.51	\$633.77	\$120,782,000
2018-19 *	2	55,200	3.58	\$170.62	\$611.40	\$101,248,500
2018-19 *	3	59,110	3.48	\$169.16	\$589.25	\$104,495,100
2018-19 *	4	55,740	3.38	\$168.92	\$570.16	\$95,351,400
2018-19 *	TOTAL	58,400	3.56	\$169.27	\$602.04	\$421,876,900
2019-20 *	1	62,990	3.74	\$182.23	\$681.04	\$128,695,300
2019-20 *	2	58,470	3.41	\$173.30	\$590.78	\$103,630,000
2019-20 *	3	60,350	3.37	\$179.10	\$603.69	\$109,291,000
2019-20 *	4	45,390	3.45	\$195.38	\$674.29	\$91,826,800
2019-20 *	TOTAL	56,800	3.50	\$181.78	\$635.92	\$433,443,000
2020-21 **	1	57,990	3.72	\$187.44	\$696.52	\$121,169,700
2020-21 **	2	59,460	3.53	\$182.77	\$644.43	\$114,947,300
2020-21 **	3	56,530	3.31	\$179.39	\$593.01	\$100,562,300
2020-21 **	4	53,680	3.37	\$181.69	\$611.69	\$98,512,300
2020-21 **	TOTAL	56,910	3.48	\$183.00	\$637.21	\$435,191,500
2021-22 **	1	62,250	3.79	\$185.23	\$701.11	\$130,934,000
2021-22 **	2	55,730	3.45	\$184.67	\$636.76	\$106,459,400
2021-22 **	3	57,290	3.45	\$180.11	\$621.35	\$106,784,000
2021-22 **	4	51,650	3.34	\$182.46	\$608.76	\$94,331,400
2021-22 **	TOTAL	56,730	3.52	\$183.23	\$644.15	\$438,508,800

\* 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 2020 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>
2018-19 *	1	513,170	2.62	\$299.22	\$782.95	\$1,205,360,500
2018-19 *	2	483,920	2.47	\$295.86	\$731.76	\$1,062,335,100
2018-19 *	3	481,490	2.48	\$300.35	\$744.52	\$1,075,446,200
2018-19 *	4	444,740	2.41	\$300.38	\$723.78	\$965,679,500
2018-19 *	TOTAL	480,830	2.50	\$298.93	\$746.77	\$4,308,821,300
2019-20 *	1	535,850	2.65	\$296.71	\$785.81	\$1,263,235,300
2019-20 *	2	484,060	2.48	\$294.13	\$729.28	\$1,059,030,800
2019-20 *	3	495,690	2.46	\$297.01	\$731.41	\$1,087,641,800
2019-20 *	4	382,150	2.45	\$320.07	\$783.11	\$897,794,500
2019-20 *	TOTAL	474,440	2.52	\$300.71	\$756.64	\$4,307,702,400
2020-21 **	1	526,990	2.70	\$307.45	\$829.94	\$1,312,104,400
2020-21 **	2	515,740	2.56	\$303.69	\$778.81	\$1,204,989,100
2020-21 **	3	465,630	2.41	\$308.77	\$744.83	\$1,040,449,700
2020-21 **	4	454,750	2.45	\$307.60	\$754.08	\$1,028,749,300
2020-21 **	TOTAL	490,780	2.54	\$306.78	\$778.75	\$4,586,292,500
2021-22 **	1	558,770	2.73	\$311.48	\$849.74	\$1,424,414,200
2021-22 **	2	494,020	2.50	\$309.16	\$773.22	\$1,145,958,900
2021-22 **	3	485,560	2.49	\$314.73	\$782.61	\$1,140,007,600
2021-22 **	4	450,490	2.41	\$312.91	\$753.17	\$1,017,875,400
2021-22 **	TOTAL	497,210	2.54	\$312.00	\$792.47	\$4,728,256,100

\* ACTUAL

\*\* ESTIMATED

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



**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	261,510	4.76	\$279.28	\$1,329.63	\$1,043,128,000
2018-19 *	2	240,510	4.29	\$283.35	\$1,215.72	\$877,195,200
2018-19 *	3	247,180	4.30	\$277.88	\$1,195.76	\$886,685,700
2018-19 *	4	232,570	4.18	\$270.48	\$1,131.64	\$789,561,700
2018-19 *	TOTAL	245,440	4.39	\$277.92	\$1,221.12	\$3,596,570,600
2019-20 *	1	258,070	4.81	\$268.85	\$1,293.26	\$1,001,243,000
2019-20 *	2	246,380	4.12	\$263.38	\$1,085.74	\$802,513,000
2019-20 *	3	248,170	4.12	\$267.61	\$1,103.71	\$821,720,500
2019-20 *	4	201,220	4.04	\$278.24	\$1,124.82	\$678,993,100
2019-20 *	TOTAL	238,460	4.29	\$269.05	\$1,154.80	\$3,304,469,600
2020-21 **	1	236,980	4.60	\$289.15	\$1,331.43	\$946,563,100
2020-21 **	2	248,950	4.30	\$274.77	\$1,182.84	\$883,389,100
2020-21 **	3	235,150	4.02	\$273.52	\$1,098.31	\$774,793,100
2020-21 **	4	229,970	4.14	\$264.67	\$1,096.01	\$756,140,000
2020-21 **	TOTAL	237,760	4.27	\$275.98	\$1,177.97	\$3,360,885,300
2021-22 **	1	259,860	4.78	\$277.74	\$1,326.30	\$1,033,946,900
2021-22 **	2	240,260	4.15	\$278.87	\$1,157.88	\$834,559,700
2021-22 **	3	243,590	4.18	\$277.00	\$1,158.38	\$846,500,900
2021-22 **	4	227,690	4.06	\$267.54	\$1,086.22	\$741,961,100
2021-22 **	TOTAL	242,850	4.30	\$275.57	\$1,186.27	\$3,456,968,500

\* 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 2020 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>
2018-19 *	1	149,690	2.28	\$213.60	\$486.50	\$218,470,500
2018-19 *	2	142,080	2.11	\$216.78	\$456.66	\$194,646,800
2018-19 *	3	141,290	2.23	\$201.25	\$448.38	\$190,051,900
2018-19 *	4	132,540	2.22	\$196.80	\$435.92	\$173,328,900
2018-19 *	TOTAL	141,400	2.21	\$207.30	\$457.63	\$776,498,100
2019-20 *	1	144,740	2.33	\$210.35	\$489.79	\$212,671,400
2019-20 *	2	140,750	2.20	\$209.97	\$461.62	\$194,924,800
2019-20 *	3	146,630	2.18	\$206.26	\$449.08	\$197,544,100
2019-20 *	4	91,240	2.19	\$241.16	\$529.03	\$144,804,900
2019-20 *	TOTAL	130,840	2.23	\$214.42	\$477.65	\$749,945,200
2020-21 **	1	131,660	2.18	\$234.16	\$509.81	\$201,360,100
2020-21 **	2	154,510	2.14	\$220.19	\$470.42	\$218,045,900
2020-21 **	3	143,150	2.09	\$210.98	\$440.66	\$189,242,300
2020-21 **	4	141,410	2.09	\$200.79	\$420.62	\$178,439,300
2020-21 **	TOTAL	142,680	2.12	\$216.48	\$459.70	\$787,087,700
2021-22 **	1	162,470	2.26	\$216.99	\$490.07	\$238,863,900
2021-22 **	2	148,670	2.10	\$219.83	\$461.48	\$205,823,600
2021-22 **	3	151,030	2.14	\$212.80	\$455.71	\$206,476,500
2021-22 **	4	139,960	2.08	\$201.43	\$418.24	\$175,616,500
2021-22 **	TOTAL	150,530	2.15	\$213.13	\$457.70	\$826,780,600

\* 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 2020 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>
2018-19 *	1	18,330	31.97	\$201.58	\$6,444.50	\$354,473,400
2018-19 *	2	17,830	28.49	\$200.12	\$5,702.10	\$304,982,700
2018-19 *	3	17,610	28.13	\$201.61	\$5,671.33	\$299,678,700
2018-19 *	4	16,110	26.48	\$205.59	\$5,443.26	\$263,061,700
2018-19 *	TOTAL	17,470	28.85	\$202.07	\$5,829.45	\$1,222,196,500
2019-20 *	1	18,670	33.89	\$221.83	\$7,517.34	\$421,136,300
2019-20 *	2	18,270	27.89	\$207.82	\$5,795.76	\$317,624,800
2019-20 *	3	18,070	27.75	\$218.67	\$6,068.28	\$329,016,100
2019-20 *	4	16,310	26.92	\$239.14	\$6,437.45	\$315,042,400
2019-20 *	TOTAL	17,830	29.20	\$221.29	\$6,462.29	\$1,382,819,600
2020-21 **	1	18,130	32.71	\$225.20	\$7,366.14	\$400,660,200
2020-21 **	2	18,200	30.62	\$219.09	\$6,707.79	\$366,260,600
2020-21 **	3	17,450	25.89	\$219.57	\$5,684.96	\$297,568,800
2020-21 **	4	16,590	26.52	\$220.33	\$5,842.96	\$290,871,300
2020-21 **	TOTAL	17,590	29.02	\$221.24	\$6,419.89	\$1,355,360,900
2021-22 **	1	18,800	33.49	\$221.45	\$7,417.19	\$418,378,500
2021-22 **	2	17,860	28.66	\$219.31	\$6,285.02	\$336,840,900
2021-22 **	3	17,800	28.05	\$219.61	\$6,159.38	\$328,922,000
2021-22 **	4	16,520	25.67	\$219.34	\$5,629.79	\$279,081,800
2021-22 **	TOTAL	17,750	29.09	\$220.04	\$6,400.86	\$1,363,223,200

\* 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 2020 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>
2018-19 *	1	45,410	3.63	\$254.02	\$921.89	\$125,597,800
2018-19 *	2	44,730	3.41	\$244.74	\$834.64	\$112,007,800
2018-19 *	3	46,780	3.45	\$256.43	\$884.42	\$124,125,000
2018-19 *	4	41,130	3.29	\$253.41	\$832.61	\$102,724,700
2018-19 *	TOTAL	44,510	3.45	\$252.22	\$869.50	\$464,455,400
2019-20 *	1	49,250	3.67	\$264.03	\$968.72	\$143,140,500
2019-20 *	2	42,860	3.64	\$271.06	\$985.36	\$126,707,800
2019-20 *	3	49,030	3.64	\$264.34	\$963.24	\$141,684,600
2019-20 *	4	34,120	3.59	\$322.73	\$1,158.39	\$118,556,500
2019-20 *	TOTAL	43,820	3.64	\$277.11	\$1,008.18	\$530,089,300
2020-21 **	1	45,180	3.99	\$286.74	\$1,145.16	\$155,231,500
2020-21 **	2	49,030	3.70	\$282.50	\$1,046.19	\$153,874,500
2020-21 **	3	47,780	3.53	\$276.74	\$976.30	\$139,930,100
2020-21 **	4	44,690	3.52	\$296.24	\$1,041.79	\$139,666,300
2020-21 **	TOTAL	46,670	3.68	\$285.34	\$1,051.21	\$588,702,400
2021-22 **	1	52,960	3.87	\$285.51	\$1,105.27	\$175,599,900
2021-22 **	2	47,670	3.63	\$283.82	\$1,030.38	\$147,342,000
2021-22 **	3	49,700	3.60	\$280.95	\$1,010.84	\$150,730,600
2021-22 **	4	43,890	3.49	\$297.55	\$1,037.74	\$136,626,800
2021-22 **	TOTAL	48,550	3.66	\$286.54	\$1,047.46	\$610,299,200

\* 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 2020 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>
2018-19 *	1	5,670	31.92	\$218.44	\$6,971.85	\$118,528,400
2018-19 *	2	5,510	28.77	\$219.85	\$6,325.89	\$104,522,700
2018-19 *	3	5,360	27.95	\$222.78	\$6,226.50	\$100,066,100
2018-19 *	4	4,990	24.88	\$226.10	\$5,625.21	\$84,254,300
2018-19 *	TOTAL	5,380	28.49	\$221.42	\$6,308.70	\$407,371,500
2019-20 *	1	5,380	33.37	\$230.29	\$7,684.34	\$123,971,400
2019-20 *	2	5,260	28.07	\$228.80	\$6,422.56	\$101,258,100
2019-20 *	3	5,180	27.75	\$233.36	\$6,475.22	\$100,715,600
2019-20 *	4	4,780	25.68	\$256.56	\$6,588.40	\$94,556,700
2019-20 *	TOTAL	5,150	28.82	\$236.10	\$6,803.69	\$420,501,800
2020-21 **	1	5,040	33.02	\$240.67	\$7,946.77	\$120,146,400
2020-21 **	2	5,080	30.83	\$232.95	\$7,181.70	\$109,434,900
2020-21 **	3	4,960	26.17	\$230.94	\$6,044.66	\$89,938,100
2020-21 **	4	4,780	25.45	\$237.58	\$6,045.66	\$86,667,400
2020-21 **	TOTAL	4,960	28.93	\$235.71	\$6,818.50	\$406,186,900
2021-22 **	1	5,190	33.98	\$235.17	\$7,990.57	\$124,327,100
2021-22 **	2	5,010	28.78	\$233.35	\$6,714.91	\$100,972,700
2021-22 **	3	5,040	28.22	\$231.01	\$6,518.31	\$98,478,800
2021-22 **	4	4,760	24.59	\$237.30	\$5,835.38	\$83,390,100
2021-22 **	TOTAL	5,000	28.99	\$234.13	\$6,786.74	\$407,168,700

\* 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 2020 BASE ESTIMATES)**

**POV 250**

**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>
2018-19 *	1	106,840	2.14	\$213.39	\$456.94	\$146,463,900
2018-19 *	2	99,100	1.91	\$220.37	\$421.87	\$125,419,300
2018-19 *	3	103,800	2.18	\$193.64	\$421.51	\$131,262,200
2018-19 *	4	101,520	2.19	\$186.30	\$407.19	\$124,016,300
2018-19 *	TOTAL	102,820	2.11	\$202.83	\$427.27	\$527,161,700
2019-20 *	1	113,050	2.20	\$208.99	\$459.62	\$155,882,200
2019-20 *	2	110,400	2.04	\$198.78	\$406.05	\$134,482,400
2019-20 *	3	113,030	2.05	\$200.10	\$410.04	\$139,043,400
2019-20 *	4	58,280	2.24	\$228.90	\$511.66	\$89,464,700
2019-20 *	TOTAL	98,690	2.12	\$206.88	\$438.12	\$518,872,800
2020-21 **	1	100,320	1.97	\$244.00	\$481.84	\$145,020,600
2020-21 **	2	118,730	1.96	\$211.51	\$413.83	\$147,397,700
2020-21 **	3	109,850	1.97	\$207.51	\$408.86	\$134,741,100
2020-21 **	4	109,300	2.02	\$196.18	\$396.91	\$130,146,900
2020-21 **	TOTAL	109,550	1.98	\$214.02	\$423.94	\$557,306,300
2021-22 **	1	123,790	2.08	\$215.26	\$447.10	\$166,037,400
2021-22 **	2	112,990	1.94	\$209.51	\$406.73	\$137,864,700
2021-22 **	3	115,590	2.00	\$207.82	\$415.86	\$144,210,400
2021-22 **	4	108,150	2.01	\$194.65	\$390.76	\$126,781,500
2021-22 **	TOTAL	115,130	2.01	\$207.20	\$416.12	\$574,894,000

\* 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 2020 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>
2018-19 *	1	82,270	3.82	\$194.22	\$742.58	\$183,282,300
2018-19 *	2	74,220	3.61	\$190.23	\$687.53	\$153,079,700
2018-19 *	3	77,030	3.54	\$193.50	\$685.77	\$158,469,000
2018-19 *	4	75,040	3.41	\$193.22	\$658.82	\$148,312,300
2018-19 *	TOTAL	77,140	3.60	\$192.85	\$694.78	\$643,143,200
2019-20 *	1	89,520	3.81	\$202.52	\$771.40	\$207,159,900
2019-20 *	2	82,510	3.44	\$195.76	\$672.92	\$166,557,900
2019-20 *	3	83,150	3.35	\$200.82	\$672.40	\$167,734,600
2019-20 *	4	63,140	3.63	\$213.43	\$775.28	\$146,841,500
2019-20 *	TOTAL	79,580	3.56	\$202.62	\$720.78	\$688,294,000
2020-21 **	1	87,570	3.72	\$207.69	\$772.83	\$203,037,800
2020-21 **	2	89,930	3.45	\$200.69	\$693.06	\$186,987,200
2020-21 **	3	84,450	3.26	\$199.06	\$648.58	\$164,312,600
2020-21 **	4	84,730	3.31	\$198.14	\$656.26	\$166,821,500
2020-21 **	TOTAL	86,670	3.44	\$201.63	\$693.38	\$721,159,000
2021-22 **	1	100,240	3.67	\$201.20	\$737.77	\$221,872,200
2021-22 **	2	90,660	3.34	\$199.18	\$664.74	\$180,805,900
2021-22 **	3	92,110	3.30	\$197.39	\$652.04	\$180,172,600
2021-22 **	4	88,340	3.22	\$195.90	\$631.13	\$167,264,200
2021-22 **	TOTAL	92,840	3.39	\$198.59	\$673.31	\$750,114,900

\* 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 2020 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>
2018-19 *	1	39,320	4.56	\$190.52	\$869.48	\$102,554,700
2018-19 *	2	33,720	4.07	\$189.57	\$771.05	\$77,996,100
2018-19 *	3	37,000	4.24	\$169.83	\$719.94	\$79,916,500
2018-19 *	4	38,100	4.18	\$184.21	\$770.79	\$88,098,500
2018-19 *	TOTAL	37,030	4.27	\$183.60	\$784.34	\$348,565,900
2019-20 *	1	44,770	4.61	\$192.35	\$886.71	\$119,096,400
2019-20 *	2	43,910	4.00	\$199.86	\$800.12	\$105,403,100
2019-20 *	3	45,530	4.07	\$193.43	\$787.91	\$107,628,300
2019-20 *	4	36,190	4.09	\$211.22	\$863.19	\$93,708,200
2019-20 *	TOTAL	42,600	4.20	\$198.37	\$833.00	\$425,835,900
2020-21 **	1	44,980	4.44	\$217.27	\$964.19	\$130,119,900
2020-21 **	2	45,640	4.26	\$208.59	\$889.37	\$121,770,400
2020-21 **	3	43,470	4.09	\$198.98	\$813.76	\$106,126,700
2020-21 **	4	42,620	4.28	\$195.20	\$835.98	\$106,891,200
2020-21 **	TOTAL	44,180	4.27	\$205.38	\$876.94	\$464,908,300
2021-22 **	1	47,910	4.76	\$208.67	\$993.62	\$142,822,200
2021-22 **	2	43,790	4.14	\$210.28	\$870.25	\$114,332,100
2021-22 **	3	44,960	4.24	\$200.06	\$849.00	\$114,513,600
2021-22 **	4	42,310	4.21	\$195.97	\$824.91	\$104,702,900
2021-22 **	TOTAL	44,740	4.35	\$204.03	\$887.22	\$476,370,900

\* 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 2020 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>
2018-19 *	1	441,100	2.46	\$206.96	\$509.60	\$674,348,900
2018-19 *	2	420,940	2.27	\$213.05	\$484.46	\$611,783,800
2018-19 *	3	418,640	2.35	\$206.55	\$485.69	\$609,980,800
2018-19 *	4	396,150	2.30	\$201.25	\$462.24	\$549,344,200
2018-19 *	TOTAL	419,200	2.35	\$207.02	\$486.13	\$2,445,457,700
2019-20 *	1	456,570	2.47	\$207.06	\$511.38	\$700,446,400
2019-20 *	2	423,910	2.29	\$206.21	\$473.13	\$601,697,400
2019-20 *	3	428,340	2.29	\$211.25	\$483.28	\$621,035,900
2019-20 *	4	285,820	2.32	\$225.56	\$522.55	\$448,066,800
2019-20 *	TOTAL	398,660	2.35	\$211.21	\$495.67	\$2,371,246,600
2020-21 **	1	425,570	2.44	\$224.86	\$548.75	\$700,592,700
2020-21 **	2	445,550	2.32	\$217.25	\$504.57	\$674,428,100
2020-21 **	3	404,560	2.27	\$214.26	\$486.88	\$590,916,500
2020-21 **	4	402,240	2.27	\$208.00	\$472.26	\$569,879,500
2020-21 **	TOTAL	419,480	2.33	\$216.41	\$503.76	\$2,535,816,800
2021-22 **	1	471,410	2.47	\$220.60	\$544.21	\$769,633,700
2021-22 **	2	423,580	2.29	\$221.60	\$506.42	\$643,517,200
2021-22 **	3	424,400	2.32	\$220.35	\$511.77	\$651,581,600
2021-22 **	4	398,240	2.24	\$212.66	\$475.36	\$567,916,900
2021-22 **	TOTAL	429,400	2.33	\$219.02	\$510.91	\$2,632,649,500

\* 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 2020 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>
2018-19 *	1	58,730	2.70	\$161.36	\$435.35	\$76,702,500
2018-19 *	2	55,330	2.57	\$166.28	\$428.02	\$71,046,300
2018-19 *	3	54,020	2.69	\$172.62	\$465.03	\$75,360,000
2018-19 *	4	47,490	2.66	\$169.81	\$451.48	\$64,321,000
2018-19 *	TOTAL	53,890	2.66	\$167.31	\$444.46	\$287,429,800
2019-20 *	1	61,810	2.76	\$175.80	\$485.10	\$89,959,100
2019-20 *	2	59,580	2.62	\$184.90	\$485.33	\$86,742,200
2019-20 *	3	58,960	2.68	\$181.32	\$485.36	\$85,857,400
2019-20 *	4	35,760	2.64	\$216.43	\$572.18	\$61,383,000
2019-20 *	TOTAL	54,030	2.68	\$186.39	\$499.64	\$323,941,800
2020-21 **	1	54,000	2.77	\$206.64	\$572.05	\$92,668,500
2020-21 **	2	61,290	2.67	\$192.59	\$515.13	\$94,714,500
2020-21 **	3	54,840	2.65	\$194.00	\$513.22	\$84,429,900
2020-21 **	4	52,680	2.59	\$195.37	\$506.44	\$80,044,700
2020-21 **	TOTAL	55,700	2.67	\$197.10	\$526.40	\$351,857,700
2021-22 **	1	64,500	2.82	\$201.23	\$567.97	\$109,894,400
2021-22 **	2	58,590	2.62	\$195.87	\$513.89	\$90,329,300
2021-22 **	3	57,300	2.72	\$197.87	\$537.90	\$92,467,700
2021-22 **	4	51,930	2.57	\$199.30	\$511.28	\$79,649,300
2021-22 **	TOTAL	58,080	2.69	\$198.66	\$534.24	\$372,340,700

\* 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 2020 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>
2018-19 *	1	1,460	9.52	\$215.01	\$2,047.93	\$8,965,800
2018-19 *	2	1,240	8.57	\$216.17	\$1,851.74	\$6,873,700
2018-19 *	3	1,140	9.51	\$225.66	\$2,145.86	\$7,330,200
2018-19 *	4	1,020	8.83	\$226.61	\$2,001.85	\$6,155,700
2018-19 *	TOTAL	1,220	9.13	\$220.25	\$2,011.21	\$29,325,400
2019-20 *	1	950	11.35	\$234.49	\$2,660.69	\$7,556,300
2019-20 *	2	590	13.59	\$240.25	\$3,265.05	\$5,733,400
2019-20 *	3	540	14.96	\$257.42	\$3,850.10	\$6,283,400
2019-20 *	4	470	14.61	\$287.43	\$4,200.57	\$5,969,000
2019-20 *	TOTAL	640	13.24	\$252.23	\$3,339.28	\$25,542,100
2020-21 **	1	480	19.10	\$284.13	\$5,426.96	\$7,737,800
2020-21 **	2	550	14.35	\$283.10	\$4,063.87	\$6,653,300
2020-21 **	3	480	15.22	\$272.59	\$4,148.94	\$5,957,200
2020-21 **	4	380	17.65	\$280.97	\$4,958.39	\$5,606,000
2020-21 **	TOTAL	470	16.44	\$280.46	\$4,610.46	\$25,954,300
2021-22 **	1	550	17.19	\$284.41	\$4,889.35	\$8,055,100
2021-22 **	2	510	14.01	\$283.17	\$3,967.83	\$6,112,300
2021-22 **	3	510	15.61	\$272.92	\$4,260.17	\$6,513,600
2021-22 **	4	370	17.23	\$279.00	\$4,807.42	\$5,344,400
2021-22 **	TOTAL	490	15.94	\$280.06	\$4,465.12	\$26,025,400

\* 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 2020 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>
2018-19 *	1	180	2.49	\$151.93	\$378.55	\$201,800
2018-19 *	2	140	2.50	\$174.03	\$434.46	\$186,400
2018-19 *	3	160	2.51	\$102.93	\$258.09	\$120,000
2018-19 *	4	180	2.85	\$138.54	\$395.03	\$212,500
2018-19 *	TOTAL	160	2.59	\$141.34	\$366.76	\$720,700
2019-20 *	1	240	2.69	\$140.12	\$377.14	\$272,700
2019-20 *	2	220	2.66	\$131.50	\$349.94	\$228,200
2019-20 *	3	210	2.77	\$183.19	\$507.77	\$325,000
2019-20 *	4	200	2.03	\$254.12	\$514.91	\$314,100
2019-20 *	TOTAL	220	2.55	\$170.36	\$434.25	\$1,139,900
2020-21 **	1	220	2.34	\$159.61	\$373.94	\$248,600
2020-21 **	2	210	1.99	\$148.05	\$294.95	\$189,600
2020-21 **	3	200	1.63	\$139.44	\$226.73	\$133,000
2020-21 **	4	200	1.98	\$143.51	\$284.20	\$168,300
2020-21 **	TOTAL	210	2.00	\$148.95	\$297.42	\$739,500
2021-22 **	1	230	2.64	\$144.32	\$380.51	\$267,000
2021-22 **	2	210	2.18	\$162.80	\$354.69	\$222,700
2021-22 **	3	200	1.93	\$149.15	\$288.14	\$173,300
2021-22 **	4	200	1.99	\$147.19	\$293.06	\$172,700
2021-22 **	TOTAL	210	2.20	\$150.49	\$331.59	\$835,700

\* 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 2020 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>
2018-19 *	1	130	20.03	\$260.34	\$5,214.25	\$2,002,300
2018-19 *	2	130	17.18	\$254.02	\$4,362.82	\$1,644,800
2018-19 *	3	110	17.86	\$278.22	\$4,970.24	\$1,689,900
2018-19 *	4	90	18.48	\$293.16	\$5,416.93	\$1,451,700
2018-19 *	TOTAL	110	18.40	\$269.48	\$4,958.86	\$6,788,700
2019-20 *	1	130	18.09	\$306.52	\$5,546.14	\$2,179,600
2019-20 *	2	90	18.27	\$320.65	\$5,857.53	\$1,640,100
2019-20 *	3	100	17.39	\$290.70	\$5,055.25	\$1,541,900
2019-20 *	4	60	19.44	\$368.59	\$7,163.89	\$1,397,000
2019-20 *	TOTAL	100	18.18	\$317.01	\$5,761.77	\$6,758,600
2020-21 **	1	100	16.01	\$282.72	\$4,526.97	\$1,365,800
2020-21 **	2	110	15.33	\$319.24	\$4,893.06	\$1,605,200
2020-21 **	3	110	12.45	\$298.17	\$3,712.04	\$1,217,800
2020-21 **	4	110	11.36	\$294.26	\$3,341.94	\$1,096,400
2020-21 **	TOTAL	110	13.74	\$299.12	\$4,110.13	\$5,285,100
2021-22 **	1	110	16.26	\$302.21	\$4,914.70	\$1,612,300
2021-22 **	2	110	14.22	\$313.54	\$4,457.90	\$1,462,500
2021-22 **	3	110	13.46	\$301.87	\$4,064.59	\$1,333,400
2021-22 **	4	110	10.89	\$291.46	\$3,174.79	\$1,041,500
2021-22 **	TOTAL	110	13.71	\$302.93	\$4,153.00	\$5,449,700

\* 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 2020 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>
2018-19 *	1	112,510	3.05	\$281.56	\$857.67	\$289,488,200
2018-19 *	2	106,030	2.90	\$297.72	\$864.69	\$275,039,000
2018-19 *	3	107,570	2.95	\$293.95	\$867.78	\$280,045,800
2018-19 *	4	93,750	2.85	\$325.93	\$927.75	\$260,925,200
2018-19 *	TOTAL	104,960	2.94	\$298.36	\$877.68	\$1,105,498,200
2019-20 *	1	104,260	3.19	\$297.99	\$950.53	\$297,319,100
2019-20 *	2	93,070	3.04	\$315.09	\$956.93	\$267,187,400
2019-20 *	3	96,040	3.02	\$303.52	\$915.12	\$263,665,700
2019-20 *	4	71,410	2.91	\$320.20	\$931.63	\$199,571,900
2019-20 *	TOTAL	91,200	3.05	\$307.92	\$939.14	\$1,027,744,000
2020-21 **	1	88,180	3.22	\$330.32	\$1,064.57	\$281,632,000
2020-21 **	2	87,850	3.20	\$324.54	\$1,037.17	\$273,355,900
2020-21 **	3	80,510	3.13	\$320.81	\$1,003.13	\$242,279,400
2020-21 **	4	74,430	3.08	\$319.80	\$984.80	\$219,901,700
2020-21 **	TOTAL	82,740	3.16	\$324.17	\$1,024.41	\$1,017,169,000
2021-22 **	1	93,270	3.43	\$317.45	\$1,089.17	\$304,774,400
2021-22 **	2	82,830	3.15	\$329.09	\$1,036.53	\$257,556,100
2021-22 **	3	84,450	3.23	\$318.84	\$1,030.63	\$261,099,000
2021-22 **	4	73,570	3.02	\$322.33	\$974.81	\$215,143,800
2021-22 **	TOTAL	83,530	3.22	\$321.63	\$1,036.15	\$1,038,573,300

\* ACTUAL

\*\* ESTIMATED

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

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2020 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>
2018-19 *	1	91,200	1.91	\$194.70	\$371.45	\$101,625,500
2018-19 *	2	85,260	1.77	\$197.55	\$349.03	\$89,276,100
2018-19 *	3	90,980	1.99	\$170.18	\$337.96	\$92,245,900
2018-19 *	4	88,100	1.98	\$167.29	\$330.66	\$87,399,400
2018-19 *	TOTAL	88,890	1.91	\$181.79	\$347.40	\$370,546,800
2019-20 *	1	95,090	2.00	\$179.07	\$358.93	\$102,387,800
2019-20 *	2	91,150	1.88	\$177.97	\$335.30	\$91,684,100
2019-20 *	3	94,060	1.87	\$182.82	\$341.73	\$96,432,300
2019-20 *	4	48,330	1.94	\$191.70	\$371.09	\$53,799,700
2019-20 *	TOTAL	82,160	1.92	\$181.68	\$349.24	\$344,303,900
2020-21 **	1	82,380	1.74	\$217.52	\$378.74	\$93,597,600
2020-21 **	2	93,840	1.84	\$195.20	\$358.70	\$100,979,400
2020-21 **	3	86,690	1.85	\$189.91	\$351.20	\$91,335,400
2020-21 **	4	86,270	1.87	\$191.43	\$357.14	\$92,433,600
2020-21 **	TOTAL	87,290	1.82	\$197.94	\$361.18	\$378,345,900
2021-22 **	1	100,270	1.88	\$212.59	\$400.01	\$120,326,600
2021-22 **	2	88,380	1.83	\$203.30	\$371.85	\$98,594,400
2021-22 **	3	91,540	1.89	\$200.20	\$377.91	\$103,781,400
2021-22 **	4	85,270	1.85	\$200.05	\$370.54	\$94,790,700
2021-22 **	TOTAL	91,370	1.86	\$204.33	\$380.79	\$417,493,200

\* 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 2020 BASE ESTIMATES)**

**POV 100**

**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>
2018-19 *	1	45,070	1.99	\$208.51	\$414.01	\$55,973,600
2018-19 *	2	42,440	1.78	\$209.82	\$372.94	\$47,487,200
2018-19 *	3	43,580	2.03	\$177.78	\$361.27	\$47,232,100
2018-19 *	4	42,510	2.04	\$176.92	\$360.17	\$45,929,500
2018-19 *	TOTAL	43,400	1.96	\$192.76	\$377.55	\$196,622,400
2019-20 *	1	48,310	2.04	\$198.36	\$404.40	\$58,603,300
2019-20 *	2	45,810	1.92	\$195.34	\$374.39	\$51,453,100
2019-20 *	3	46,080	1.90	\$193.35	\$367.72	\$50,838,100
2019-20 *	4	23,280	2.06	\$215.25	\$444.36	\$31,027,500
2019-20 *	TOTAL	40,870	1.97	\$198.69	\$391.34	\$191,922,100
2020-21 **	1	41,370	1.84	\$237.03	\$435.43	\$54,038,900
2020-21 **	2	48,840	1.74	\$205.26	\$356.82	\$52,282,700
2020-21 **	3	44,420	1.67	\$192.60	\$320.77	\$42,746,000
2020-21 **	4	45,020	1.76	\$191.95	\$336.94	\$45,508,700
2020-21 **	TOTAL	44,910	1.75	\$206.61	\$361.03	\$194,576,300
2021-22 **	1	51,550	1.89	\$212.99	\$401.62	\$62,113,800
2021-22 **	2	46,290	1.72	\$207.45	\$357.02	\$49,583,000
2021-22 **	3	46,970	1.69	\$196.99	\$333.42	\$46,980,800
2021-22 **	4	44,510	1.74	\$194.17	\$337.71	\$45,096,400
2021-22 **	TOTAL	47,330	1.76	\$203.49	\$358.77	\$203,774,000

\* ACTUAL

\*\* ESTIMATED

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



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**BASE POLICY CHANGES**

*The Base Policy Change section provides detailed information on baseline benefits expenditures beyond those reflected in the Fee-for-Service (FFS) base.*

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### **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 13 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  
Medicare Payments  
State Hospital/Developmental Centers  
Miscellaneous Services (Misc. Svcs.)  
Recoveries  
Drug Medi-Cal

## SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2020-21

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>ELIGIBILITY</u></b>					
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$38,257,000	\$24,485,000	\$0	\$13,772,000
7	CHILDREN'S HEALTH INSURANCE PROGRAM	\$8,159,000	\$5,891,950	\$2,267,050	\$0
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,158,000	\$2,280,550	\$877,450	\$0
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$49,574,000</b>	<b>\$32,657,500</b>	<b>\$3,144,500</b>	<b>\$13,772,000</b>
<b><u>DRUG MEDI-CAL</u></b>					
60	NARCOTIC TREATMENT PROGRAM	\$10,927,000	\$10,309,000	\$618,000	\$0
61	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$1,847,000	\$1,719,100	\$127,900	\$0
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$803,000	\$564,900	\$238,100	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$104,000	\$99,100	\$4,900	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$13,681,000</b>	<b>\$12,692,100</b>	<b>\$988,900</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>					
67	SMHS FOR ADULTS	\$1,589,549,000	\$1,446,087,470	\$74,961,530	\$68,500,000
68	SMHS FOR CHILDREN	\$1,295,135,000	\$1,203,707,170	\$46,176,830	\$45,251,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$2,884,684,000</b>	<b>\$2,649,794,640</b>	<b>\$121,138,360</b>	<b>\$113,751,000</b>
<b><u>MANAGED CARE</u></b>					
86	TWO PLAN MODEL	\$20,418,873,000	\$13,506,257,760	\$6,912,615,240	\$0
87	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,797,107,000	\$5,736,615,000	\$3,060,492,000	\$0
88	GEOGRAPHIC MANAGED CARE	\$3,667,038,000	\$2,417,084,570	\$1,249,953,430	\$0
94	REGIONAL MODEL	\$1,262,054,000	\$853,753,390	\$408,300,610	\$0
95	PACE (Other M/C)	\$803,282,000	\$401,641,000	\$401,641,000	\$0
99	DENTAL MANAGED CARE (Other M/C)	\$102,927,000	\$61,833,680	\$41,093,320	\$0
100	SENIOR CARE ACTION NETWORK (Other M/C)	\$59,259,000	\$29,629,500	\$29,629,500	\$0
103	AIDS HEALTHCARE CENTERS (Other M/C)	\$16,756,000	\$8,378,000	\$8,378,000	\$0
104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,811,000	(\$3,325,000)	\$5,136,000	\$0
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$35,129,107,000</b>	<b>\$23,011,867,910</b>	<b>\$12,117,239,090</b>	<b>\$0</b>
<b><u>OTHER</u></b>					
181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,640,885,000	\$1,706,666,500	\$1,934,218,500	\$0
182	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,841,109,000	\$2,841,109,000	\$0	\$0
183	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,188,827,000	\$0	\$2,188,827,000	\$0
184	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,451,946,000	\$2,451,946,000	\$0	\$0
185	DENTAL SERVICES	\$1,604,027,000	\$964,472,300	\$639,554,700	\$0
186	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$329,693,000	\$329,693,000	\$0	\$0
191	MEDI-CAL TCM PROGRAM	\$36,909,000	\$36,909,000	\$0	\$0

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2020-21**

<b>NO.</b>	<b>POLICY CHANGE TITLE</b>	<b>TOTAL FUNDS</b>	<b>FEDERAL FUNDS</b>	<b>GENERAL FUNDS</b>	<b>OTHER STATE FUNDS</b>
	<b><u>OTHER</u></b>				
192	LAWSUITS/CLAIMS	\$36,001,000	\$18,000,500	\$18,000,500	\$0
195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$40,545,000	\$40,545,000	\$0	\$0
207	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,598,000	\$1,598,000	\$0	\$0
208	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$911,000	\$511,500	\$399,500	\$0
224	BASE RECOVERIES	(\$460,373,000)	(\$266,534,500)	(\$193,838,500)	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$12,712,078,000</b>	<b>\$8,124,916,300</b>	<b>\$4,587,161,700</b>	<b>\$0</b>
	<b>GRAND TOTAL</b>	<b>\$50,789,124,000</b>	<b>\$33,831,928,450</b>	<b>\$16,829,672,550</b>	<b>\$127,523,000</b>

## SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2021-22

NO.	POLICY CHANGE TITLE	TOTAL FUNDS	FEDERAL FUNDS	GENERAL FUNDS	OTHER STATE FUNDS
<b><u>ELIGIBILITY</u></b>					
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$38,257,000	\$21,462,000	\$0	\$16,795,000
7	CHILDREN'S HEALTH INSURANCE PROGRAM	\$8,258,000	\$5,367,700	\$2,890,300	\$0
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,158,000	\$2,052,700	\$1,105,300	\$0
<b>ELIGIBILITY SUBTOTAL</b>		<b>\$49,673,000</b>	<b>\$28,882,400</b>	<b>\$3,995,600</b>	<b>\$16,795,000</b>
<b><u>DRUG MEDI-CAL</u></b>					
60	NARCOTIC TREATMENT PROGRAM	\$11,298,000	\$10,657,100	\$640,900	\$0
61	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$1,877,000	\$1,748,300	\$128,700	\$0
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$822,000	\$578,400	\$243,600	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$108,000	\$103,000	\$5,000	\$0
<b>DRUG MEDI-CAL SUBTOTAL</b>		<b>\$14,105,000</b>	<b>\$13,086,800</b>	<b>\$1,018,200</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>					
67	SMHS FOR ADULTS	\$1,667,275,000	\$1,505,568,500	\$88,803,500	\$72,903,000
68	SMHS FOR CHILDREN	\$1,343,054,000	\$1,239,974,500	\$54,116,500	\$48,963,000
<b>MENTAL HEALTH SUBTOTAL</b>		<b>\$3,010,329,000</b>	<b>\$2,745,543,000</b>	<b>\$142,920,000</b>	<b>\$121,866,000</b>
<b><u>MANAGED CARE</u></b>					
86	TWO PLAN MODEL	\$20,442,357,000	\$13,472,645,450	\$6,969,711,550	\$0
87	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,790,395,000	\$5,714,268,300	\$3,076,126,700	\$0
88	GEOGRAPHIC MANAGED CARE	\$3,672,552,000	\$2,412,108,950	\$1,260,443,050	\$0
94	REGIONAL MODEL	\$1,264,782,000	\$853,954,150	\$410,827,850	\$0
95	PACE (Other M/C)	\$948,444,000	\$474,222,000	\$474,222,000	\$0
99	DENTAL MANAGED CARE (Other M/C)	\$105,071,000	\$62,998,750	\$42,072,250	\$0
100	SENIOR CARE ACTION NETWORK (Other M/C)	\$61,547,000	\$30,773,500	\$30,773,500	\$0
103	AIDS HEALTHCARE CENTERS (Other M/C)	\$17,906,000	\$8,953,000	\$8,953,000	\$0
104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,686,000	\$0	\$1,686,000	\$0
<b>MANAGED CARE SUBTOTAL</b>		<b>\$35,304,740,000</b>	<b>\$23,029,924,100</b>	<b>\$12,274,815,900</b>	<b>\$0</b>
<b><u>OTHER</u></b>					
181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,829,336,000	\$1,794,408,000	\$2,034,928,000	\$0
182	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,577,181,000	\$2,577,181,000	\$0	\$0
183	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,476,374,000	\$0	\$2,476,374,000	\$0
184	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,167,416,000	\$2,167,416,000	\$0	\$0
185	DENTAL SERVICES	\$1,617,493,000	\$965,079,550	\$652,413,450	\$0
186	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$253,965,000	\$253,965,000	\$0	\$0
191	MEDI-CAL TCM PROGRAM	\$28,861,000	\$28,861,000	\$0	\$0

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2021-22**

<b>NO.</b>	<b>POLICY CHANGE TITLE</b>	<b>TOTAL FUNDS</b>	<b>FEDERAL FUNDS</b>	<b>GENERAL FUNDS</b>	<b>OTHER STATE FUNDS</b>
	<b><u>OTHER</u></b>				
192	LAWSUITS/CLAIMS	\$32,350,000	\$16,175,000	\$16,175,000	\$0
195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$35,038,000	\$35,038,000	\$0	\$0
207	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$1,028,000	\$0	\$0
208	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$956,000	\$478,000	\$478,000	\$0
224	BASE RECOVERIES	(\$364,943,000)	(\$211,285,100)	(\$153,657,900)	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$12,655,055,000</b>	<b>\$7,628,344,450</b>	<b>\$5,026,710,550</b>	<b>\$0</b>
	<b>GRAND TOTAL</b>	<b>\$51,033,902,000</b>	<b>\$33,445,780,750</b>	<b>\$17,449,460,250</b>	<b>\$138,661,000</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>ELIGIBILITY</u></b>						
4	5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$68,383,000	\$0	\$38,257,000	\$0	(\$30,126,000)	\$0
5	7	CHILDREN'S HEALTH INSURANCE PROGRAM	\$8,769,000	\$2,832,480	\$8,159,000	\$2,267,050	(\$610,000)	(\$565,430)
6	9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL	\$3,967,000	\$1,274,370	\$3,158,000	\$877,450	(\$809,000)	(\$396,920)
		<b>ELIGIBILITY SUBTOTAL</b>	<b>\$81,119,000</b>	<b>\$4,106,850</b>	<b>\$49,574,000</b>	<b>\$3,144,500</b>	<b>(\$31,545,000)</b>	<b>(\$962,350)</b>
		<b><u>DRUG MEDI-CAL</u></b>						
64	60	NARCOTIC TREATMENT PROGRAM	\$30,087,000	\$1,785,900	\$10,927,000	\$618,000	(\$19,160,000)	(\$1,167,900)
65	61	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$3,828,000	\$268,700	\$1,847,000	\$127,900	(\$1,981,000)	(\$140,800)
66	62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$1,531,000	\$433,300	\$803,000	\$238,100	(\$728,000)	(\$195,200)
68	65	RESIDENTIAL TREATMENT SERVICES	\$533,000	\$19,000	\$104,000	\$4,900	(\$429,000)	(\$14,100)
		<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$35,979,000</b>	<b>\$2,506,900</b>	<b>\$13,681,000</b>	<b>\$988,900</b>	<b>(\$22,298,000)</b>	<b>(\$1,518,000)</b>
		<b><u>MENTAL HEALTH</u></b>						
71	67	SMHS FOR ADULTS	\$1,544,652,000	\$77,135,190	\$1,589,549,000	\$74,961,530	\$44,897,000	(\$2,173,660)
72	68	SMHS FOR CHILDREN	\$1,208,875,000	\$60,954,030	\$1,295,135,000	\$46,176,830	\$86,260,000	(\$14,777,200)
		<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$2,753,527,000</b>	<b>\$138,089,220</b>	<b>\$2,884,684,000</b>	<b>\$121,138,360</b>	<b>\$131,157,000</b>	<b>(\$16,950,860)</b>
		<b><u>MANAGED CARE</u></b>						
92	86	TWO PLAN MODEL	\$20,578,936,000	\$6,962,987,970	\$20,418,873,000	\$6,912,615,240	(\$160,063,000)	(\$50,372,730)
93	87	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,865,094,000	\$3,078,314,040	\$8,797,107,000	\$3,060,492,000	(\$67,987,000)	(\$17,822,050)
94	88	GEOGRAPHIC MANAGED CARE	\$3,685,633,000	\$1,257,492,480	\$3,667,038,000	\$1,249,953,430	(\$18,595,000)	(\$7,539,040)
98	94	REGIONAL MODEL	\$1,275,951,000	\$414,807,400	\$1,262,054,000	\$408,300,610	(\$13,897,000)	(\$6,506,780)
99	95	PACE (Other M/C)	\$878,983,000	\$439,491,500	\$803,282,000	\$401,641,000	(\$75,701,000)	(\$37,850,500)
102	99	DENTAL MANAGED CARE (Other M/C)	\$109,892,000	\$44,104,840	\$102,927,000	\$41,093,320	(\$6,965,000)	(\$3,011,530)

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>MANAGED CARE</b>						
105	100	SENIOR CARE ACTION NETWORK (Other M/C)	\$60,230,000	\$30,115,000	\$59,259,000	\$29,629,500	(\$971,000)	(\$485,500)
106	103	AIDS HEALTHCARE CENTERS (Other M/C)	\$16,544,000	\$8,272,000	\$16,756,000	\$8,378,000	\$212,000	\$106,000
109	104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,655,000	\$3,964,000	\$1,811,000	\$5,136,000	\$156,000	\$1,172,000
		<b>MANAGED CARE SUBTOTAL</b>	<b>\$35,472,918,000</b>	<b>\$12,239,549,230</b>	<b>\$35,129,107,000</b>	<b>\$12,117,239,090</b>	<b>(\$343,811,000)</b>	<b>(\$122,310,140)</b>
		<b>OTHER</b>						
173	181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,624,292,000	\$1,924,326,000	\$3,640,885,000	\$1,934,218,500	\$16,593,000	\$9,892,500
175	182	HOME & COMMUNITY-BASED SVCS.- CDDS (Misc.)	\$2,312,584,000	\$0	\$2,841,109,000	\$0	\$528,525,000	\$0
174	183	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$2,365,613,000	\$2,365,613,000	\$2,188,827,000	\$2,188,827,000	(\$176,786,000)	(\$176,786,000)
176	184	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,153,343,000	\$0	\$2,451,946,000	\$0	\$298,603,000	\$0
177	185	DENTAL SERVICES	\$1,015,986,000	\$409,459,380	\$1,604,027,000	\$639,554,700	\$588,041,000	\$230,095,320
179	186	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$248,594,000	\$0	\$329,693,000	\$0	\$81,099,000	\$0
184	191	MEDI-CAL TCM PROGRAM	\$32,950,000	\$0	\$36,909,000	\$0	\$3,959,000	\$0
187	192	LAWSUITS/CLAIMS	\$32,350,000	\$16,175,000	\$36,001,000	\$18,000,500	\$3,651,000	\$1,825,500
183	195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$29,476,000	\$0	\$40,545,000	\$0	\$11,069,000	\$0
195	207	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$0	\$1,598,000	\$0	\$570,000	\$0
196	208	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$672,000	\$336,000	\$911,000	\$399,500	\$239,000	\$63,500
212	224	BASE RECOVERIES	(\$497,873,000)	(\$224,071,000)	(\$460,373,000)	(\$193,838,500)	\$37,500,000	\$30,232,500



**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>OTHER</b>						
185	--	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$48,467,000	\$24,233,500	\$0	\$0	(\$48,467,000)	(\$24,233,500)
		<b>OTHER SUBTOTAL</b>	<b>\$11,367,482,000</b>	<b>\$4,516,071,880</b>	<b>\$12,712,078,000</b>	<b>\$4,587,161,700</b>	<b>\$1,344,596,000</b>	<b>\$71,089,820</b>
		<b>GRAND TOTAL</b>	<b>\$49,711,025,000</b>	<b>\$16,900,324,080</b>	<b>\$50,789,124,000</b>	<b>\$16,829,672,550</b>	<b>\$1,078,099,000</b>	<b>(\$70,651,530)</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>ELIGIBILITY</u></b>							
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213 -322% FPL	\$38,257,000	\$0	\$38,257,000	\$0	\$0	\$0
7	CHILDREN'S HEALTH INSURANCE PROGRAM	\$8,159,000	\$2,267,050	\$8,258,000	\$2,890,300	\$99,000	\$623,250
9	MEDI-CAL ACCESS INFANT PROGRAM 266- 322% FPL	\$3,158,000	\$877,450	\$3,158,000	\$1,105,300	\$0	\$227,850
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$49,574,000</b>	<b>\$3,144,500</b>	<b>\$49,673,000</b>	<b>\$3,995,600</b>	<b>\$99,000</b>	<b>\$851,100</b>
<b><u>DRUG MEDI-CAL</u></b>							
60	NARCOTIC TREATMENT PROGRAM	\$10,927,000	\$618,000	\$11,298,000	\$640,900	\$371,000	\$22,900
61	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$1,847,000	\$127,900	\$1,877,000	\$128,700	\$30,000	\$800
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$803,000	\$238,100	\$822,000	\$243,600	\$19,000	\$5,500
65	RESIDENTIAL TREATMENT SERVICES	\$104,000	\$4,900	\$108,000	\$5,000	\$4,000	\$100
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$13,681,000</b>	<b>\$988,900</b>	<b>\$14,105,000</b>	<b>\$1,018,200</b>	<b>\$424,000</b>	<b>\$29,300</b>
<b><u>MENTAL HEALTH</u></b>							
67	SMHS FOR ADULTS	\$1,589,549,000	\$74,961,530	\$1,667,275,000	\$88,803,500	\$77,726,000	\$13,841,970
68	SMHS FOR CHILDREN	\$1,295,135,000	\$46,176,830	\$1,343,054,000	\$54,116,500	\$47,919,000	\$7,939,670
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$2,884,684,000</b>	<b>\$121,138,360</b>	<b>\$3,010,329,000</b>	<b>\$142,920,000</b>	<b>\$125,645,000</b>	<b>\$21,781,640</b>
<b><u>MANAGED CARE</u></b>							
86	TWO PLAN MODEL	\$20,418,873,000	\$6,912,615,240	\$20,442,357,000	\$6,969,711,550	\$23,484,000	\$57,096,310
87	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,797,107,000	\$3,060,492,000	\$8,790,395,000	\$3,076,126,700	(\$6,712,000)	\$15,634,700
88	GEOGRAPHIC MANAGED CARE	\$3,667,038,000	\$1,249,953,430	\$3,672,552,000	\$1,260,443,050	\$5,514,000	\$10,489,620
94	REGIONAL MODEL	\$1,262,054,000	\$408,300,610	\$1,264,782,000	\$410,827,850	\$2,728,000	\$2,527,240
95	PACE (Other M/C)	\$803,282,000	\$401,641,000	\$948,444,000	\$474,222,000	\$145,162,000	\$72,581,000
99	DENTAL MANAGED CARE (Other M/C)	\$102,927,000	\$41,093,320	\$105,071,000	\$42,072,250	\$2,144,000	\$978,940
100	SENIOR CARE ACTION NETWORK (Other M/C)	\$59,259,000	\$29,629,500	\$61,547,000	\$30,773,500	\$2,288,000	\$1,144,000
103	AIDS HEALTHCARE CENTERS (Other M/C)	\$16,756,000	\$8,378,000	\$17,906,000	\$8,953,000	\$1,150,000	\$575,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b>MANAGED CARE</b>							
104	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,811,000	\$5,136,000	\$1,686,000	\$1,686,000	(\$125,000)	(\$3,450,000)
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$35,129,107,000</b>	<b>\$12,117,239,090</b>	<b>\$35,304,740,000</b>	<b>\$12,274,815,900</b>	<b>\$175,633,000</b>	<b>\$157,576,810</b>
<b>OTHER</b>							
181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$3,640,885,000	\$1,934,218,500	\$3,829,336,000	\$2,034,928,000	\$188,451,000	\$100,709,500
182	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$2,841,109,000	\$0	\$2,577,181,000	\$0	(\$263,928,000)	\$0
183	MEDICARE PAYMENTS - PART D PHASED- DOWN	\$2,188,827,000	\$2,188,827,000	\$2,476,374,000	\$2,476,374,000	\$287,547,000	\$287,547,000
184	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,451,946,000	\$0	\$2,167,416,000	\$0	(\$284,530,000)	\$0
185	DENTAL SERVICES	\$1,604,027,000	\$639,554,700	\$1,617,493,000	\$652,413,450	\$13,466,000	\$12,858,750
186	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$329,693,000	\$0	\$253,965,000	\$0	(\$75,728,000)	\$0
191	MEDI-CAL TCM PROGRAM	\$36,909,000	\$0	\$28,861,000	\$0	(\$8,048,000)	\$0
192	LAWSUITS/CLAIMS	\$36,001,000	\$18,000,500	\$32,350,000	\$16,175,000	(\$3,651,000)	(\$1,825,500)
195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$40,545,000	\$0	\$35,038,000	\$0	(\$5,507,000)	\$0
207	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,598,000	\$0	\$1,028,000	\$0	(\$570,000)	\$0
208	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$911,000	\$399,500	\$956,000	\$478,000	\$45,000	\$78,500
224	BASE RECOVERIES	(\$460,373,000)	(\$193,838,500)	(\$364,943,000)	(\$153,657,900)	\$95,430,000	\$40,180,600
	<b>OTHER SUBTOTAL</b>	<b>\$12,712,078,000</b>	<b>\$4,587,161,700</b>	<b>\$12,655,055,000</b>	<b>\$5,026,710,550</b>	<b>(\$57,023,000)</b>	<b>\$439,548,850</b>
	<b>GRAND TOTAL</b>	<b>\$50,789,124,000</b>	<b>\$16,829,672,550</b>	<b>\$51,033,902,000</b>	<b>\$17,449,460,250</b>	<b>\$244,778,000</b>	<b>\$619,787,700</b>

## MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b><u>ELIGIBILITY</u></b>
5	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
7	CHILDREN'S HEALTH INSURANCE PROGRAM
9	MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL
	<b><u>DRUG MEDI-CAL</u></b>
60	NARCOTIC TREATMENT PROGRAM
61	OUTPATIENT DRUG FREE TREATMENT SERVICES
62	INTENSIVE OUTPATIENT TREATMENT SERVICES
65	RESIDENTIAL TREATMENT SERVICES
	<b><u>MENTAL HEALTH</u></b>
67	SMHS FOR ADULTS
68	SMHS FOR CHILDREN
	<b><u>MANAGED CARE</u></b>
86	TWO PLAN MODEL
87	COUNTY ORGANIZED HEALTH SYSTEMS
88	GEOGRAPHIC MANAGED CARE
94	REGIONAL MODEL
95	PACE (OTHER M/C)
99	DENTAL MANAGED CARE (OTHER M/C)
100	SENIOR CARE ACTION NETWORK (OTHER M/C)
103	AIDS HEALTHCARE CENTERS (OTHER M/C)
104	FAMILY MOSAIC CAPITATED CASE MGMT. (OTH. M/C)
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181	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
182	HOME & COMMUNITY-BASED SVCS.-CDDS (MISC.)
183	MEDICARE PAYMENTS - PART D PHASED-DOWN
184	PERSONAL CARE SERVICES (MISC. SVCS.)
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186	TARGETED CASE MGMT. SVCS. - CDDS (MISC. SVCS.)
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192	LAWSUITS/CLAIMS
195	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
207	CLPP CASE MANAGEMENT SERVICES (MISC. SVCS.)
208	HIPP PREMIUM PAYOUTS (MISC. SVCS.)
224	BASE RECOVERIES

## MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

**BASE POLICY CHANGE NUMBER:** 5  
**IMPLEMENTATION DATE:** 7/2014  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1837

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$38,257,000	\$38,257,000
<b>- STATE FUNDS</b>	\$13,772,000	\$16,795,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$38,257,000	\$38,257,000
<b>STATE FUNDS</b>	\$13,772,000	\$16,795,000
<b>FEDERAL FUNDS</b>	\$24,485,000	\$21,462,000

**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 17-043  
 SPA 17-044  
 SPA CA 18-0028  
 Families First Coronavirus Response Act (FFCRA)

**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 made 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 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP).

## MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

### BASE POLICY CHANGE NUMBER: 5

The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 (COVID-19) national public health (PHE) emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to declining enrollment for calendar year 2020 and fewer deliveries than previously estimated. Additionally, delivery expenditures are now projected using historical actuals. There is no total fund change from FY 2020-21 to FY 2021-22 in the current estimate. There is an increase in state fund expenditures due to the Title XXI FMAP change as well as increased federal funding being available in FY 2020-21 due to the FFCRA.

#### Methodology:

1. Based on actual enrollment, the Department estimates the following:

Program Forecast	FY 2020-21	FY 2021-22
Average Monthly Caseload	4,132	4,132
Average Expected Deliveries	324	324
Per Member Per Month (PMPM)	\$278.69	\$278.69
Supplemental Capitation Payment	\$7,384	\$7,384

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 \$2,865,000 in FY 2020-21 and FY 2021-22. Premium projections include reductions from waiving premiums due to statewide disasters such as the COVID-19 PHE and California wildfire season.
4. The Department assumes 10% of monthly subscribers have a maternity only deductible exceeding \$500 and are ineligible for FFP.
5. The total estimated costs for MCAP mothers in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

FY 2020-21	TF	SF	FF
76.5% Title XXI FFP / 23.5% Perinatal Insurance Fund	\$12,328	\$2,897	\$9,431
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$24,657	\$8,630	\$16,027
FFCRA 4.34% Increased FFP	\$0	(\$1,605)	\$1,605
100% Perinatal Insurance Fund	\$4,137	\$4,137	\$0
Premium Payments	(\$2,865)	(\$287)	(\$2,578)
<b>Total</b>	<b>\$38,257</b>	<b>\$13,772</b>	<b>\$24,485</b>

**MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL**  
**BASE POLICY CHANGE NUMBER: 5**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
65% Title XXI FFP / 35% Perinatal Insurance Fund	\$36,985	\$12,945	\$24,040
100% Perinatal Insurance Fund	\$4,137	\$4,137	\$0
Premium Payments	(\$2,865)	(\$287)	(\$2,578)
<b>Total</b>	<b>\$38,257</b>	<b>\$16,795</b>	<b>\$21,462</b>

**Funding:**

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% Perinatal Insurance Fund (4260-602-0309)

## CHILDREN'S HEALTH INSURANCE PROGRAM

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

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,159,000	\$8,258,000
<b>- STATE FUNDS</b>	\$2,267,050	\$2,890,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$8,159,000	\$8,258,000
<b>STATE FUNDS</b>	\$2,267,050	\$2,890,300
<b>FEDERAL FUNDS</b>	\$5,891,950	\$5,367,700

**Purpose:**

This policy change estimates the costs for the County Health Initiative Matching (CHIM) fund for the Children's Health Initiative Program (CHIP), as well as Medi-Cal costs and premium collection.

**Authority:**

AB 495 (Chapter 648, Statutes of 2001)  
 SB 800 (Chapter 448, Statutes of 2013)  
 SB 857 (Chapter 31, Statutes of 2014)  
 SPA 17-043  
 SPA 17-044  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

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.



## CHILDREN'S HEALTH INSURANCE PROGRAM

### BASE POLICY CHANGE NUMBER: 7

On March 7, 2016, CCHIP integrated into the California Healthcare Eligibility, Enrollment, and Retention System.

Effective October 1, 2019, the Department transitioned CCHIP beneficiaries into the Medi-Cal Managed Care (MCMC) delivery system and also transitioned all administrative functions, such as premium collection and case management, for CCHIP to MAXIMUS. MAXIMUS is the current administrator vendor for the Medi-Cal Access Program (MCAP) and the Optional Targeted Low Income Program (OTLICP). The OTLICP, MCAP, Special Populations Admin Costs policy change contains costs for MAXIMUS' administrative functions and contract transition responsibilities. CCHIP premium collections and benefit costs for CCHIP eligibles are still reflected in this policy change.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to fewer projected MCMC eligibles and due to a slight decrease in projected premium collection.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in General Fund expenditures due to the Title XXI FMAP change as well as enhanced federal funding being available in FY 2020-21 due to FFCRA act. There is a slight increase in total fund expenditures due to a change in projected rates.

#### Methodology:

1. Beginning January 1, 2014, Santa Clara and San Mateo Counties elected not to provide funding for the non-federal share of the IGTs. Beginning January 1, 2015, San Francisco County elected not to provide funding for the non-federal share of the IGTs.
2. Assume a multi-year reconciliation was completed in FY 2019-20.
3. Assume annual premiums collected for CCHIP will be \$1,500,000 in both FY 2020-21 and FY 2021-22. Premium projections include reductions from waiving premiums due to statewide disasters such as the COVID-19 PHE and California wildfire season.
4. Effective October 2019, CCHIP beneficiaries transitioned into the MCMC delivery system and all administrative functions transitioned to MAXIMUS.
5. Assume a one-month lag in costs for Managed Care.
6. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**CHILDREN'S HEALTH INSURANCE PROGRAM**  
**BASE POLICY CHANGE NUMBER: 7**

7. Assume there will be approximately 8,000 CCHIP beneficiaries in FY 2020-21 and FY 2021-22.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Benefits Title XXI 76.5/23.5 GF	\$2,040,000	\$479,000	\$1,561,000
Benefits Title XXI 65/35 GF	\$6,119,000	\$2,142,000	\$3,977,000
FFCRA 4.34% Increased FFP	\$0	(\$354,000)	\$354,000
<b>Total FY 2020-21</b>	<b>\$8,159,000</b>	<b>\$2,267,000</b>	<b>\$5,892,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Benefits Title XXI 65/35 GF	\$8,258,000	\$2,890,300	\$5,367,700
<b>Total FY 2021-22</b>	<b>\$8,258,000</b>	<b>\$2,890,300</b>	<b>\$5,367,700</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

**BASE POLICY CHANGE NUMBER:** 9  
**IMPLEMENTATION DATE:** 11/2013  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1797

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,158,000	\$3,158,000
<b>- STATE FUNDS</b>	\$877,450	\$1,105,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,158,000	\$3,158,000
<b>STATE FUNDS</b>	\$877,450	\$1,105,300
<b>FEDERAL FUNDS</b>	\$2,280,550	\$2,052,700

**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)  
 SPA 17-043  
 SPA 17-044  
 Families First Coronavirus Response Act (FFCRA)

**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 targeted to occur in 2020. 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL

### BASE POLICY CHANGE NUMBER: 9

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to a change in the weighted average PMPM. There is no total fund change from FY 2020-21 to FY 2021-22 in the current estimate. The change in general fund expenditures is due to the change in the Title XXI FMAP as well as enhanced federal funding being available in FY 2020-21 due to FFCRA and CARES act.

#### Methodology:

- The Department estimates the following average monthly infants with family income between 266% and 322% FPL will enroll in FY 2020-21 and FY 2021-22:

Delivery System	FY 2020-21	FY 2021-22
FFS	247	247
Medi-Cal Managed Care	663	663
<b>Total Monthly Enrollment</b>	<b>910</b>	<b>910</b>

- The Department estimates the weighted average PMPM cost in FY 2020-21 and FY 2021-22 is \$638.04 for FFS infants and \$177.56 for Medi-Cal Managed Care infants.
- MCAIP subscribers are subject to monthly premiums. Premiums are estimated to total \$142,000 in FY 2020-21 and FY 2021-22. Premium projections include reductions from waiving premiums due to statewide disasters such as the COVID-19 PHE and California wildfire season.
- 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.
- The total estimated costs for MCAIP infants in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Benefits	\$3,300	\$1,060	\$2,240
Premiums	(\$142)	(\$46)	(\$96)
FFCRA 4.34% Increased FFP	\$0	(\$137)	\$137
<b>Net</b>	<b>\$3,158</b>	<b>\$877</b>	<b>\$2,281</b>

FY 2021-22	TF	GF	FF
Benefits	\$3,300	\$1,155	\$2,145
Premiums	(\$142)	(\$50)	(\$92)
<b>Net</b>	<b>\$3,158</b>	<b>\$1,105</b>	<b>\$2,053</b>

\*Totals may differ due to rounding.

**MEDI-CAL ACCESS INFANT PROGRAM 266-322% FPL**  
**BASE POLICY CHANGE NUMBER: 9**

**Funding:**

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

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

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

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)

## NARCOTIC TREATMENT PROGRAM

**BASE POLICY CHANGE NUMBER:** 60  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Devon Dyer  
**FISCAL REFERENCE NUMBER:** 1728

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$10,927,000	\$11,298,000
<b>- STATE FUNDS</b>	\$618,000	\$640,900
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$10,927,000	\$11,298,000
<b>STATE FUNDS</b>	\$618,000	\$640,900
<b>FEDERAL FUNDS</b>	\$10,309,000	\$10,657,100

**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  
 COVID-19 Increased FMAP - DHCS  
 COVID-19 Increased FMAP Extension - DHCS

**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 that 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: 60

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, FY 2020-21, is due to counties shifting to the DMC-ODS waiver, resulting in decreased users for the most recent months of actual data dampening the historical trend.

Expenditures remain fairly stable between fiscal years in the current estimate.

#### Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2017-July 2020) and trending the Users, Units/User, and Rate.

FY 2020-21				FY 2021-22			
Average Monthly			Total	Average Monthly			Total
Users	Units/ User	Rate		Users	Units/ User	Rate	

#### Regular

All Others	901	60.5	\$14.48	\$9,465,000	983	57.1	\$14.48	\$9,746,000
ACA Optional	649	54.8	\$14.48	\$6,176,000	707	52.1	\$14.48	\$6,405,000
Regular Subtotal				\$15,641,000				\$16,152,000

#### Perinatal

All Others	5	31.9	\$14.95	\$30,000	6	30.0	\$14.95	\$31,000
ACA Optional	2	12.7	\$15.01	\$4,000	2	12.7	\$15.01	\$4,000
Perinatal Subtotal				\$34,000				\$35,000

<b>Total</b>				<b>\$15,675,000</b>				<b>\$16,187,000</b>
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- Rate Year 2020-21 rate increases are not included in this policy change. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC.
- Funding for populations eligible prior to the implementation of the Affordable Care Act (ACA) in 2014 is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Counties do not have a share of cost for services provided to beneficiaries as part of the Drug Medi-Cal program expansion under the ACA. Instead the non-federal share is funded through the State General Fund. Beginning January 2020, ongoing funding for ACA Optional beneficiaries is 90% FF/10% GF.

## NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 60

Total estimated expenditures for NTP services are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$4,747,000	\$0	\$4,747,000	\$4,748,000
ACA 90% FFP/10% GF (2020)	\$6,180,000	\$618,000	\$5,562,000	\$0
<b>Total</b>	<b>\$10,927,000</b>	<b>\$618,000</b>	<b>\$10,309,000</b>	\$4,748,000

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$4,889,000	\$0	\$4,889,000	\$4,889,000
ACA 90% FFP/10% GF (2020)	\$6,409,000	\$640,000	\$5,769,000	\$0
<b>Total</b>	<b>\$11,298,000</b>	<b>\$640,000</b>	<b>\$10,658,000</b>	\$4,889,000

**Funding:**

Title XIX FF (4260-101-0890)

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

\* County Funds are not included in Total Fund

\*\* Totals may differ due to rounding



## OUTPATIENT DRUG FREE TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 61  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Devon Dyer  
**FISCAL REFERENCE NUMBER:** 1727

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,847,000	\$1,877,000
<b>- STATE FUNDS</b>	\$127,900	\$128,700
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,847,000	\$1,877,000
<b>STATE FUNDS</b>	\$127,900	\$128,700
<b>FEDERAL FUNDS</b>	\$1,719,100	\$1,748,300

**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  
 COVID-19 Increased FMAP - DHCS  
 COVID-19 Increased FMAP Extension - DHCS

**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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

### BASE POLICY CHANGE NUMBER: 61

September 30, 2012 that 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. 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, FY 2020-21, is due to counties shifting to the DMC-ODS waiver, resulting in decreased users for the most recent months of actual data dampening the historical trend.

Expenditures remain fairly stable between fiscal years in the current estimate.

#### Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2017-July 2020) and trending the Users, Units/User, and Rate.

FY 2020-21				FY 2021-22			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

#### Regular

All Others	467	5.0	\$39.03	\$1,094,000	510	4.8	\$39.06	\$1,137,000
ACA Optional	508	5.5	\$38.15	\$1,273,000	555	5.0	\$38.15	\$1,281,000
Regular Subtotal				\$2,367,000				\$2,418,000

#### Perinatal

All Others	9	4.1	\$53.13	\$23,000	9	3.9	\$53.13	\$24,000
ACA Optional	3	3.2	\$54.33	\$6,000	3	2.9	\$54.33	\$6,000
Perinatal Subtotal				\$29,000				\$30,000

<b>Total</b>				<b>\$2,396,000</b>				<b>\$2,447,000</b>
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## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 61

2. Rate Year 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.
3. Funding for populations eligible prior to the implementation of the Affordable Care Act (ACA) in 2014 is generally 50% County Funds (CF) and 50% Title XIX Federal Funds (FF).. Certain aid codes are eligible for Title XXI federal reimbursement at 76.5% October 2019 through September 2020, and 65% October 2020 and thereafter. Counties do not have a share of cost for services provided to beneficiaries as part of the Drug Medi-Cal program expansion under the ACA. Instead the non-federal share is funded through the State General Fund. Beginning January 2020, ongoing funding for ACA Optional beneficiaries is 90% FF / 10% GF.

Total estimated expenditures for ODF services are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$528,000	\$0	\$528,000	\$529,000
ACA 90% FFP/10% GF (2020)	\$1,279,000	\$128,000	\$1,151,000	\$0
Title XXI 100%	\$40,000	\$0	\$40,000	\$20,000
<b>Total</b>	<b>\$1,847,000</b>	<b>\$128,000</b>	<b>\$1,719,000</b>	<b>\$549,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$548,000	\$0	\$548,000	\$548,000
ACA 90% FFP/10% GF (2020)	\$1,287,000	\$129,000	\$1,158,000	\$0
Title XXI 100%	\$42,000	\$0	\$42,000	\$22,000
<b>Total</b>	<b>\$1,877,000</b>	<b>\$129,000</b>	<b>\$1,748,000</b>	<b>\$570,000</b>

### Funding:

Title XIX FF (4260-101-0890)

Title XXI FF (4260-113-0890)

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

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

\* County Funds are not included in Total Fund

\*\* Totals may differ due to rounding

## INTENSIVE OUTPATIENT TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 62  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Devon Dyer  
**FISCAL REFERENCE NUMBER:** 1726

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$803,000	\$822,000
<b>- STATE FUNDS</b>	\$238,100	\$243,600
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$803,000	\$822,000
<b>STATE FUNDS</b>	\$238,100	\$243,600
<b>FEDERAL FUNDS</b>	\$564,900	\$578,400

**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  
 COVID-19 Increased FMAP - DHCS  
 COVID-19 Increased FMAP Extension - DHCS

**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 that 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: 62

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, FY 2020-21, is due to counties shifting to the DMC-ODS waiver, resulting in decreased users for the most recent months of actual data dampening the historical trend.

Expenditures remain fairly stable between fiscal years in the current estimate.

#### Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2017-July 2020) and trending the Users, Units/User, and Rate.

FY 2020-21				FY 2021-22			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

#### Regular

All Others	61	8.0	\$68.41	\$396,000	66	7.5	\$68.38	\$404,000
ACA Optional	59	8.2	\$69.27	\$404,000	65	7.7	\$69.27	\$414,000
Regular Subtotal				\$800,000				\$818,000

#### Perinatal

All Others	1	3.6	\$87.89	\$3,000	1	3.6	\$87.89	\$4,000
ACA Optional	1	2.6	\$88.57	\$2,000	1	2.6	\$88.57	\$2,000
Perinatal Subtotal				\$5,000				\$6,000

<b>Total</b>				<b>\$805,000</b>				<b>\$824,000</b>
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- Rate Year 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.

## INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

3. Funding for populations eligible prior to the implementation of the Affordable Care Act (ACA) in 2014 is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Counties do not have a share of cost for services provided to beneficiaries as part of the Drug Medi-Cal program expansion under the ACA. Instead the non-federal share is funded through the State General Fund. Beginning January 2020, ongoing funding for ACA Optional beneficiaries is 90% FF/10% GF.

Total estimated expenditures for IOT services are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$2,000	\$0	\$2,000	\$2,000
50% Title XIX / 50% GF	\$395,000	\$197,000	\$198,000	\$0
ACA 90% FFP/10% GF (2020)	\$406,000	\$40,000	\$366,000	\$0
<b>Total</b>	<b>\$803,000</b>	<b>\$237,000</b>	<b>\$566,000</b>	<b>\$2,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$2,000	\$0	\$2,000	\$2,000
50% Title XIX / 50% GF	\$404,000	\$202,000	\$202,000	\$0
ACA 90% FFP/10% GF (2020)	\$416,000	\$41,000	\$375,000	\$0
<b>Total</b>	<b>\$822,000</b>	<b>\$243,000</b>	<b>\$579,000</b>	<b>\$2,000</b>

**Funding:**

Title XIX FF (4260-101-0890)

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

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

\* County Funds are not included in Total Fund

\*\* Totals may differ due to rounding

## RESIDENTIAL TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 65  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Devon Dyer  
**FISCAL REFERENCE NUMBER:** 1725

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$104,000	\$108,000
<b>- STATE FUNDS</b>	\$4,900	\$5,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$104,000	\$108,000
<b>STATE FUNDS</b>	\$4,900	\$5,000
<b>FEDERAL FUNDS</b>	\$99,100	\$103,000

**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  
 COVID-19 Increased FMAP - DHCS  
 COVID-19 Increased FMAP Extension - DHCS

**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.

## RESIDENTIAL TREATMENT SERVICES

### BASE POLICY CHANGE NUMBER: 65

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 that 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, FY 2020-21, is due to counties shifting to the DMC-ODS waiver, resulting in decreased users for the most recent months of actual data dampening the historical trend.

Expenditures remain fairly stable between fiscal years in the current estimate.

#### Methodology:

- Expenditures are estimated using 36-months of cash-basis expenditure data (August 2017-July 2020) and trending the Users, Units/User, and Rate.

FY 2020-21				FY 2021-22			
Average Monthly				Average Monthly			
Users	Units/ User	Rate	Total	Users	Units/ User	Rate	Total

#### Perinatal

All Others	6	15.0	\$99.13	\$110,000	7	14.3	\$99.13	\$115,000
ACA Optional	3	13.3	\$102.32	\$49,000	3	12.5	\$102.32	\$50,000

<b>Total</b>				<b>\$159,000</b>				<b>\$165,000</b>
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## RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

2. RY 2020-21 rate increases are budgeted in the Drug Medi-Cal Annual Rate Adjustment PC and are not included in this policy change.
3. Funding for populations eligible prior to the implementation of the Affordable Care Act (ACA) in 2014 is 50% County Funds (CF) and 50% Title XIX Federal Funds (FF). Counties do not have a share of cost for services provided to beneficiaries as part of the Drug Medi-Cal program expansion under the ACA. Instead the non-federal share is funded through the State General Fund. Beginning January 2020, ongoing funding for ACA Optional beneficiaries is 90% FF/10% GF.

Total estimate expenditures for Residential services are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$55,000	\$0	\$55,000	\$55,000
ACA 90% FFP/10% GF (2020)	\$49,000	\$5,000	\$44,000	\$0
<b>Total</b>	<b>\$104,000</b>	<b>\$5,000</b>	<b>\$99,000</b>	\$55,000

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF*</b>
Title XIX 100%	\$58,000	\$0	\$58,000	\$57,000
ACA 90% FFP / 10% GF (2020)	\$50,000	\$5,000	\$45,000	\$0
<b>Total</b>	<b>\$108,000</b>	<b>\$5,000</b>	<b>\$103,000</b>	\$57,000

### Funding:

Title XIX FF (4260-101-0890)

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

\* County Funds are not included in Total Fund

\*\* Totals may differ due to rounding

## SMHS FOR ADULTS

**BASE POLICY CHANGE NUMBER:** 67  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1780

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,589,549,000	\$1,667,275,000
<b>- STATE FUNDS</b>	\$143,461,530	\$161,706,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,589,549,000	\$1,667,275,000
<b>STATE FUNDS</b>	\$143,461,530	\$161,706,500
<b>FEDERAL FUNDS</b>	\$1,446,087,470	\$1,505,568,500

**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  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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: 67**

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net increase due to updated estimated Affordable Care Act (ACA) utilization and costs for Short Doyle/Medi-Cal (SD/MC), based on additional paid claims data through March 31, 2020.

The change between FY 2020-21 and FY 2021-22, in the current estimate, is an increase due to an overall increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2021-22, based on projections for SD/MC claims 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, 2020, with dates of service from June 2014 through March 2020. The FFS data is current as of June 30, 2020, with dates of service from April 2014 through January 2020.
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

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 67

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.

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 2020-21 Utilization	FY 2021-22 Utilization
SD/MC	196,304	190,490
SD/MC ACA	143,348	149,274
FFS	11,925	11,668
FFS ACA	17,246	18,331
Total	368,823	369,763

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 2018-19	\$1,975,815	\$1,696,970	\$278,845
FY 2019-20	\$2,072,146	\$1,769,081	\$303,065
FY 2020-21	\$2,165,439	\$1,839,055	\$326,384
FY 2021-22	\$2,258,731	\$1,909,029	\$349,702

6. On a cash basis for FY 2020-21, the Department will be paying 1% of FY 2018-19 claims, 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2018-19 claims, 54% of FY 2019-20 claims, and 45% of FY 2020-21 claims. The cash amounts (rounded) for Adult's SMHS are:

(Dollars in Thousands)

Fiscal Year	TF	SD/MC	FFS Inpatient
FY 2018-19	\$19,758	\$16,970	\$2,788
FY 2019-20	\$1,242,794	\$1,079,139	\$163,655
FY 2020-21	\$845,714	\$698,841	\$146,873
Total FY 2020-21	\$2,108,266	\$1,794,950	\$313,316

7. On a cash basis for FY 2021-22, the Department will be paying 1% of FY 2019-20 claims, 61% of FY 2020-21 claims, and 38% of FY 2021-22 claims for SD/MC claims. For FFS Inpatient claims, the Department will be paying 1% of FY 2019-20 claims, 54% of FY 2020-21 claims, and 45% of FY 2021-22 claims. The cash amounts (rounded) are:

**SMHS FOR ADULTS**  
**BASE POLICY CHANGE NUMBER: 67**

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2019-20	\$20,722	\$17,691	\$3,031
FY 2020-21	\$1,298,070	\$1,121,823	\$176,247
FY 2021-22	\$882,797	\$725,431	\$157,366
<b>Total FY 2021-22</b>	<b>\$2,201,589</b>	<b>\$1,864,945</b>	<b>\$336,644</b>

8. The chart below shows the FY 2020-21 and FY 2021-22 estimate with the following funding adjustments:

- Medi-Cal claims are eligible for 50% federal reimbursement;
- ACA is funded by 94% federal funds (FF) 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)

<b>Fiscal Year</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>ACA GF</b>	<b>GF Reimbursement</b>	<b>County</b>
FY 2020-21	\$2,108,265	\$642,329	\$748,647	\$74,961	\$75,267	\$567,062
FY 2021-22	\$2,201,589	\$656,179	\$800,428	\$88,803	\$78,095	\$578,084

9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF Reimbursement</b>	<b>CF</b>	<b>FFCRA</b>
FFCRA 6.2% XIX Increased FFP	\$0	(\$6,767)	(\$48,345)	\$55,112
<b>Total</b>	<b>\$0</b>	<b>(\$6,767)</b>	<b>(\$48,345)</b>	<b>\$55,112</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF Reimbursement</b>	<b>CF</b>	<b>FFCRA</b>
FFCRA 6.2% XIX Increased FFP	\$0	(\$5,192)	(\$43,769)	\$48,961
<b>Total</b>	<b>\$0</b>	<b>(\$5,192)</b>	<b>(\$43,769)</b>	<b>\$48,961</b>

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>ACA GF</b>	<b>GF Reimbursement</b>	<b>CF</b>	<b>FFCRA</b>
<b>FY 2020-21</b>	<b>\$2,053,154</b>	<b>\$642,329</b>	<b>\$748,647</b>	<b>\$74,962</b>	<b>\$68,500</b>	<b>\$518,717</b>	<b>\$55,112</b>
<b>FY 2021-22</b>	<b>\$2,152,628</b>	<b>\$656,179</b>	<b>\$800,428</b>	<b>\$88,803</b>	<b>\$72,903</b>	<b>\$534,315</b>	<b>\$48,961</b>

**SMHS FOR ADULTS**  
**BASE POLICY CHANGE NUMBER: 67**

**Funding:**

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

100% Reimbursement (4260-601-0995)

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)

FFCRA 6.2% Increased FFP (4260-101-0890)

## SMHS FOR CHILDREN

**BASE POLICY CHANGE NUMBER:** 68  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1779

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,295,135,000	\$1,343,054,000
<b>- STATE FUNDS</b>	\$91,427,830	\$103,079,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,295,135,000	\$1,343,054,000
<b>STATE FUNDS</b>	\$91,427,830	\$103,079,500
<b>FEDERAL FUNDS</b>	\$1,203,707,170	\$1,239,974,500

**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  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

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

## **SMHS FOR CHILDREN**

### **BASE POLICY CHANGE NUMBER: 68**

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

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net increase due to:

- Updated estimated utilization and costs for Short Doyle/Medi-Cal (SD/MC) and Fee-For-Service (FFS) Inpatient clients, based on additional paid claims data through March 31, 2020 for SD/MC and FFS inpatient claims data through January 31, 2020, and
- Updated estimated funding for full scope undocumented children at 100% General Fund (GF), and
- Adding the FFCRA increased funding estimates for FY 2019-20 and FY 2020-21.

The change between FY 2020-21 and FY 2021-22, in the current estimate, is a net increase due to an increase of SD/MC, FFS Inpatient, and ACA utilization for FY 2021-22 based on projections.

#### **Methodology:**

1. The costs and clients are developed using 70 months of SD/MC and 70 months FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2020, with dates of service from June 2014 through March 2020. The FFS data is current as of June 30, 2020, with dates of service from April 2014 through January 2020.
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



**SMHS FOR CHILDREN**  
**BASE POLICY CHANGE NUMBER: 68**

claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

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

<b>Children</b>	<b>FY 2020-21 Utilization</b>	<b>FY 2021-22 Utilization</b>
SD/MC	272,202	274,278
SD/MC ACA	10,148	11,283
FFS	12,478	12,497
FFS ACA	1,887	2,103
<b>Total</b>	<b>296,715</b>	<b>300,161</b>

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

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2018-19	\$1,953,579	\$1,842,341	\$111,238
FY 2019-20	\$2,041,915	\$1,920,772	\$121,143
FY 2020-21	\$2,114,484	\$1,985,302	\$129,182
FY 2021-22	\$2,187,053	\$2,049,832	\$137,221

5. On a cash basis for FY 2020-21, the Department will be paying 1% of FY 2018-19 claims, 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2018-19 claims, 53% of FY 2019-20 claims, and 46% of FY 2020-21 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2018-19	\$19,535	\$18,423	\$1,112
FY 2019-20	\$1,235,877	\$1,171,671	\$64,206
FY 2020-21	\$813,839	\$754,415	\$59,424
<b>Total FY 2020-21</b>	<b>\$2,069,251</b>	<b>\$1,944,509</b>	<b>\$124,742</b>

**SMHS FOR CHILDREN**  
**BASE POLICY CHANGE NUMBER: 68**

6. On a cash basis for FY 2021-22, the Department will be paying 1% of FY 2019-20 claims, 61% of FY 2020-21 claims, and 38% of FY 2021-22 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2019-20 claims, 53% of FY 2020-21 claims, and 46% of FY 2021-22 claims. The cash amounts (rounded) for Children's SMHS are:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2019-20	\$20,419	\$19,208	\$1,211
FY 2020-21	\$1,279,501	\$1,211,034	\$68,467
FY 2021-22	\$842,058	\$778,936	\$63,122
<b>Total FY 2021-22</b>	<b>\$2,141,978</b>	<b>\$2,009,178</b>	<b>\$132,800</b>

7. On a cash basis, the Department estimates SD/MC costs of \$40,571,000 in FY 2020-21 and \$47,791,000 in FY 2021-22, for full scope undocumented children funded with 100% GF.
8. The chart below shows the FY 2020-21 and FY 2021-22 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, are 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), 76.5% federal reimbursement (beginning October 1, 2019), and 65% federal reimbursement (beginning October 1, 2020),
  - ACA is funded by 94% federal funds (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)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>MCHIP</b>	<b>ACA FF</b>	<b>ACA GF</b>	<b>GF Reimb.</b>	<b>CF</b>
Total FY 2020-21	\$2,069,251	\$40,571	\$813,048	\$255,093	\$55,808	\$5,606	\$49,962	\$849,163
Total FY 2021-22	\$2,141,978	\$47,791	\$826,338	\$278,345	\$63,015	\$6,326	\$52,504	\$867,660

**SMHS FOR CHILDREN**  
**BASE POLICY CHANGE NUMBER: 68**

9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF Reimb</b>	<b>CF</b>	<b>FFCRA</b>
FFCRA 6.2% XIX Increased FFP	\$0	(\$3,996)	(\$65,506)	\$69,502
FFCRA 4.34% XXI Increased FFP	\$0	(\$715)	(\$9,541)	\$10,256
<b>Total</b>	\$0	(\$4,711)	(\$75,047)	\$79,758

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF Reimb</b>	<b>CF</b>	<b>FFCRA</b>
FFCRA 6.2% XIX Increased FFP	\$0	(\$2,995)	(\$59,196)	\$62,191
FFCRA 4.34% XXI Increased FFP	\$0	(\$546)	(\$9,541)	\$10,086
<b>Total</b>	\$0	<b>(\$3,541)</b>	(\$68,736)	<b>\$72,277</b>

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>MCHIP</b>	<b>ACA FF</b>	<b>ACA GF</b>	<b>GF Reimb</b>	<b>CF</b>	<b>FFCRA</b>
<b>Total FY 2020-21</b>	\$1,989,493	\$40,571	\$813,048	\$255,093	\$55,808	\$5,606	\$45,251	\$774,116	\$79,758
<b>Total FY 2021-22</b>	\$2,069,701	\$47,791	\$826,338	\$278,345	\$63,015	\$6,326	\$48,963	\$798,923	\$72,277

**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)  
 FFCRA 6.20% Increased FFP (4260-101-0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)

## TWO PLAN MODEL

**BASE POLICY CHANGE NUMBER:** 86  
**IMPLEMENTATION DATE:** 7/2000  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 56

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$20,418,873,000	\$20,442,357,000
<b>- STATE FUNDS</b>	\$6,912,615,240	\$6,969,711,550
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$20,418,873,000	\$20,442,357,000
<b>STATE FUNDS</b>	\$6,912,615,240	\$6,969,711,550
<b>FEDERAL FUNDS</b>	\$13,506,257,760	\$13,472,645,450

**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 2021-22  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

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

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to lower than previously anticipated eligibles. FY 2020-21 weighted draft rates were updated. The change from FY 2020-21 to FY 2021-22, is an increase due to an anticipated growth in eligibles in the aged aid categories.

**Methodology:**

1. Capitation rates are typically rebased annually. However, the Department has implemented a onetime 18-month rating period for the period of July 1, 2019, through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year (CY) basis thereafter. 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 (FFP). The rebasing process includes refreshed data and adjustments to trends.

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 86**

2. On an accrual basis, the last six months of the Bridge Period (post-risk adjustment) and the first six months of the draft CY 2021 rates (pre-risk adjustment) have been budgeted for FY 2020-21.
3. FY 2020-21 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2022 rating period to occur in FY 2021-22 is captured in the Capitated Rate Adjustment for FY 2021-22 policy change as a percentage assumption applied to five months of the CY 2021 rates on a cash basis.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$196,500,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$230,200,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
7. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in the base PCs.
8. Acupuncture services are included in the rates as of July 1, 2016.
9. 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.
10. Services provided through the LA Mobile Vision Pilot Project are no longer included in the base rates, as of July 1, 2018.
11. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The anticipated costs associated with this transition are reflected in the base rates.
12. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates.
13. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are currently reflected in this PC.
14. The County Children's Health Insurance Program (CCHIP) transitioned to Medi-Cal Managed Care for Santa Clara and San Francisco counties on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.
15. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are currently reflected in this PC.

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 86**

16. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.
17. The Department receives federal reimbursement of 90% for family planning services.
18. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2019, an FMAP split of 76.5/23.5 was budgeted for OTLICP. On October 1, 2020, the FMAP became 65/35.

Two-Plan Model costs on an accrual basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	3,615,257	\$1,080,935
Contra Costa	2,392,755	\$699,655
Kern	3,903,095	\$947,449
Los Angeles	35,083,098	\$8,749,536
Riverside	8,286,817	\$2,118,247
San Bernardino	8,106,051	\$2,116,089
San Francisco	1,691,661	\$570,496
San Joaquin	2,707,936	\$663,225
Santa Clara	3,537,123	\$896,238
Stanislaus	2,276,570	\$610,203
Tulare	2,442,424	\$465,934
Fresno	4,665,135	\$1,112,980
Kings	587,427	\$128,630
Madera	689,041	\$136,571
<b>Total</b>	<b>79,984,388</b>	<b>\$20,296,188</b>
Hepatitis C Adjustment		\$145,684
<b>Total FY 2020-21</b>		<b>\$20,441,872</b>

(Dollars in Thousands)

<b>Included in the Above Dollars</b>	<b>FY 2020-21</b>
Mental Health	\$196,500
AB 97	(\$230,200)

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 86**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	3,615,240	\$1,085,835
Contra Costa	2,389,572	\$702,149
Kern	3,898,821	\$948,695
Los Angeles	35,062,167	\$8,762,682
Riverside	8,264,137	\$2,112,142
San Bernardino	8,087,655	\$2,112,778
San Francisco	1,694,083	\$571,970
San Joaquin	2,705,533	\$664,242
Santa Clara	3,522,202	\$893,036
Stanislaus	2,273,782	\$610,686
Tulare	2,438,560	\$465,646
Fresno	4,655,482	\$1,113,260
Kings	586,622	\$128,544
Madera	687,416	\$136,335
Total	79,881,271	\$20,308,000
Hepatitis C Adjustment		\$145,684
<b>Total FY 2021-22</b>		<b>\$20,453,684</b>

(Dollars in Thousands)

<b>Included in the Above Dollars</b>	<b>FY 2021-22</b>
Mental Health	\$196,500
AB 97	(\$230,200)

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 86**

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

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$11,737,392	\$5,868,696	\$5,868,696
100% GF (4260-101-0001)	\$25,454	\$25,454	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$90,102	\$9,010	\$81,092
65% Title XXI / 35% GF (4260-113-0001/0890)	\$484,622	\$169,618	\$315,004
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$241,824	\$56,829	\$184,995
ACA 90% FFP / 10% GF (2020)	\$7,830,087	\$783,008	\$7,047,079
Title XIX 100% FFP	\$9,392	\$0	\$9,392
<b>Total</b>	<b>\$20,418,873</b>	<b>\$6,912,615</b>	<b>\$13,506,258</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$11,817,062	\$5,908,531	\$5,908,531
100% GF (4260-101-0001)	\$25,395	\$25,395	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$86,242	\$8,624	\$77,618
65% Title XXI / 35% GF (4260-113-0001/0890)	\$707,127	\$247,495	\$459,632
ACA 90% FFP / 10% GF (2020)	\$7,796,669	\$779,667	\$7,017,002
Title XIX 100% FFP	\$9,862	\$0	\$9,862
<b>Total</b>	<b>\$20,442,357</b>	<b>\$6,969,712</b>	<b>\$13,472,645</b>

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## COUNTY ORGANIZED HEALTH SYSTEMS

**BASE POLICY CHANGE NUMBER:** 87  
**IMPLEMENTATION DATE:** 12/1987  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 57

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,797,107,000	\$8,790,395,000
<b>- STATE FUNDS</b>	\$3,060,492,000	\$3,076,126,700
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$8,797,107,000	\$8,790,395,000
<b>STATE FUNDS</b>	\$3,060,492,000	\$3,076,126,700
<b>FEDERAL FUNDS</b>	\$5,736,615,000	\$5,714,268,300

**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 2021-22  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

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

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to updated FY 2020-21 weighted draft rates.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due lower expected eligible months.

**Methodology:**

1. Capitation rates are typically rebased annually. However, DHCS has implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year (CY) basis thereafter. 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

## COUNTY ORGANIZED HEALTH SYSTEMS

### BASE POLICY CHANGE NUMBER: 87

participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. On an accrual basis, the last 6 months of the Bridge Period rates and the first 6 months of the draft CY 2021 rates have been budgeted for FY 2020-21.
3. FY 2020-21 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2022 rating period to occur in FY 2021-22 is captured in the Capitated Rate Adjustment for FY 2021-22 policy change as a percentage assumption applied to five months of the CY 2021 rates on a cash basis.
5. 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).
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$113,800,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$77,300,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
8. Indian Health Services and Hepatitis C costs are reflected in this PC.
9. Acupuncture services are included in the rates as of July 1, 2016.
10. The MCAP services are included in the rates as of July 1, 2017.
11. Non-Medical Transportation (NMT) for covered Managed Care services are included in the rates as of July 1, 2017. NMT for non-covered Managed Care services are included in the rates as of October 1, 2017.
12. The Diabetes Prevention Program benefit implemented on January 1, 2019. The costs associated with these services are included in the rates.
13. Services covered through the Pediatric Palliative Care Waiver Program were transitioned to Medi-Cal Managed Care January 1, 2019. The anticipated costs associated with this transition are included in the rates.
14. As of July 1, 2018, WCM implemented on the following phase-in schedule by county:
  - July 1, 2018: Monterey, Santa Cruz, Merced, Santa Barbara, San Luis Obispo, and San Mateo
  - January 1, 2019: Napa, Solano, Yolo, Marin, Lake, Mendocino, Sonoma, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Trinity, and Del Norte
  - July 1, 2019: Orange
  - Ventura County is not part of the WCM

## **COUNTY ORGANIZED HEALTH SYSTEMS**

**BASE POLICY CHANGE NUMBER: 87**

15. As of July 1, 2019, the care coordination costs associated with Home and Community-Based Services (HCBS) High supplemental payments for CCI counties are reflected in this PC.
16. The County Children's Health Insurance Program (CCHIP) transitioned to Medi-Cal Managed Care for San Mateo County on October 1, 2019. The costs associated with CCHIP are not currently reflected in this PC.
17. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC.
18. As of January 1, 2020, lens fabrication services have been removed from the rates for Santa Barbara, San Luis Obispo, and San Mateo counties.
19. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.
20. The Department receives 90% federal reimbursement for family planning services.
21. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2019, a FMAP split of 76.5/23.5 was budgeted for OTLICP. On October 1, 2020, the FMAP became 65/35.
22. As of January 1, 2021, maternity costs were carved-out of the regular COHS capitation rates in an effort to align with rate development methodologies employed for other managed care plan model types. Health plans will begin receiving maternity supplemental payments for qualified delivery events.

**COUNTY ORGANIZED HEALTH SYSTEMS**  
**BASE POLICY CHANGE NUMBER: 87**

23. COHS dollars on an accrual basis are shown below, which excludes both WCM dollars and eligibles:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Eligible Months</b>	<b>Total</b>
501- San Luis Obispo	612,512	\$192,807
502- Santa Barbara	1,496,062	\$442,733
503- San Mateo	1,197,327	\$404,779
504- Solano	1,257,179	\$480,819
505- Santa Cruz	777,395	\$275,475
506-Orange	8,572,336	\$2,629,519
507- Napa	330,958	\$125,119
508-Monterey	1,824,982	\$502,668
509- Yolo	595,153	\$228,526
513- Sonoma	1,220,046	\$449,191
514- Merced	1,449,855	\$406,467
510 - Marin	446,930	\$180,754
512 - Mendocino	419,483	\$151,175
515 - Ventura	2,331,060	\$793,038
523 - Del Norte	133,786	\$54,231
517 - Humboldt	622,683	\$238,889
511 - Lake	353,609	\$137,505
518 - Lassen	86,259	\$33,336
519 - Modoc	39,957	\$17,878
520 - Shasta	692,269	\$287,349
521 - Siskiyou	201,045	\$74,497
522 - Trinity	50,794	\$20,323
Total FY 2020-21	24,711,680	\$8,127,078
Hepatitis C Adjustment		\$44,897
<b>Total with Adjustments</b>		<b>\$8,171,975</b>

(Dollars in Thousands)

<b>Included in Above Dollars</b>	<b>FY 2020-21</b>
Mental Health	\$113,800
AB 97	(\$77,300)

**COUNTY ORGANIZED HEALTH SYSTEMS**  
**BASE POLICY CHANGE NUMBER: 87**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Eligible Months</b>	<b>Total</b>
501- San Luis Obispo	610,277	\$193,254
502- Santa Barbara	1,493,206	\$445,156
503- San Mateo	1,191,165	\$404,620
504- Solano	1,254,238	\$480,208
505- Santa Cruz	775,764	\$276,747
506-Orange	8,541,358	\$2,629,776
507- Napa	330,136	\$124,779
508-Monterey	1,822,102	\$507,900
509- Yolo	593,906	\$228,018
513- Sonoma	1,218,053	\$448,298
514- Merced	1,446,464	\$410,534
510 - Marin	444,980	\$179,651
512 - Mendocino	419,538	\$151,193
515 - Ventura	2,323,593	\$789,698
523 - Del Norte	133,617	\$54,194
517 - Humboldt	622,096	\$238,544
511 - Lake	353,524	\$137,330
518 - Lassen	86,083	\$33,263
519 - Modoc	39,652	\$17,746
520 - Shasta	689,966	\$286,223
521 - Siskiyou	201,021	\$74,393
522 - Trinity	50,375	\$20,177
Total FY 2021-22	24,641,113	\$8,131,702
Hepatitis C Adjustment		\$44,897
<b>Total with Adjustments</b>		<b>\$8,176,599</b>

(Dollars in Thousands)

<b>Included in Above Dollars</b>	<b>FY 2021-22</b>
Mental Health	\$113,800
AB 97	(\$77,300)

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 87

**Funding:**

The dollars below account for a one-month payment deferral and includes WCM dollars:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,272,461	\$2,636,231	\$2,636,230
100% GF (4260-101-0001)	\$4,988	\$4,988	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$38,858	\$3,886	\$34,972
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$116,817	\$27,452	\$89,365
65% Title XXI / 35% GF (4260-113-0001/0890)	\$228,864	\$80,102	\$148,762
ACA 90% FFP / 10% GF (2020)	\$3,078,333	\$307,833	\$2,770,500
Title XIX 100% FFP	\$56,786	\$0	\$56,786
<b>Total</b>	<b>\$8,797,107</b>	<b>\$3,060,492</b>	<b>\$5,736,615</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,281,637	\$2,640,818	\$2,640,819
100% GF (4260-101-0001)	\$4,970	\$4,970	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$36,867	\$3,687	\$33,180
65% Title XXI / 35% GF (4260-113-0001/0890)	\$343,688	\$120,291	\$223,397
ACA 90% FFP / 10% GF (2020)	\$3,063,607	\$306,361	\$2,757,246
Title XIX 100% FFP	\$59,626	\$0	\$59,626
<b>Total</b>	<b>\$8,790,395</b>	<b>\$3,076,127</b>	<b>\$5,714,268</b>

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## GEOGRAPHIC MANAGED CARE

**BASE POLICY CHANGE NUMBER:** 88  
**IMPLEMENTATION DATE:** 4/1994  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 58

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,667,038,000	\$3,672,552,000
<b>- STATE FUNDS</b>	\$1,249,953,430	\$1,260,443,050
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,667,038,000	\$3,672,552,000
<b>STATE FUNDS</b>	\$1,249,953,430	\$1,260,443,050
<b>FEDERAL FUNDS</b>	\$2,417,084,570	\$2,412,108,950

**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 2021-22  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to updated FY 2020-21 weighted draft rates. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to an anticipated growth in eligibles in the aged aid categories.

**Methodology:**

1. Capitation rates are typically rebased annually. However, DHCS has implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period), to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year (CY) basis thereafter. Federal rules

## **GEOGRAPHIC MANAGED CARE**

### **BASE POLICY CHANGE NUMBER: 88**

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 (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. On an accrual basis, the last six months of the Bridge Period (post-risk adjustment) and the first six months of the draft CY 2021 rates (pre-risk adjustment) have been budgeted for FY 2020-21.
3. FY 2020-21 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2022 rating period to occur in FY 2021-22 is captured in the Capitated Rate Adjustment for FY 2021-22 policy change as a percentage assumption applied to five months of the CY 2021 rates on a cash basis.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$35,800,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$39,100,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
7. Hepatitis C, Indian Health Services, and Maternity supplemental payments are budgeted in the base PCs.
8. Acupuncture services are included in the base rates as of July 1, 2016.
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. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The anticipated costs associated with this transition are reflected in the base rates.
11. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates.
12. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC.
13. As of January 1, 2020, undocumented young adults aged 19 through 25 became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.
14. The Department receives 90% federal reimbursement for family planning services.



## GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 88

15. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2019, a FMAP split of 76.5/23.5 was budgeted for OTLICP. This FMAP split became 65/35 on October 1, 2020.

GMC dollars on an accrual basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento	5,140,863	\$1,417,675
San Diego	8,028,111	\$2,228,639
Total	13,168,974	\$3,646,314
Hepatitis C Adjustment		\$23,984
<b>Total FY 2020-21</b>		<b>\$3,670,298</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2020-21</b>
Mental Health	\$35,800
AB 97	(\$39,100)

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento	5,137,268	\$1,419,480
San Diego	8,004,787	\$2,227,166
Total	13,142,055	\$3,646,646
Hepatitis C Adjustment		\$23,984
<b>Total FY 2021-22</b>		<b>\$3,670,630</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2021-22</b>
Mental Health	\$35,800
AB 97	(\$39,100)

## GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 88

**Funding:**

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

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,132,092	\$1,066,046	\$1,066,046
100% GF (4260-101-0001)	\$4,735	\$4,735	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$16,169	\$1,617	\$14,552
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$41,488	\$9,750	\$31,738
65% Title XXI / 35% GF (4260-113-0001/0890)	\$82,945	\$29,031	\$53,914
ACA 90% FFP / 10% GF (2020)	\$1,387,751	\$138,774	\$1,248,976
Title XIX 100% FFP	\$1,858	\$0	\$1,858
<b>Total*</b>	<b>\$3,667,038</b>	<b>\$1,249,953</b>	<b>\$2,417,084</b>

\*Difference due to rounding.

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,145,120	\$1,072,560	\$1,072,560
100% GF (4260-101-0001)	\$4,719	\$4,719	\$0
90% Family Planning / 10% GF (4260-101-0001/0890)	\$15,505	\$1,551	\$13,954
65% Title XXI / 35% GF (4260-113-0001/0890)	\$124,351	\$43,523	\$80,828
ACA 90% FFP / 10% GF (2020)	\$1,380,907	\$138,090	\$1,242,817
Title XIX 100% FFP	\$1,950	\$0	\$1,950
<b>Total</b>	<b>\$3,672,552</b>	<b>\$1,260,443</b>	<b>\$2,412,109</b>

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## REGIONAL MODEL

**BASE POLICY CHANGE NUMBER:** 94  
**IMPLEMENTATION DATE:** 11/2013  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1842

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,262,054,000	\$1,264,782,000
<b>- STATE FUNDS</b>	\$408,300,610	\$410,827,850
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,262,054,000	\$1,264,782,000
<b>STATE FUNDS</b>	\$408,300,610	\$410,827,850
<b>FEDERAL FUNDS</b>	\$853,753,390	\$853,954,150

**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 2021-22  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 coordinates their care and leads to better health outcomes and lower costs.

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

**Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease due to lower than previously expected eligibles. FY 2020-21 weighted rates have been updated. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to an anticipated growth in eligibles in the disabled and aged aid categories for prepaid health plans.

**Methodology:**

1. Capitation rates are typically rebased annually. However, the Department implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period) to aid in future prospective rate development as federally required. Rates will be developed and rebased annually on a calendar year basis thereafter. Federal rules require that the rates be developed according to generally accepted actuarial principles and

## **REGIONAL MODEL**

### **BASE POLICY CHANGE NUMBER: 94**

must be certified by an actuary as actuarially sound in order to ensure federal financial participation (FFP). The rebasing process includes refreshed data and adjustments to trends.

2. On an accrual basis, the last six months of the Bridge Period rates (post-risk adjustment) and the first six months of the draft CY 2021 rates (pre-risk adjustment) have been budgeted for FY 2020-21.
3. FY 2020-21 weighted rates have been updated from the previous estimate.
4. The estimated rate adjustment anticipated for the CY 2022 rating period to occur in FY 2021-22 is captured in the Capitated Rate Adjustment for FY 2021-22 policy change as a percentage assumption applied to five months of the CY 2021 rates on a cash basis.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$20,800,000 for FY 2020-21 and for FY 2021-22 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$10,400,000 for FY 2020-21 and FY 2021-22 were included in the rates.
7. Hepatitis C, Indian Health Services, and Maternity supplemental payments are reflected in this PC.
8. Acupuncture services are included in the rates as of July 1, 2016.
9. 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.
10. Services covered through the Pediatric Palliative Care Waiver transitioned to Medi-Cal Managed Care on January 1, 2019. The costs associated with this transition are reflected in the rates.
11. The Diabetes Prevention Program new benefit implemented on January 1, 2019. The costs associated with these services are reflected in the rates.
12. As of January 1, 2020, audiology and speech therapy service, incontinence creams and washes, optician and optical lab services, and podiatric services were restored as managed care benefits. The costs associated with the restoration of these benefits are reflected in this PC.
13. As of January 1, 2020, undocumented young adults aged 19 through 25, became eligible for full-scope Medi-Cal. The costs associated with these beneficiaries are not reflected in this PC.
14. The Department receives 90% federal reimbursement for family planning services.
15. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted in the managed care model policy changes. Beginning October 1, 2019, a FMAP split of 76.5/23.5 was budgeted for OTLICP. On October 1, 2020, the FMAP became 65/35.

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 94**

16. Regional Model dollars on an accrual basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Eligible Months</b>	<b>Total</b>
Alpine	2,387	\$661
Amador	73,047	\$18,774
Butte	722,489	\$225,542
Calaveras	110,218	\$31,071
Colusa	93,754	\$20,189
El Dorado	335,327	\$94,344
Glenn	120,997	\$30,939
Inyo	45,585	\$11,247
Mariposa	47,860	\$13,033
Mono	28,215	\$6,468
Nevada	228,765	\$62,231
Placer	534,374	\$145,183
Plumas	61,222	\$17,235
Sierra	6,666	\$1,821
Sutter	371,774	\$95,741
Tehama	241,681	\$66,757
Tuolumne	117,671	\$35,171
Yuba	300,665	\$82,437
Imperial	900,046	\$221,475
San Benito	93,039	\$15,585
Total FY 2020-21	4,435,781	\$1,195,904
Hepatitis C Adjustment		\$8,059
<b>Total with Adjustments</b>		<b>\$1,203,963</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2020-21</b>
Mental Health	\$20,800
AB 97	(\$10,400)

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 94**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Eligible Months</b>	<b>Total</b>
Alpine	2,388	\$661
Amador	72,806	\$18,708
Butte	720,975	\$225,351
Calaveras	109,750	\$31,022
Colusa	93,593	\$20,172
El Dorado	334,112	\$94,270
Glenn	120,855	\$30,932
Inyo	45,260	\$11,173
Mariposa	47,645	\$12,976
Mono	27,991	\$6,416
Nevada	227,566	\$61,937
Placer	533,173	\$145,570
Plumas	61,081	\$17,195
Sierra	6,646	\$1,816
Sutter	371,053	\$95,850
Tehama	240,352	\$66,433
Tuolumne	117,141	\$35,112
Yuba	299,323	\$82,119
Imperial	901,942	\$223,766
San Benito	92,529	\$15,537
Total FY 2021-22	4,426,183	\$1,197,016
Hepatitis C Adjustment		\$8,059
<b>Total with Adjustments</b>		<b>\$1,205,075</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2021-22</b>
Mental Health	\$20,800
AB 97	(\$10,400)

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 94**

**Funding:**

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

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$696,622	\$348,312	\$348,312
100% GF (4260-101-0001)	\$1,432	\$1,432	\$0
ACA 90% FFP / 10% GF (2020)	\$459,868	\$45,987	\$413,881
90% Family Planning / 10% GF (4260-101-0001/0890)	\$5,591	\$560	\$5,031
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$12,807	\$3,009	\$9,798
65% Title XXI / 35% GF (4260-113-0001/0890)	\$25,719	\$9,001	\$16,717
Title XIX 100% (4260-101-0890)	\$60,015	\$0	\$60,015
<b>Total</b>	<b>\$1,262,054</b>	<b>\$408,301</b>	<b>\$853,753</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$701,329	\$350,664	\$350,664
100% GF (4260-101-0001)	\$1,422	\$1,422	\$0
ACA 90% FFP / 10% GF (2020)	\$458,331	\$45,833	\$412,498
90% Family Planning / 10% GF (4260-101-0001/0890)	\$5,326	\$533	\$4,793
65% Title XXI / 35% GF (4260-113-0001/0890)	\$35,359	\$12,376	\$22,984
Title XIX 100% (4260-101-0890)	\$63,015	\$0	\$63,015
<b>Total</b>	<b>\$1,264,782</b>	<b>\$410,828</b>	<b>\$853,954</b>

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## PACE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 95  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 62

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$803,282,000	\$948,444,000
<b>- STATE FUNDS</b>	\$401,641,000	\$474,222,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$803,282,000	\$948,444,000
<b>STATE FUNDS</b>	\$401,641,000	\$474,222,000
<b>FEDERAL FUNDS</b>	\$401,641,000	\$474,222,000

**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  
 Welfare & Institutions Code 14301.1(n)  
 Balanced Budget Act of 1997 (BBA)  
 SB 870 (Chapter 40, Statutes 2014)  
 SB 840 (Chapter 29, Statutes 2018)

**Interdependent Policy Changes:**

COVID-19 Increase FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 nineteen contracts with PACE organizations for risk-based capitated lifetime care for the frail elderly. PACE rates are developed using actuarial principles, including actual experience of the PACE population, in a manner consistent with Welfare and Institutions Code Section 14301.1(n), effective January 1, 2018.



**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 95**

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
	Orange	July 1, 2021
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home (Brandman)	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Innovative Integrated Health	Fresno	August 1, 2014
	Kern	January 1, 2020
	Tulare	January 1, 2020
	Orange	July 1, 2021
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	July 1, 2019
Family Health Centers of San Diego	San Diego	July 1, 2019
Pacific PACE	Los Angeles	July 1, 2019
Sequoia	Fresno	July 1, 2020
	Kings	July 1, 2020
	Madera	July 1, 2020
	Tulare	July 1, 2020
InnovAge - Sacramento	Sacramento	July 1, 2020
	Placer	July 1, 2020
	Sutter	July 1, 2020
	Yuba	July 1, 2020
	El Dorado	July 1, 2020
	San Joaquin	July 1, 2020
LA Coast	Los Angeles	January 1, 2020
Central Valley	San Joaquin	July 1, 2020
	Stanislaus	July 1, 2020
North East Medical Services (NEMS)	San Francisco	January 1, 2021
Neighborhood Health	Riverside	July 1, 2021
	San Bernardino	July 1, 2021

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 95**

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to lower than estimated actuals through June 2020, an estimate lower 2021 rate adjustment, and new health care plans taken out of the total cost in FY 2020-21 and FY 2021-22. The change from FY 2020-21 to FY 2021-22, is a net increase due to a projected increase in enrollment and higher rates.

**Methodology:**

1. Assume the CY 2020, CY 2021, and CY 2022 rates will be calculated using plan specific experienced-based data to build actuarially sound prospective rates.
2. FY 2020-21 and FY 2021-22 estimated funding is based on CMS approved CY 2019 rates and projected CY 2020, CY 2021, and CY 2022 rates.
3. Assume enrollment will increase based on past enrollment in PACE organizations by county and plan and projected enrollments for new PACE organizations.
4. The Department plans to implement the CY 2021 rates during the February 2021 capitation cycle. A retroactive payment of approximately \$22,343,000 will be paid to the PACE organizations during the March 2021 capitation.
5. The Department plans to implement the CY 2022 rates during the February 2022 capitation cycle. A retroactive payment of approximately \$5,966,000 will be paid to the PACE organizations during the March 2022 capitation.
6. Health care plans that began January 2020 or later are not in the total fund (TF) or general fund (GF) due to costs being recognized in other fee-for-service Medi-Cal plans or managed care plans. The new health care plans estimated costs are \$37,215,000 TF in FY 2020-21 and \$133,882,000 TF in FY 2021-22.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 95**

<b>FY 2020-21</b>	<b>TF Cost (Rounded)</b>	<b>Eligible Months</b>	<b>Avg. Mo. Enrollment</b>
Centers for Elders' Independence (Alameda and Contra Costa)	\$59,789,000	9,786	816
Sutter Senior Care	\$32,773,000	5,550	463
AltaMed Senior Care (Los Angeles)	\$177,236,000	34,614	2,885
OnLok (SF, Alameda and Santa Clara)	\$138,583,000	19,320	1,610
St. Paul's PACE	\$59,282,000	12,474	1,040
Los Angeles Jewish Homes	\$16,458,000	3,210	268
CalOptima PACE	\$30,878,000	4,920	410
InnovAge (San Bernardino and Riverside)	\$57,051,000	10,434	870
Redwood Coast (Humboldt)	\$13,373,000	2,430	203
Innovative Integrated Health (Fresno, Kern, Tulare)	\$60,297,000	10,818	902
San Ysidro San Diego	\$88,269,000	15,360	1,280
Stockton PACE (San Joaquin and Stanislaus)	\$21,577,000	3,304	275
Gary & Mary West (San Diego)	\$7,733,000	1,365	114
Family Health Centers of San Diego	\$7,337,000	1,161	97
Pacific PACE (Los Angeles)	\$10,303,000	1,758	147
<b>Total Capitation Payments</b>	<b>\$780,939,000</b>	<b>136,504</b>	<b>11,380</b>
2021 Rate Adjustment	\$22,343,000		
<b>Total FY 2020-21</b>	<b>\$803,282,000</b>		

\*Totals may differ due to rounding.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 95**

<b>FY 2021-22</b>	<b>TF Cost (Rounded)</b>	<b>Eligible Months</b>	<b>Avg. Mo. Enrollment</b>
Centers for Elders' Independence (Alameda and Contra Costa)	\$67,392,000	10,506	876
Sutter Senior Care	\$38,872,000	6,270	523
AltaMed Senior Care (Los Angeles & Orange)	\$194,612,000	36,198	3,017
OnLok (SF, Alameda and Santa Clara)	\$149,461,000	19,896	1,658
St. Paul's PACE	\$67,274,000	13,482	1,124
Los Angeles Jewish Homes	\$18,049,000	3,354	280
CalOptima PACE	\$36,212,000	5,496	458
InnovAge (San Bernardino and Riverside)	\$64,044,000	11,154	930
Redwood Coast (Humboldt)	\$14,874,000	2,574	215
Innovative Integrated Health (Fresno, Kern, Tulare, Orange)	\$72,571,000	12,402	1,034
San Ysidro San Diego	\$130,821,000	21,696	1,808
Stockton PACE (San Joaquin and Stanislaus)	\$38,909,000	5,689	474
Gary & Mary West (San Diego)	\$13,516,000	2,274	190
Family Health Centers of San Diego	\$17,079,000	2,568	214
Pacific PACE (Los Angeles)	\$18,792,000	3,126	261
<b>Total Capitation Payments</b>	<b>\$942,478,000</b>	<b>156,685</b>	<b>13,062</b>
2022 Rate Adjustment	\$5,966,000		
<b>Total FY 2021-22</b>	<b>\$948,444,000</b>		

\*Totals may differ due to rounding.

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## DENTAL MANAGED CARE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 99  
**IMPLEMENTATION DATE:** 7/2004  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1029

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$102,927,000	\$105,071,000
<b>- STATE FUNDS</b>	\$41,093,320	\$42,072,250
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$102,927,000	\$105,071,000
<b>STATE FUNDS</b>	\$41,093,320	\$42,072,250
<b>FEDERAL FUNDS</b>	\$61,833,680	\$62,998,750

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 Clinics (RHCs), is limited to the adult optional benefits restored May

## DENTAL MANAGED CARE (Other M/C)

### BASE POLICY CHANGE NUMBER: 99

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.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, are a decrease due a recoupment from an in-year retroactive payment for updated rates and decreased in the DMC rates overall. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to an anticipated increase in rates.

#### 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. Any portion of the rate attributable to Proposition 56 Supplemental Payments is captured in its respective policy change.
3. HIPF payments will be paid in FY 2020-21 for \$2,260,372.
4. A 3% withhold is held back every month per the contract with the health plans. The withhold amount is returned no sooner than April of the following fiscal year if performance measures in the contract are met.

FY 2020-21	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,755,680	229,640	\$29,055,015
Child - GMC	2,422,068	201,839	\$33,295,230
Adult - PHP	2,877,264	239,772	\$26,375,556
Child - PHP	1,544,760	128,730	\$17,447,327

FY 2021-22	Total Member Months	Average Monthly Eligibles	Total Costs
Adult - GMC	2,755,680	229,640	\$28,675,722
Child - GMC	2,422,068	201,839	\$33,730,809
Adult - PHP	2,877,264	239,772	\$25,667,166
Child - PHP	1,544,760	128,730	\$16,948,218

**DENTAL MANAGED CARE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 99**

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Regular FMAP T19	\$74,680,000	\$37,340,000	\$37,340,000
ACA 90% FFP/10% GF (2020)	\$24,050,000	\$2,405,000	\$21,645,000
Title 21 76.5% FFP/23.5% GF	\$1,049,000	\$246,000	\$803,000
Title 21 65% FFP/35% GF	\$3,148,000	\$1,102,000	\$2,046,000
<b>Total</b>	<b>\$102,927,000</b>	<b>\$41,093,000</b>	<b>\$61,834,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Regular FMAP T19	\$76,236,000	\$38,118,000	\$38,118,000
ACA 90% FFP/10% GF (2020)	\$24,552,000	\$2,455,000	\$22,097,000
Title 21 65% FFP/35% GF	\$4,283,000	\$1,499,000	\$2,784,000
<b>Total</b>	<b>\$105,071,000</b>	<b>\$42,072,000</b>	<b>\$62,999,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## SENIOR CARE ACTION NETWORK (Other M/C)

**BASE POLICY CHANGE NUMBER:** 100  
**IMPLEMENTATION DATE:** 2/1985  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 61

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$59,259,000	\$61,547,000
<b>- STATE FUNDS</b>	\$29,629,500	\$30,773,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$59,259,000	\$61,547,000
<b>STATE FUNDS</b>	\$29,629,500	\$30,773,500
<b>FEDERAL FUNDS</b>	\$29,629,500	\$30,773,500

**Purpose:**

This policy change estimates the capitated payments associated with the 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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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) levels 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 2020-21, is a decrease due to updated calendar year (CY) 2021 rates. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to updated CY 2021 rates and projected CY 2022 rates.

**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 the beneficiary type – Aged and Disabled or Long-Term Care.
2. Assume an average monthly enrollment of 13,762 in FY 2020-21 and 14,188 in FY 2021-22.
3. CY 2020 rates are final rates and CY 2021 rates are draft rates.



**SENIOR CARE ACTION NETWORK (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 100**

4. CY 2022 rates were projected by trending forward the CY 2021 draft rates.
5. Assume one month of FY 2019-20 payments and 11 months of FY 2020-21 are paid in FY 2020-21.
6. Assume one month of FY 2020-21 payments and 11 months of FY 2021-22 are paid in FY 2021-22.
7. Anticipated costs on a cash basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Los Angeles	\$36,294	113,611	9,468
Riverside	\$11,030	30,306	2,525
San Bernardino	\$7,041	21,231	1,769
FY 2020-21*	\$54,365	165,147	13,762
FY 2019-20**	\$4,894		
<b>Total FY 2020-21</b>	<b>\$59,259</b>		

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Los Angeles	\$38,278	117,879	9,823
Riverside	\$11,156	30,785	2,565
San Bernardino	\$7,113	21,598	1,800
FY 2021-22*	\$56,547	170,262	14,188
FY 2020-21**	\$5,000		
<b>Total FY 2021-22</b>	<b>\$61,547</b>		

\*Assumes 11 months of capitation payments.

\*\*Assumes 1 month of capitation payments.

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## AIDS HEALTHCARE CENTERS (Other M/C)

**BASE POLICY CHANGE NUMBER:** 103  
**IMPLEMENTATION DATE:** 5/1985  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 63

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$16,756,000	\$17,906,000
<b>- STATE FUNDS</b>	\$8,378,000	\$8,953,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$16,756,000	\$17,906,000
<b>STATE FUNDS</b>	\$8,378,000	\$8,953,000
<b>FEDERAL FUNDS</b>	\$8,378,000	\$8,953,000

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14088.85

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS

COVID-19 Increased FMAP Extension – DHCS

**Background:**

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995. The Department held a contract with AIDS Healthcare Centers as a Primary Care Case Management (PCCM) plan through June 30, 2019. Effective July 1, 2019, AIDS Healthcare Foundation transitioned to a full risk-managed care plan as approved by the Department. The Department developed a full-risk amendment that added inpatient services as a benefit, changed plan pharmacy coverage, and extended the contract to December 31, 2021.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to updated rates and enrollment projections.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to higher projected enrollment and rate growth.

**Methodology:**

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

**AIDS HEALTHCARE CENTERS (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 103**

Member Months	Dual	Medi-Cal Only
FY 2019-20	3,466	3,959
Bridge Period July-Dec 2020	1,801	2,098
Calendar Year (CY) 2021	3,710	4,322
CY 2022	1,911	2,226

2) Assume the following paid rates:

Paid Rates	Dual	Medi-Cal Only
FY 2019-20*	\$161.88	\$3,765.01
Bridge Period July-Dec 2020	\$161.88	\$3,765.01
CY 2021	\$167.55	\$3,896.79
CY 2022	\$172.57	\$4,013.69

\*One month of FY 2019-20 rates to pay in FY 2020-21

3) The following amounts are estimated for this policy change based on the updated eligible months and rates:

FY 2020-21	Year	Paid Rate	MM	TF
Dual	FY 2019-20	\$161.88	289	\$47,000
Medi-Cal Only	FY 2019-20	\$3,765.01	330	\$1,242,000
Dual	Bridge July-Dec 2020	\$161.88	1,801	\$292,000
Medi-Cal Only	Bridge July-Dec 2020	\$3,765.01	2,098	\$7,899,000
Dual	CY 2021	\$167.55	1,546	\$259,000
Medi-Cal Only	CY 2021	\$3,896.79	1,801	\$7,017,000
Total	N/A	N/A	N/A	\$16,756,000

FY 2021-22	Year	Paid Rate	MM	TF
Dual	Bridge July-Dec 2020	\$167.55	309	\$52,000
Medi-Cal Only	Bridge July-Dec 2020	\$3,896.79	360	\$1,403,000
Dual	CY 2021	\$167.55	1,855	\$311,000
Medi-Cal Only	CY 2021	\$3,896.79	2,161	\$8,421,000
Dual**	CY 2022	\$172.57	1,592	\$275,000
Medi-Cal Only**	CY 2022	\$4,013.69	1,855	\$7,445,000
Total	N/A	N/A	N/A	\$17,906,000

\*\*Paid rate change due to shift to CY 2022 rate.

**AIDS HEALTHCARE CENTERS (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 103**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dual	\$597,000	\$298,000	\$299,000
Medi-Cal Only	\$16,158,000	\$8,079,000	\$8,079,000
<b>Total FY 2020-21***</b>	<b>\$16,756,000</b>	<b>\$8,377,000</b>	<b>\$8,378,000</b>

\*\*\*Difference due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dual	\$637,000	\$319,000	\$318,000
Medi-Cal Only	\$17,269,000	\$8,634,000	\$8,635,000
<b>Total FY 2021-22</b>	<b>\$17,906,000</b>	<b>\$8,953,000</b>	<b>\$8,953,000</b>

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

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

**BASE POLICY CHANGE NUMBER:** 104  
**IMPLEMENTATION DATE:** 3/2018  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 66

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,811,000	\$1,686,000
<b>- STATE FUNDS</b>	\$5,136,000	\$1,686,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,811,000	\$1,686,000
<b>STATE FUNDS</b>	\$5,136,000	\$1,686,000
<b>FEDERAL FUNDS</b>	-\$3,325,000	\$0

**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 children diagnoses with emotional disturbance who are at risk for out-of-home placement.

Family Mosaic has historically served a small population. Due to the small size of the population, actuarially sound capitation rates are unable to be developed pursuant to actuarial standards. In order to obtain federal funding, capitation rates must be actuarially sound and approved by the Centers for Medicare & Medicaid Services (CMS).

It has been determined Family Mosaic Project capitation rates for calendar year (CY) 2014 to current are not compliant with actuarial standards, therefore, federal funding is unable to be claimed for this program retroactive back to CY 2014. The Department historically claimed federal funding for all capitation payments issued for this program, therefore, State General Fund will be used to pay back the previously claimed federal funding for CY 2014 through FY 2019-20. FY 2020-21 and FY 2021-22 capitation rates will be funded solely by State General Fund.

The Department will continue to calculate annual capitation rates for this program; however, annually developed rates will be unable to be actuarially certified and will not be submitted to CMS for review and approval.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to a growth in projected capitation rates for the FY 2018-19 rating period going forward.

**FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)**  
**BASE POLICY CHANGE NUMBER: 104**

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to retroactive rate adjustments occurring in FY 2020-21 and no rate adjustments in FY 2021-22.

**Methodology:**

- 1) The Family Mosaic member months are assumed to be the following:
  - 413 in FY 2018-19
  - 413 in FY 2019-20
  - 413 in FY 2020-21
  - 413 in FY 2021-22
  
- 2) The Family Mosaic capitation rates are assumed to be:
  - \$3,627.51 in FY 2018-19
  - \$3,808.88 for July 1, 2019 through December 31, 2020 (Bridge Period)
  - \$3,999.33 in CY 2021
  - \$4,199.29 in CY 2022
  
- 3) The retroactive federal funding payback is estimated to be a total of \$3,574,000 for the periods CY 2014 through FY 2019-20. The FY 2017-18 rate was paid through the FY 2018-19, FY 2019-20, and part of the FY 2020-21 service periods.
  
- 4) A retroactive rate adjustment for FY 2018-19, FY 2019-20, and FY 2020-21 are expected to be made in FY 2020-21.
  
- 5) Anticipated costs on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Prior Years Retro	\$499,000	\$250,000	\$249,000
CY 2014 through FY 2019-20 FFP Payback	\$0	\$3,574,000	(\$3,574,000)
FY 2020-21	\$1,312,000	\$1,312,000	\$0
<b>Total FY 2020-21</b>	<b>\$1,811,000</b>	<b>\$5,136,000</b>	<b>(\$3,325,000)</b>

One month of FY 2019-20 capitation pays in FY 2020-21.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2020-21	\$138,000	\$138,000	\$0
FY 2021-22	\$1,549,000	\$1,549,000	\$0
<b>Total FY 2021-22</b>	<b>\$1,687,000</b>	<b>\$1,687,000</b>	<b>\$0</b>

One month of FY 2020-21 capitation pays in FY 2021-22.

**Funding:**

- 100% State GF (4260-101-0001)
- 100% Federal Funds (4260-101-0890)

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

**BASE POLICY CHANGE NUMBER:** 181  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Joulia Dib  
**FISCAL REFERENCE NUMBER:** 76

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,640,885,000	\$3,829,336,000
<b>- STATE FUNDS</b>	\$1,934,218,500	\$2,034,928,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,640,885,000	\$3,829,336,000
<b>STATE FUNDS</b>	\$1,934,218,500	\$2,034,928,000
<b>FEDERAL FUNDS</b>	\$1,706,666,500	\$1,794,408,000

**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:**

COVID-19 Caseload Impact  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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:**

Expenditures for FY 2020-21 are 0.50% higher than previously estimated due to an upward revision of estimated beneficiaries of 0.4%, and an upward revision of the 2021 Part B premium of \$3.30, offset by a downward revision of the 2021 Part A premium of \$1.00.

Expenditures are projected to grow 5.2% between FY 2020-21 and FY 2021-22 due to a moderate expected growth in beneficiaries of 0.7% based on the historical trend and a projected increase in the Part A premium of \$18.00 and Part B premium of \$4.40 between 2021 and 2022.

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

BASE POLICY CHANGE NUMBER: 181

**Premiums:**

Calendar Year	2020	2021		2022
	Actual	May 2020 Estimate	Nov 2020 Estimate	Nov 2020 Estimate
Part A	\$458.00	\$479.00	\$478.00	\$496.00
Part B	\$144.60	\$150.00	\$153.30	\$157.70

**Average Monthly Beneficiaries:**

FY	2019-20	2020-21		2021-22
	Actual	May 2020 Estimate	Nov 2020 Estimate	Nov 2020 Estimate
Part A	173,000	174,300	172,600	171,900
Part B	1,405,700	1,425,300	1,433,200	1,444,300

**Methodology:**

- The Centers for Medicare and Medicaid set the following premiums for 2020.

Calendar Year	Part A	Part B
2020	\$ 458.00	\$ 144.60

- For 2021 and 2022, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 4.37% and 3.77% respective growth in the Medicare Part A premium. Applying this growth to the prior year Part A premium calculates as  $\$458.00 \times 1.0437 = \$478.00$ , and  $\$478.00 \times 1.0377 = \$496.00$  (rounded).
- For 2021 and 2022, the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance, is projecting a 6.02% and 2.87% respective growth in the Medicare Part B premium. Applying this growth to the prior year Part B premium calculates as  $\$144.60 \times 1.0602 = \$153.30$ , and  $\$153.30 \times 1.0287 = \$157.70$  (rounded).

<b>FY 2020-21</b>	<b>Part A</b>	<b>Part B</b>
Average Monthly Beneficiaries	172,600	1,433,200
Rate 07/2020-12/2020	\$458.00	\$144.60
Rate 01/2021-06/2021	\$478.00	\$153.30
<b>FY 2021-22</b>	<b>Part A</b>	<b>Part B</b>
Average Monthly Beneficiaries	171,900	1,444,300
Rate 07/2021-12/2021	\$478.00	\$153.30
Rate 01/2022-06/2022	\$496.00	\$157.70



**MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS**  
**BASE POLICY CHANGE NUMBER: 181**

4. The Families First Coronavirus Response Act (FFCRA) requires the department suspend eligibility redeterminations during the national public health emergency. The increase in beneficiaries from this suspension are budgeted in the COVID-19 Caseload Impact policy change.

FFCRA also increased the FMAP by 6.2 percentage points for certain expenditures in Medicaid. The expenditures from the increased FMAP through June 30, 2021 are budgeted in the COVID-19 Increased FMAP – DHCS policy change. The expenditures from the increased FMAP after July 1, 2021 are roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$3,295,760	\$1,647,880	\$1,647,880
State GF 100%	\$286,339	\$286,339	\$0
Title XIX 100% FFP	\$58,787	\$0	\$58,787
<b>Total</b>	<b>\$3,640,886</b>	<b>\$1,934,219</b>	<b>\$1,706,667</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$3,464,542	\$1,732,271	\$1,732,271
State GF 100%	\$302,657	\$302,657	\$0
Title XIX 100% FFP	\$62,137	\$0	\$62,137
<b>Total</b>	<b>\$3,829,336</b>	<b>\$2,034,928</b>	<b>\$1,794,408</b>

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

**BASE POLICY CHANGE NUMBER:** 182  
**IMPLEMENTATION DATE:** 7/1990  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 23

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,841,109,000	\$2,577,181,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,841,109,000	\$2,577,181,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$2,841,109,000	\$2,577,181,000

**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  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

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

### BASE POLICY CHANGE NUMBER: 182

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to increased expenditures related to COVID-19, federal requirements to keep all individuals on the HCBS Waiver who were enrolled at the start of the Public Health Emergency (PHE).

The change from FY 2020-21 and FY 2021-22, is a decrease due to reduced COVID-related expenditures.

#### Methodology:

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	DHCS FFP	FFCRA
FY 2020-21	\$5,056,324	\$2,215,215	\$2,528,162	\$312,947
FY 2021-22	\$5,008,779	\$2,431,598	\$2,504,167	\$73,014

#### Funding:

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## MEDICARE PAYMENTS - PART D PHASED-DOWN

**BASE POLICY CHANGE NUMBER:** 183  
**IMPLEMENTATION DATE:** 1/2006  
**ANALYST:** Joulia Dib  
**FISCAL REFERENCE NUMBER:** 1019

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,188,827,000	\$2,476,374,000
<b>- STATE FUNDS</b>	\$2,188,827,000	\$2,476,374,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,188,827,000	\$2,476,374,000
<b>STATE FUNDS</b>	\$2,188,827,000	\$2,476,374,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**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:**

COVID-19 Increased FMAP – DHCS

COVID-19 Increased FMAP Extension – DHCS

**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  $\frac{2}{3}$ % 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.

## MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 183

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2018	\$124.89
2019	\$127.31
2020	\$133.94
2021	\$137.76
2022	\$143.44 (estimated)

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

Fiscal Year	Total Payment	Ave. Monthly Beneficiaries
<b>FY 2017-18</b>	\$2,094,822,127	1,409,284
<b>FY 2018-19</b>	\$2,138,142,285	1,417,617
<b>FY 2019-20</b>	\$2,210,196,898	1,422,203

### Reason for Change:

The change in expenditures from the prior estimate for FY 2020-21 is due to:

- A 0.5% downward revision in average monthly beneficiaries, and
- The Families First Coronavirus Response Act (FFCRA) has resulted in a reduced PMPM through the end of the national public health emergency. This temporary reduction in PMPM produced lower payments for FY 2020-21, including
  - A retroactive adjustment for January to May 2020, which occurred in July 2020, and
  - A reduced PMPM for June and July 2020, which occurred in August and September 2020.

The change in projected expenditures between FY 2020-21 and FY 2021-22 is due to:

- An estimated increase in the PMPM rate of \$5.68 for 2022,
- An estimated historical growth in average monthly beneficiaries of 1.8%, and
- A retroactive adjustment for January to May 2020, which occurred in July 2020 and reduced PMPM for June and July 2020, which occurred in August and September 2020, resulting from the FFCRA and in FY 2020-21 expenditures.

The projected reduction in payments from FFCRA that are not already reflected in expenditures are budgeted in the COVID-19 Increased FMAP – DHCS and COVID-19 Increased FMAP Extension – DHCS policy changes.

## MEDICARE PAYMENTS - PART D PHASED-DOWN

### BASE POLICY CHANGE NUMBER: 183

#### Methodology:

1. The 2020 growth increased 5.21% over 2019 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2020 is \$133.94.
2. The 2021 growth increased 2.85% over 2020 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM rate for 2021 is \$137.76.
3. The 2022 growth is estimated to increase 4.12% over 2021 amounts per the *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM rate for 2022 is \$143.44.
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 May 2015 to July 2020.
6. The Phased-down Contribution is funded 100% by State General Fund.
7. The FFCRA increased the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid through the end of the national public health emergency. This reduced the phased-down State contribution (PMPM) rate for 2020 retroactive to January 2020 by \$16.61 below the \$133.94 PMPM and the PMPM rate for 2021 by \$17.08 below the \$137.76 PMPM. A billing adjustment for the retroactive rate change for January to May 2020 occurred in August 2020, and the reduced PMPM rate for June and July 2020 occurred in August and September 2020 and are captured in this policy change for FY 2020-21. Savings through June 30, 2021 from the reduced PMPM rate that are not already reflected in expenditures are budgeted in the COVID-19 Increased FMAP – DHCS policy change. Savings after July 1, 2021 from the reduced PMPM rate are roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
<b>FY 2020-21</b>	12	1,451,000	\$182,402,200	<b>\$2,188,827,000</b>
<b>FY 2021-22</b>	12	1,477,600	\$206,364,500	<b>\$2,476,374,000</b>

#### Funding:

100% GF (4260-101-0001)

## PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 184  
**IMPLEMENTATION DATE:** 4/1993  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 22

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,451,946,000	\$2,167,416,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,451,946,000	\$2,167,416,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$2,451,946,000	\$2,167,416,000

### 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.)  
 PCSP Interagency Agreements (IA) 03-75676  
 IPO IA 09-86307  
 SB 1036 (Chapter 45, Statutes of 2012)  
 SB 1008 (Chapter 33, Statutes of 2012)  
 Families First Coronavirus Response Act (FFCRA)

### Interdependent Policy Changes:

COVID-19 Increased FMAP Extension – DHCS

### 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 through IA's 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. Beginning April 1, 2014, some IHSS costs were paid through managed care capitation due to IHSS recipients transitioning into managed care. 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.

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

**PERSONAL CARE SERVICES (Misc. Svcs.)**  
**BASE POLICY CHANGE NUMBER: 184**

The Governor's Budget estimates the CCI project 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 IHSS, into managed care. IHSS were removed from capitation rate payments effective January 1, 2018.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

**Reason for Change:**

The change for FY 2020-21, from the previous estimate, is an increase due to updated expenditure data provided by CDSS and the temporary increased federal funding for COVID-19. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to updated expenditure data provided by CDSS and the temporary increased federal funding ending on June 30, 2021.

**Methodology:**

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021, in this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
2. The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>FFP</b>	<b>CDSS GF/ County Share</b>
PCSP/IPO	\$4,355,260	\$2,177,630	\$2,177,630
FFCRA	\$0	\$274,316	(\$274,316)
<b>Total</b>	<b>\$4,355,260</b>	<b>\$2,451,946</b>	<b>\$1,903,314</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>FFP</b>	<b>CDSS GF/ County Share</b>
PCSP/IPO	\$4,334,832	\$2,167,416	\$2,167,416
FFCRA	\$0	\$67,190	(\$67,190)
<b>Total</b>	<b>\$4,334,832</b>	<b>\$2,234,606</b>	<b>\$2,100,226</b>

**Funding:**

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

FFCRA 6.2% Increased FFP (4260-106-0890)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## DENTAL SERVICES

**BASE POLICY CHANGE NUMBER:** 185  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Devon Dyer  
**FISCAL REFERENCE NUMBER:** 135

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,604,027,000	\$1,617,493,000
<b>- STATE FUNDS</b>	\$639,554,700	\$652,413,450
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,604,027,000	\$1,617,493,000
<b>STATE FUNDS</b>	\$639,554,700	\$652,413,450
<b>FEDERAL FUNDS</b>	\$964,472,300	\$965,079,550

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension - DHCS  
 COVID-19 Utilization Change

**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).

## DENTAL SERVICES

### BASE POLICY CHANGE NUMBER: 185

#### Reason for Change:

The Dental Services base estimate has transitioned to a 36-month trend analysis and now includes Proposition 56 Supplemental Payments and some Dental Transformation Initiative costs that are processed by the fiscal intermediary, increasing FY 2020-21 from the prior Estimate.

Expenditures are projected to increase between fiscal years in the current estimate due to FY 2020-21 including one month of lower expenditures resulting from COVID19 decreased utilization. Projections have been returned to normal levels and the ongoing impact of COVID-19 is estimated in the COVID-19 Utilization Change policy change.

#### Methodology:

1. Dental expenditures are estimated using 36-months of cash-basis expenditure data (August 2017-July 2020) and trending the Users, Units/User, and Rate.
2. A portion of Proposition 56 Supplemental Payments and Domain 2 of Dental Transformation Initiative estimates are included in this policy change.
3. The estimates for Breast and Cervical Cancer Treatment Program (BCCTP) for dental services is now included in the BCCTP policy change.

#### Funding:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$1,057,745	\$528,873	\$528,873
ACA 90% FFP/10% GF (2020)	\$294,038	\$29,404	\$264,634
65% Title XXI/35% GF (10/2020)	\$188,849	\$66,097	\$122,752
76.5% Title XXI / 23.5% GF (7-9/2020)	\$62,950	\$14,793	\$48,157
Title XIX 100% GF	\$388	\$388	\$0
Title XIX 100% FFP	\$57	\$0	\$57
<b>Total</b>	<b>\$1,604,027</b>	<b>\$639,555</b>	<b>\$964,473</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$1,067,567	\$533,784	\$533,784
65% Title XXI/35% GF (10/2020)	\$296,312	\$29,631	\$266,681
ACA 90% FFP/10% GF (2020)	\$253,165	\$88,608	\$164,557
Title XIX 100% GF	\$391	\$391	\$0
Title XIX 100% FFP	\$58	\$0	\$58
<b>Total</b>	<b>\$1,617,494</b>	<b>\$652,414</b>	<b>\$965,080</b>

COVID-19 funding through June 30, 2021 is identified in the COVID 19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

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

**BASE POLICY CHANGE NUMBER:** 186  
**IMPLEMENTATION DATE:** 7/1991  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 26

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$329,693,000	\$253,965,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$329,693,000	\$253,965,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$329,693,000	\$253,965,000

**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  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

**TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)**  
**BASE POLICY CHANGE NUMBER: 186**

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change for FY 2020-21, from the prior estimate, is due to invoices to be paid in FY 2019-20 were paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, is a decrease due to FY an anticipated decrease in COVID-related expenditures, and that FY 2020-21 invoices will not be paid in FY 2021-22.

**Methodology:**

1. The 6.2% Title XIX FFCRA increased FMAP for expenditures paid through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

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

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>	<b>FFCRA</b>
<b>FY 2020-21</b>	\$575,567	\$245,874	<b>\$287,783</b>	<b>\$41,910</b>
<b>FY 2021-22</b>	\$498,614	\$244,650	<b>\$249,308</b>	<b>\$4,657</b>

**Funding:**

100% Title XIX (4260-101-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

## MEDI-CAL TCM PROGRAM

**BASE POLICY CHANGE NUMBER:** 191  
**IMPLEMENTATION DATE:** 6/1995  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 27

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$36,909,000	\$28,861,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$36,909,000	\$28,861,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$36,909,000	\$28,861,000

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

The TCM program provides funding to LGAs based on certified public expenditures incurred 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) and receive interim payments. Counties are then required to submit annual cost reports which are audited by the Department and are used to reconcile those interim payments with a county's audited costs. Counties either receive additional funding if costs exceeded the interim payments or counties are required to reimburse the federal funds if interim payments exceeded their costs.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## **MEDI-CAL TCM PROGRAM**

### **BASE POLICY CHANGE NUMBER: 191**

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a net increase due to:

- Updating reconciliations based on the completion of audit reports for seven fiscal years, resulting in the Department making payments to LGAs, therefore causing an increase from the prior estimate;
- Increased costs from counties adding or deleting TCM populations as a result of State Plan Amendment #10-010;
- Adding FFCRA increased funding estimates for FY 2019-20 and FY 2020-21; and
- An increased regular base estimate and a decreased Affordable Care Act (ACA) base estimate resulting from the addition on two additional quarters of actual FY 2019-20 expenditures.

The change in FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to:

- Net recoupments instead of net payments expected from the reconciliations occurring in FY 2021-22;
- No impact estimated resulting from SPA#10-010 in FY 2021-22; and
- Lower FFCRA increased funding estimated in FY 2021-22.

**Methodology:**

1. State Plan Amendment (SPA) #10-010, approved on December 19, 2013, and effective October 16, 2010, included interim and final reconciliations of LGAs costs for providing TCM.
2. The projected base payment amounts of \$30,104,000 (regular invoices) and \$3,105,000 (ACA invoices) for FY 2020-21 and FY 2021-22, are based on average expenditures from FY 2015-16 through FY 2019-20 for regular and ACA payments.
3. In FY 2020-21, the Department will complete reconciliations for FY 2010-11 through FY 2019-20. In addition, the Department anticipates an increase of \$1,511,000 in payments due to the SPA impact of five LGAs opting in or out of the TCM program by adding or deleting TCM target populations.
4. In FY 2021-22, the Department will complete reconciliations for FY 2016-17 through FY 2020-21.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change
6. On a cash basis, the FFCRA increased FMAP for dates of service FY 2019-20 and the first half of FY 2020-21 is expected to be paid in FY 2020-21. The FFCRA increased FMAP for the second half of FY 2020-21 is expected to be paid in FY 2021-22.

**MEDI-CAL TCM PROGRAM**  
**BASE POLICY CHANGE NUMBER: 191**

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>FFCRA</b>
FY 2020-21 Base (Regular Expenditures)	\$30,104,000	\$30,104,000	\$0
FY 2020-21 Base (ACA Expenditures)	\$3,105,000	\$3,105,000	\$0
6.2% FMAP Increase (FY 2019-20)	\$311,000	\$0	\$311,000
6.2% FMAP Increase (FY 2020-21)	\$933,000	\$0	\$933,000
SPA Impact	\$1,511,000	\$1,511,000	\$0
Reconciliation			
Regular Claims	\$425,000	\$425,000	\$0
ACA Claims	\$520,000	\$520,000	\$0
<b>Total FY 2020-21</b>	<b>\$36,909,000</b>	<b>\$35,665,000</b>	<b>\$1,244,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>FFCRA</b>
FY 2021-22 Base (Regular Expenditures)	\$30,104,000	\$30,104,000	\$0
FY 2021-22 Base (ACA Expenditures)	\$3,105,000	\$3,105,000	\$0
6.2% FMAP Increase (FY 2020-21)	\$933,000	\$0	\$933,000
Reconciliation			
Regular Claims	(\$3,971,000)	(\$3,971,000)	\$0
ACA Claims	(\$1,310,000)	(\$1,310,000)	\$0
<b>Total FY 2021-22</b>	<b>\$28,861,000</b>	<b>\$27,928,000</b>	<b>\$933,000</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## LAWSUITS/CLAIMS

**BASE POLICY CHANGE NUMBER:** 192  
**IMPLEMENTATION DATE:** 7/2017  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2080

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$36,001,000	\$32,350,000
<b>- STATE FUNDS</b>	\$18,000,500	\$16,175,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$36,001,000	\$32,350,000
<b>STATE FUNDS</b>	\$18,000,500	\$16,175,000
<b>FEDERAL FUNDS</b>	\$18,000,500	\$16,175,000

**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 eligible lawsuit settlements approved by the Legislature and the Governor.

**Reason for Change:**

The change from FY 2020-21, from the prior estimate, is an increase due to an increase in the number of matters subject to settlement and lawsuit payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to fewer settlement and lawsuit payments expected to be made.



**LAWSUITS/CLAIMS**  
**BASE POLICY CHANGE NUMBER: 192**

**Methodology:**

<b>FY 2020-21</b>	<b>Total Amount</b>
<u>Other Attorneys Fees</u>	
Independent Living Center, et al. v. Kent, et al. (Hooper, Lundy and Bookman)	\$4,255,000
Jane H. v. Kent	\$445,000
Ivory N. and James B. v. Kent, et al. (second installment payment)	\$218,000
Kelley v. Kent et al.	\$700,000
Total	\$5,618,000
<u>Other Provider Settlements</u>	
LA Care	\$31,000,000
AHF	(\$624,000)
Total	\$30,376,000
<b>FY 2020-21 Total (rounded)</b>	<b>\$36,001,000</b>
<b>FY 2021-22</b>	
<u>Other Provider Settlements</u>	
LA Care	\$31,000,000
Total	\$31,000,000
<b>FY 2020-21 Total</b>	<b>\$31,000,000</b>

**LAWSUITS/CLAIMS**  
**BASE POLICY CHANGE NUMBER: 192**

<b>FY 2020-21</b>			
	<b>Committed</b>	<b>Balance</b>	<b>Budgeted</b>
Attorney Fees <\$30,000	\$0	\$200,000	\$200,000
Provider Settlements <\$100,000	\$0	\$1,000,000	\$1,000,000
Beneficiary Settlements <\$10,000	\$7,000	\$143,000	\$150,000
Small Claims Court	\$0	\$0	\$0
Other Attorney Fees	\$5,618,000	\$0	\$5,618,000
Other Provider Settlements	\$30,376,000	\$0	\$30,376,000
Other Beneficiary Settlements	\$0	\$0	\$0
Interest Paid	\$0	\$0	\$0
<b>Totals (Rounded)</b>	<b>\$36,001,000</b>	<b>\$1,343,000</b>	<b>\$37,344,000</b>

<b>FY 2021-22</b>	
	<b>Budgeted</b>
Attorney Fees<\$30,000;Provider Settlements<\$100,000; Beneficiary Settlements<\$10,000	\$1,350,000
Other Attorney Fees	\$0
Other Provider Settlements	\$31,000,000
Other Beneficiary Settlements	\$0
Interest Paid	\$0
<b>Totals (Rounded)</b>	<b>\$32,350,000</b>

**Funding:**

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

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

**BASE POLICY CHANGE NUMBER:** 195  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 77

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$40,545,000	\$35,038,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$40,545,000	\$35,038,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$40,545,000	\$35,038,000

**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  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 two 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**  
**BASE POLICY CHANGE NUMBER: 195**

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to increased expenditures due to FFCRA increased FMAP and a higher settlement figure than anticipated.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to FFCRA increased FMAP and a higher settlement figure than anticipated.

**Methodology:**

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

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

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>FFP Regular</b>	<b>FFCRA</b>
<b>FY 2020-21</b>	\$78,581	\$38,036	<b>\$38,035</b>	<b>\$2,510</b>
<b>FY 2021-22</b>	\$71,215	\$34,930	<b>\$34,929</b>	<b>\$109</b>

**Funding:**

100% Title XIX (4260-101-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

## CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 207  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1083

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,598,000	\$1,028,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,598,000	\$1,028,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,598,000	\$1,028,000

**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 targeted case management services utilizing revenues collected from fees. County governments receive the CLPP revenues matched with the federal funds on a reimbursement basis for targeted case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an IA.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to updating the assumption that FY 2018-19 and FY 2019-20 invoices will be paid in FY 2020-21, that was previously assumed to be paid in FY 2020-21, as a result of a delay in local jurisdictions submitting invoices to the State.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to more prior year claims paid in FY 2020-21.

**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: 207**

2. The estimates are provided by CDPH on a cash basis.

<b>FY 2020-21</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
FY 2018-19 Benefits Costs	\$342,00	\$342,000
FY 2019-20 Benefits Costs	\$485,000	\$485,000
FY 2020-21 Benefits Costs	\$771,000	\$771,000
<b>Total for FY 2020-21</b>	<b>\$1,598,000</b>	<b>\$1,598,000</b>

<b>FY 2021-22</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
FY 2020-21 Benefits Costs	\$257,000	\$257,000
FY 2021-22 Benefits Costs	\$771,000	\$771,000
<b>Total for FY 2021-22</b>	<b>\$1,028,000</b>	<b>\$1,028,000</b>

**Funding:**

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

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 208  
**IMPLEMENTATION DATE:** 1/1993  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 91

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$911,000	\$956,000
<b>- STATE FUNDS</b>	\$399,500	\$478,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$911,000	\$956,000
<b>STATE FUNDS</b>	\$399,500	\$478,000
<b>FEDERAL FUNDS</b>	\$511,500	\$478,000

**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 1905(a), 1906(a)(3), 1906A(e), and 1916(e)  
 Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)  
 State Plan Amendment 19-0045  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

The HIPP program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. Under the HIPP program, the Department pays for premiums, 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. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 19-0045 allowing the Department to revise the methodology for determining cost effectiveness and introduce new eligibility criteria for the HIPP program. Currently, HIPP members are not enrolled in Medi-Cal managed care. The California Advancing and Innovating Medi-Cal (CalAIM) proposal would have changed managed care enrollment to include HIPP members. Due to COVID-19 and the delay of the CalAIM, changes to managed care enrollment have also been delayed. As a result, the new eligibility criteria under which those enrolled in managed care would no longer be eligible for the HIPP program will not have an impact until CalAIM is implemented. Furthermore, the fiscal impact of the CalAIM changes are not anticipated until FY 2022-23.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

### BASE POLICY CHANGE NUMBER: 208

the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Updating the projections based on actual FY 2019-20 data on average premium costs, plus a projected 5% increase, and actual current HIPP member counts. Due to the delay in the implementation of CalAIM, the new eligibility criteria will have less of an impact than previously expected. HIPP enrollment is projected to remain steady until the implementation of CalAIM.
- Applying FFCRA increased FMAP for FY 2020-21 HIPP premium payments, shifting costs from the state to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to a projected 5% increase in the premium rates while holding steady the estimated member enrollment.

#### Methodology:

1. HIPP premium costs are determined by:
  - Actual premium expense for FY 2019-20,
  - The average monthly per member per month (PMPM) premium amount,
  - Current member count, and
  - The assumption that premium costs will increase by 5% each fiscal year based on historical trends.
2. The average monthly PMPM premium cost including ancillary costs is estimated to be \$593 in FY 2020-21 and \$622 in FY 2021-22.
3. The average monthly HIPP enrollment is estimated to be 128 in FY 2020-21 and FY 2021-22.
4. Costs for FY 2020-21 and FY 2021-22 are estimated to be:
 

FY 2020-21: \$593 (average monthly PMPM premium cost) x 128 (current member count) x 12 months = \$911,000 TF

FY 2021-22: \$622 (average monthly PMPM premium cost) x 128 (current member count) x 12 months = \$956,000 TF
5. The FFCRA increased FMAP of 6.2% is assumed for HIPP premium payments through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.



**HIPP PREMIUM PAYOUTS (Misc. Svcs.)**  
BASE POLICY CHANGE NUMBER: 208

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
<b>FY 2020-21</b>	<b>\$911,000</b>	<b>\$399,000</b>	<b>\$456,000</b>	<b>\$56,000</b>
<b>FY 2021-22</b>	<b>\$956,000</b>	<b>\$478,000</b>	<b>\$478,000</b>	<b>\$0</b>

**Funding:**

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

56.2% Title XIX / 43.8% GF (4260-101-0001/0890)

## BASE RECOVERIES

**BASE POLICY CHANGE NUMBER:** 224  
**IMPLEMENTATION DATE:** 7/1987  
**ANALYST:** Stephanie Hockman  
**FISCAL REFERENCE NUMBER:** 127

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$460,373,000	-\$364,943,000
<b>- STATE FUNDS</b>	-\$193,838,500	-\$153,657,900
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$460,373,000	-\$364,943,000
<b>STATE FUNDS</b>	-\$193,838,500	-\$153,657,900
<b>FEDERAL FUNDS</b>	-\$266,534,500	-\$211,285,100

### Purpose:

This policy change estimates estate, personal injury, workers' compensation, provider/beneficiary overpayments, and other insurance recoveries used to offset the cost of Medi-Cal services.

### Authority:

- Welfare & Institutions Code 10022, 14009, 14009.5, 14024, 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 50489.9, 50781-50791, 51045, 51047, and 51458.1
- United States Code 42, 1396a(25)

### Interdependent Policy Changes:

COVID-19 Base Recoveries  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

### 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.

## BASE RECOVERIES

### BASE POLICY CHANGE NUMBER: 224

#### 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 fluctuations in settlements, judgements, and awards.

FY 2020-21 recoveries are projected to be lower than the prior estimate due to decreases in Medi-Cal provider and estate recoveries:

- Estate and Medi-Cal Provider recoveries declined in the latter half of FY 2019-20 resulting from the economic impact of the public health emergency. The Department has experienced delayed repayments for Estate recoveries due to court closures and deferred repayments due to hardship requests expected from provider audits. FY 2020-21 includes one month of lower actual collections for these recovery types and projections have been returned to normal levels. The ongoing impact of public health emergency is estimated in the COVID-19 Base Recoveries policy change.
- Decreases are partially offset by some Health Insurance recoveries shifting from FY 2019-20 to FY 2020-21.

FY 2021-22 recoveries are projected to be lower than FY 2020-21 due to the following:

- FY 2020-21 includes additional one-time recovery efforts for health insurance recoveries related to Mental Health/Substance Use Disorder (MH/SUD), Dental, and Managed Care plans. These one-time collections have been delayed due operational delays resulting from the public health emergency. The impact of the public health emergency on collections were included in the prior estimate and are estimated in the COVID-19 Base Recoveries Policy change.
- A one-time high recovery value for Workers' Compensation was received in FY 2020-21 and not included in FY 2021-22 projections.
- Medi-Cal Provider and Estate recoveries are projected to increase between fiscal years due to FY 2020-21 including one month of lower collections resulting from the public health emergency. Projections have been returned to normal levels.

(Dollars in Thousands)

Recovery Type	FY 2020-21	FY 2021-22
Personal Injury Collections	(\$121,388)	(\$120,934)
Workers' Comp. Collections	(\$4,223)	(\$2,459)
Health Insurance Collections	(\$181,130)	(\$73,500)
General Collections	(\$153,632)	(\$168,050)
<b>TOTAL</b>	<b>(\$460,373)</b>	<b>(\$364,943)</b>

#### Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2017 – July 2020.
2. Projected funding has been updated to reflect funding splits based on prior years reported recoveries.

**BASE RECOVERIES**  
**BASE POLICY CHANGE NUMBER: 224**

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$369,488)	(\$184,744)	(\$184,744)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$5,086)	(\$1,780)	(\$3,306)
Title XIX FFP (4260-101-0890)	(\$12,655)	\$0	(\$12,655)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$73,144)	(\$7,314)	(\$65,830)
<b>TOTAL</b>	<b>(\$460,373)</b>	<b>(\$193,839)</b>	<b>(\$266,535)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$292,897)	(\$146,449)	(\$146,449)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$4,032)	(\$1,411)	(\$2,621)
Title XIX FFP (4260-101-0890)	(\$10,032)	\$0	(\$10,032)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$57,982)	(\$5,798)	(\$52,184)
<b>TOTAL</b>	<b>(\$364,943)</b>	<b>(\$153,658)</b>	<b>(\$211,285)</b>

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

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POLICY CHANGE INDEX**

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## FPL INCREASE FOR AGED AND DISABLED PERSONS

**REGULAR POLICY CHANGE NUMBER:** 1  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2140

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$100,498,000	\$208,596,000
<b>- STATE FUNDS</b>	\$50,249,000	\$104,298,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$100,498,000	\$208,596,000
<b>STATE FUNDS</b>	\$50,249,000	\$104,298,000
<b>FEDERAL FUNDS</b>	\$50,249,000	\$104,298,000

**Purpose:**

This policy change estimates the benefit and premium costs to disregard countable income up to 138% of the Federal Poverty Level (FPL) for the Aged, Blind, and Disabled (ABD) FPL program.

**Authority:**

SB 104 (Chapter 67, Statutes of 2019)  
SPA 19-005

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

State law requires the Department to exercise its option under federal law to implement a program for aged and disabled persons. The law requires an individual under these provisions to satisfy certain financial eligibility requirements, including, among other things, that the individual's countable income does not exceed an income standard equal to 100% of the applicable FPL, plus an income disregard of \$230 for an individual, or \$310 in the case of a couple, except that the income standard determined shall not be less than the Supplemental Security Income/State Supplementary Payment level for a disabled individual or couple, as applicable.

SB 104 requires, upon receipt of federal approval, all countable income over 100% and up to 138% of the FPL to be disregarded after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons.

On September 30, 2019, the Department submitted State Plan Amendment 19-0050 to the Centers for Medicare & Medicaid Services (CMS) to obtain approval for program implementation. The Department received CMS approval on December 20, 2019. Formal guidance was published on January 31, 2020, and the Statewide Automated Welfare Systems begun system changes for the program updates.

## **FPL INCREASE FOR AGED AND DISABLED PERSONS**

**REGULAR POLICY CHANGE NUMBER: 1**

**Reason for Change:**

The change for FY 2020-21, in the current estimate, is a decrease due to a delay in the program implementation to December 2020. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase as FY 2021-22 has a full year of costs.

**Methodology:**

1. Assume program implementation in December 2020.
2. Assume beneficiaries with incomes between 124%-138% FPL who have met their share of cost (SOC) will shift into aid codes without a SOC requirement.
3. Assume the Department will pay Medicare Part B premiums for dual eligibles.
4. Assume an estimated cost of **\$100,498,000 (\$50,249,000 GF)** in FY 2020-21 and **\$208,596,000 (\$104,298,000 GF)** in FY 2021-22 for premiums and benefits.

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDI-CAL STATE INMATE PROGRAMS

**REGULAR POLICY CHANGE NUMBER:** 2  
**IMPLEMENTATION DATE:** 12/2016  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1569

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$70,059,000	\$47,603,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$70,059,000	\$47,603,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$70,059,000	\$47,603,000

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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% General Fund (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 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 with 100% GF.

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 2020-21, from the prior estimate, is a decrease due to updating the estimate with actuals based on current invoices from FY 2019-20. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to completing all retro payments in FY 2020-21.

#### **Methodology:**

1. The adult State inmate program began in November 2010. Eligibility began in April 2011 with claiming beginning in April 2012. The Medical Parole program began in June 2011 with claiming beginning in April 2013. The juvenile State inmate program began in January 2012 with claiming beginning in April 2013.
2. Estimated costs for FY 2020-21 and FY 2021-22 are annualized projections primarily based on actual claims data for FY 2019-20 quarter 1 and quarter 4.
3. Assume \$22,456,000 federal funds (FF) in retroactive payments will be paid in FY 2020-21 starting in October 2020.
4. 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 and beyond.
5. Assume a six-month lag in ongoing payments.
6. 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 (Non-ACA and ACA) adult and juvenile inmates in FY 2020-21 and FY 2021-22:



**MEDI-CAL STATE INMATE PROGRAMS**  
REGULAR POLICY CHANGE NUMBER: 2

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>
Adults - Non ACA	\$12,328,000	\$6,164,000
Adults - ACA	\$45,469,000	\$40,922,000
Medical Parole	\$1,024,000	\$512,000
Juveniles	\$9,000	\$5,000
Total Retroactive Payments ACA	\$7,490,000	\$7,490,000
Total Retroactive Payments Non-ACA	\$29,932,000	\$14,966,000
<b>Total FY 2020-21</b>	<b>\$96,252,000</b>	<b>\$70,059,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
Adults - Non ACA	\$12,328,000	\$6,164,000
Adults - ACA	\$45,469,000	\$40,922,000
Medical Parole	\$1,024,000	\$512,000
Juveniles	\$9,000	\$5,000
<b>Total FY 2021-22</b>	<b>\$58,830,000</b>	<b>\$47,603,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

**REGULAR POLICY CHANGE NUMBER:** 3  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2127

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$265,377,000	\$323,031,000
<b>- STATE FUNDS</b>	\$182,915,000	\$218,868,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	74.50 %	63.56 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$67,671,100	\$117,712,500
<b>STATE FUNDS</b>	\$46,643,320	\$79,755,500
<b>FEDERAL FUNDS</b>	\$21,027,810	\$37,957,000

**Purpose:**

This policy change estimates the benefit costs to expand full scope Medi-Cal benefits to adults 19 through 25 years of age, regardless of immigration status.

**Authority:**

SB 104 (Chapter 67, Statutes of 2019)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

California provides restricted scope Medi-Cal coverage (emergency and pregnancy related services only) to low income adults who are not eligible for full scope because of their immigration status. Federal financial participation (FFP) is available, regardless of immigration status, for emergency and pregnancy related services. Individuals who are between 19 through 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:**

The change from the prior estimate, for FY 2020-21, is a decrease due to a reduced restricted scope population, and due to slower than anticipated ramp-up for the population that is eligible, but has not enrolled into Medi-Cal. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to a higher year-end population as phase-in continues in FY 2021-22 for the population that is eligible, but has not enrolled into Medi-Cal.

**Methodology:**

1. Program implementation occurred on January 1, 2020.

## UNDOCUMENTED YOUNG ADULTS FULL SCOPE EXPANSION

### REGULAR POLICY CHANGE NUMBER: 3

2. In-Home Supportive Services (IHSS) are not budgeted in this policy change as they are included in the budget for the Department of Social Services. IHSS costs are estimated to be \$27,497,000 in FY 2020-21 and \$44,116,000 in FY 2021-22.
3. The Department assumes approximately 90,000 adults from two populations will transition to full scope benefits by FY 2021-22, current restricted scope adults and adults that are currently eligible, but have not enrolled into Medi-Cal.
4. Full scope SB 75 children turning 19 and current restricted scope adults 19 through 25 years of age will be passively enrolled into full scope Medi-Cal.
5. Assume 100% of the adults that are eligible, but not enrolled will take up phased-in coverage over 48 months.
6. Assume offsetting cost savings for those who were enrolled in restricted scope Medi-Cal and transitioned into full scope Medi-Cal beginning January 1, 2020.
7. Net expenditures are expected to be:

(Dollars in Thousands)

Full Scope Costs for Young Adults	TF	GF	FF
FY 2020-21	\$265,377	\$182,915	\$82,462
FY 2021-22	\$323,031	\$218,868	\$104,163

**Funding:**

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

100% GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## BREAST AND CERVICAL CANCER TREATMENT

**REGULAR POLICY CHANGE NUMBER:** 4  
**IMPLEMENTATION DATE:** 1/2002  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 3

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$63,661,000	\$64,135,000
<b>- STATE FUNDS</b>	\$25,147,750	\$25,332,150
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$63,661,000	\$64,135,000
<b>STATE FUNDS</b>	\$25,147,750	\$25,332,150
<b>FEDERAL FUNDS</b>	\$38,513,250	\$38,802,850

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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% FF / 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 was 18 months for breast cancer and 24 months for cervical cancer, however, coverage limits were 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.

Effective July 1, 2018, Health Omnibus Trailer Bill AB 1810, Chapter 34, Statutes of 2018, signed June 27, 2018, appropriated funding to the General Fund for the elimination of the 18 and 24-month treatment limitations.

## BREAST AND CERVICAL CANCER TREATMENT

### REGULAR POLICY CHANGE NUMBER: 4

**Reason for Change:**

The change from the prior estimate, FY 2020-21, is a slight decrease due to updating the enrollment data for August 2019 through July 2020. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase due to higher expenditures anticipated in FY 2021-22.

**Methodology:**

1. As of July 2020, there were a total of 4,064 beneficiaries, of which 2,698 were in FFS and 1,366 were in managed care. Additionally, 1,465 of the FFS beneficiaries were eligible for State-Only services.
2. As of July 2020, 132 of the FFS beneficiaries were in accelerated enrollment.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 261 beneficiaries monthly in FY 2020-21 and FY 2020-22. Assume an average monthly premium cost per beneficiary of \$159.28.
4. Assume 45% of beneficiaries will require a third year of treatment, and 20% of those beneficiaries will require a fourth year of treatment.
5. 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.
6. FFS costs are estimated as follows:

(Dollars in Thousands)

FFS Costs	FY 2020-21			FY 2021-22		
	TF	GF	FF	TF	GF	FF
Full Scope Costs	\$59,312	\$20,799	\$38,513	\$59,760	\$20,956	\$38,803
State-Only Services	\$3,849	\$3,849	\$0	\$3,877	\$3,877	\$0
State-Only Premiums	\$499	\$499	\$0	\$499	\$499	\$0
<b>Total</b>	<b>\$63,661</b>	<b>\$25,148</b>	<b>\$38,513</b>	<b>\$64,135</b>	<b>\$25,332</b>	<b>\$38,803</b>

\* Totals may differ due to rounding.

**Funding:**

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
General Fund 4260-101-0001	\$4,348	\$4,348	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$268	\$134	\$134
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$59,045	\$20,666	\$38,379
<b>Total</b>	<b>\$63,661</b>	<b>\$25,148</b>	<b>\$38,513</b>

**BREAST AND CERVICAL CANCER TREATMENT**  
REGULAR POLICY CHANGE NUMBER: 4

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
General Fund 4260-101-0001	\$4,376	\$4,376	\$0
50 Title XIX FF / 50 GF (4260-101-0890/0001)	\$270	\$135	\$135
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$59,489	\$20,821	\$38,668
<b>Total</b>	<b>\$64,135</b>	<b>\$25,332</b>	<b>\$38,803</b>

\* Totals may differ due to rounding.

\*\* COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

\*\*\*COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDICARE OPTIONAL EXPANSION ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 6  
**IMPLEMENTATION DATE:** 7/2017  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2033

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$14,938,000	\$0
<b>- STATE FUNDS</b>	\$26,286,680	\$489,600
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$14,938,000	\$0
<b>STATE FUNDS</b>	\$26,286,680	\$489,600
<b>FEDERAL FUNDS</b>	-\$11,348,680	-\$489,600

**Purpose:**

This policy change adjusts the funding from the Optional Expansion Federal Medical Assistance Percentage (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 and other contributing factors, 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 reduce further enrollment of Medicare Part A and/or Part B eligibles into the Optional Expansion eligibility group. The Department initiated additional work efforts to address the various causes of the erroneous enrollments.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a General Fund (GF) decrease due to utilizing more recent actual memos for the FY 2020-21 projection. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a GF decrease due to fewer months being adjusted for in FY 2021-22.

## MEDICARE OPTIONAL EXPANSION ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 6

**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
CY 2020	90% FFP

2. Adjustments will continue for Medicare Part A and/or Part B eligibles remaining in the Optional Expansion aid codes. The Department is researching claiming methodologies that will reduce or eliminate the need for adjustments. For January 2014 – June 2016, the actual expenditures were adjusted for in FY 2018-19 and FY 2019-20. For July 2016 – June 2019, the expenditures were adjusted for in FY 2019-20. For July 2019 – June 2020, the expenditures will be adjusted for in FY 2020-21. For any additional adjustment periods, the expenditures will be adjusted for in FY 2021-22.
3. Those Medi-Cal eligibles with Part A and/or Part B are estimated in the Optional Expansion aid category.
4. Assume the Department will reimburse any Long Term Care services these duals may have received from managed care plans participating in the Coordinated Care Initiative. This will be a one-time payment made at 50/50 FMAP.
5. The overall adjustment is estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	FF	GF
FY 2020-21	\$14,938	(\$11,347)	\$26,285
FY 2021-22	\$0	(\$490)	\$490

**Funding:**

(Dollars in Thousands)

FY 2020-21	TF	FF	GF
93% ACA Title XIX FF /7% GF (4260-101-0890/0001)	(\$32,556)	(\$30,276)	(\$2,280)
90% ACA Title XIX FF /10% GF (4260-101-0890/0001)	(\$15,054)	(\$13,548)	(\$1,506)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	\$62,548	\$31,274	\$31,274
100% Title XIX FF (4260-101-0890)	\$1,203	\$1,203	\$0
100% GF (4260-101-0001)	(\$1,203)	\$0	(\$1,203)
<b>Total</b>	<b>\$14,938</b>	<b>(\$11,347)</b>	<b>\$26,285</b>



**MEDICARE OPTIONAL EXPANSION ADJUSTMENT**  
**REGULAR POLICY CHANGE NUMBER: 6**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>GF</b>
90% ACA Title XIX FF /10% GF (4260-101-0890/0001)	(\$1,224)	(\$1,102)	(\$122)
50 % Title XIX FF / 50% GF (4260-101-0890/0001)	\$1,224	\$612	\$612
<b>Total</b>	<b>\$0</b>	<b>(\$490)</b>	<b>\$490</b>

\* Totals may differ due to rounding

## DISABLED ADULT CHILDREN PROGRAM CLEANUP

**REGULAR POLICY CHANGE NUMBER:** 8  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2191

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,232,000	\$0
<b>- STATE FUNDS</b>	\$5,847,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,232,000	\$0
<b>STATE FUNDS</b>	\$5,847,000	\$0
<b>FEDERAL FUNDS</b>	-\$2,615,000	\$0

**Purpose:**

This policy change estimates the cost for Medicare Part B premium and out-of-pocket expense reimbursement for individuals who were eligible to Medi-Cal under the Disabled Adult Child(ren) (DAC) program but were granted eligibility to Medi-Cal with a share-of-cost (SOC) in error.

**Authority:**

Section 6 of Public Law 99-643  
42 U.S.C. Section 1383(c)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Individuals who are potentially eligible to Medi-Cal under the DAC program must meet certain criteria in order to be considered a DAC. These individuals receive special income exclusions due to the DAC status, and are eligible under a zero SOC aid code. The Department discovered that an estimated 1,113 individuals with potential eligibility to the DAC program were aided in Medi-Cal with a SOC in error. As a result of these eligibility errors, some of these individuals are incorrectly paying for out-of-pocket expenses to meet their SOC and self-paying their Medicare Part B premiums. This clean-up effort will require counties to retroactively correct the eligibility for individuals who are in the incorrect Medi-Cal aid code and place them in the correct DAC zero SOC aid code.

Counties will retroactively redetermine eligibility for this population to the correct aid code to mitigate incurring additional costs in error for these eligibles. The Centers for Medicare and Medicaid Services (CMS) will reimburse Part B premiums to identified eligibles. The Department will then reimburse CMS for any Part B premiums CMS refunded to those individuals. Additionally, the Department will refund out-of-pocket expenses that identified eligibles incurred to meet their SOC.

## DISABLED ADULT CHILDREN PROGRAM CLEANUP

### REGULAR POLICY CHANGE NUMBER: 8

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase due to a delay in processing the FY 2019-20 Part B Adjustments and Share of Cost Adjustments as a result of the COVID-19 impacts on county workload efforts. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to completing all adjustments in FY 2020-21.

#### Methodology:

1. Assume Part B repayments to CMS and out-of-pocket expense repayments to the identified beneficiaries began April 2020.
2. Assume the below costs for FY 2020-21:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Part B Adjustment	\$0	\$2,615	(\$2,615)
Share of Cost Adjustment	\$3,232	\$3,232	\$0
<b>FY 2020-21 Total</b>	<b>\$3,232</b>	<b>\$5,847</b>	<b>(\$2,615)</b>

#### Funding:

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

100% GF (4260-101-0001)

## MEDICARE PART B DISREGARD

**REGULAR POLICY CHANGE NUMBER:** 10  
**IMPLEMENTATION DATE:** 12/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2175

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,115,000	\$1,911,000
<b>- STATE FUNDS</b>	\$1,115,000	\$1,911,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,115,000	\$1,911,000
<b>STATE FUNDS</b>	\$1,115,000	\$1,911,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the cost for eligibles in the Aged, Blind, and Disabled (ABD) program to remain eligible for the program regardless of the state's payment of their Medicare Part B premiums, as long as they meet all other Medi-Cal eligibility requirements.

**Authority:**

AB 1088 (Chapter 450, Statutes of 2019)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department provides Medi-Cal coverage to low-income individuals, seniors and persons with a disability, at no cost through the ABD program. Applicants for the ABD program are entitled to certain deductions from their income when qualifying for Medi Cal, including the deduction for health insurance and/or Medicare premiums self-paid by the individual or their family. This health insurance premium deduction reduces the net countable income. For some applicants and beneficiaries, this deduction can reduce the net countable income to at or below the income threshold for these programs and results in eligibility for no cost Medi-Cal.

The Department operates a state Medicare Buy-in program (state Buy-in program) for full scope Medi-Cal beneficiaries who are eligible for Medicare. Through this state Buy-in program, the Department begins paying the Medicare Part B premium for recipients who qualify for no cost Medi-Cal, and the beneficiary no longer has to pay the premium. As long as the beneficiary is self-paying their Part B premiums, they will receive this health insurance premium deduction. Once the beneficiary qualifies for no cost Medi-Cal and the state begins to pay their Medicare premium (state Buy-in), they no longer receive the deduction, and their countable income for program eligibility purposes increases accordingly. For some beneficiaries, this can result in moving from no cost Medi-Cal to share of cost (SOC) Medi-Cal, solely because of the state Buy-in.

## **MEDICARE PART B DISREGARD**

### **REGULAR POLICY CHANGE NUMBER: 10**

AB 1088 allows for an ABD beneficiary whose Part B premiums are being paid by the Department to continue to receive Medi-Cal benefits without a SOC, as long as they meet all eligibility requirements.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to a projected earlier implementation date. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the program implementing in FY 2020-21, resulting in a partial year of costs for FY 2020-21.

#### **Methodology:**

1. The Department must obtain federal approval prior to implementing this policy. Formal policy instructions will be provided to the counties through an All County Welfare Directors Letter (ACWDL). Statewide Automated Welfare Systems changes will be programed after the publication of the ACWDL. Assume this policy will implement no sooner than December 1, 2020.
2. Assume an annual impact for beneficiaries who have a monthly SOC of at least \$672.
3. Assume the Department will continue to pay Part B premiums for this population.
4. Assume an estimated cost of **\$1,115,000 General Fund in FY 2020-21 and \$1,911,000 General Fund in FY 2021-22.**

#### **Funding:**

100% GF (4260-101-0001)

## PROVISIONAL POSTPARTUM CARE EXTENSION

**REGULAR POLICY CHANGE NUMBER:** 11  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2141

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$27,058,000
<b>- STATE FUNDS</b>	\$0	\$27,058,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$27,058,000
<b>STATE FUNDS</b>	\$0	\$27,058,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the benefit costs associated with allowing beneficiaries who receive pregnancy-related services, and are diagnosed with a mental health condition, to remain eligible for Medi-Cal partum care for up to 12 months after the last day of the pregnancy.

**Authority:**

SB 104 (Chapter 67, Statutes of 2019)

**Interdependent Policy Changes:**

COVID-19 Caseload Impact

**Background:**

For those that qualify, Medi-Cal offers coverage for pregnancy and pregnancy-related services as well as postpartum care. Services include prenatal care, labor, delivery, care after delivery, family planning services, care related to pregnancy loss and services for conditions that might complicate the pregnancy. Additionally, mental health services are also included in the coverage. Previously, due to income limitations and other eligibility factors, postpartum care terminated 60 days after the last day of pregnancy.

SB 104 allows an eligible individual who is receiving pregnancy-related services and is diagnosed with a mental health condition to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy.

Medi-Cal is temporarily suspending the annual renewal process to meet the Families First Coronavirus Response Act continuous coverage requirements and receive a temporary increase in the federal medical assistance percentage. As such, the COVID-19 Caseload Impact policy change captures individuals who would have otherwise been disenrolled after receiving Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy. The federal public health emergency (PHE) is assumed to end on December 31, 2021. Until the PHE ends, it is assumed costs that would have been budgeted within this policy change will be carried in the COVID-19 Caseload Impact policy change.

## **PROVISIONAL POSTPARTUM CARE EXTENSION**

**REGULAR POLICY CHANGE NUMBER: 11**

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to costs for this program being carried in the COVID-19 Caseload Impact policy change until the PHE ends. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to including costs from January 1, 2022, through June 30, 2022, in this policy change for FY 2021-22 after the PHE ends.

**Methodology:**

1. Assume this population would have otherwise not been eligible to receive services after the 60 day postpartum period.
2. Assume implementation occurred August 2020. Assume this policy sunsets December 31, 2022.
3. Assume the PHE ends on December 31, 2021.
4. Assume costs for this program will be carried in the COVID-19 Caseload Impact until the PHE ends. After the PHE ends, assume these eligibles will receive services for up to an additional 6 months of postpartum care in FY 2021-22.
5. Assume an estimated cost of **\$27,058,000 General Fund in FY 2021-22.**

**Funding:**

100% GF (4260-101-0001)

## MEDI-CAL COUNTY INMATE PROGRAMS

**REGULAR POLICY CHANGE NUMBER:** 12  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1755

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$42,506,000	\$59,632,000
<b>- STATE FUNDS</b>	\$2,340,000	\$2,457,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	100.00 %	74.85 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$14,997,400
<b>STATE FUNDS</b>	\$0	\$617,940
<b>FEDERAL FUNDS</b>	\$0	\$14,379,510

### 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:

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

### Background:

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

- Claim FFP for inpatient hospital services for 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



## **MEDI-CAL COUNTY INMATE PROGRAMS**

### **REGULAR POLICY CHANGE NUMBER: 12**

medical probation. Counties are 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 2020-21, from the prior estimate, is a decrease due to updated payment data from FY 2018-19 quarter 4 and FY 2019-20 quarter 1, 2, and 3. Additionally, the retro payments have shifted to FY 2021-22. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the retro payments being paid in FY 2021-22.

#### **Methodology:**

1. The adult county inmate program began in November 2010. The juvenile county inmate program began in January 2012. The compassionate release inmate program began in January 2013.
2. Claims with dates of services prior to April 1, 2017, retroactive to the beginning of the adult, compassionate release, and juvenile programs, will be part of the retroactive claiming process that will begin in FY 2021-22. Previously, counties paid for these services. The retroactive claiming will be processed manually and the counties will be reimbursed with federal funds (FF) for the non-general funds (GF) payment portions made for dates of services prior to April 1, 2017.
3. Assume \$15,000,000 in retroactive payments will be paid in FY 2021-22.
4. Claims with dates of services starting April 1, 2017, are processed by the fiscal intermediary and paid with GF and 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. See the Medi-Cal County Inmate Reimbursement policy change for more information.

## MEDI-CAL COUNTY INMATE PROGRAMS

### REGULAR POLICY CHANGE NUMBER: 12

5. The Department will continue to pay Affordable Care Act (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 and beyond.
6. County inmate claims data for FY 2020-21 and FY 2021-22 is based on actual claims paid from April 2019 through March 2020. To project for FY 2020-21 and FY 2021-22, program applied a consumer price index growth to the most recent actual claims data.
7. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for county adult, compassionate release, and juvenile inmates in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)	FY 2020-21			FY 2021-22		
<b>County Adult</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Adult County - Non ACA	\$3,307	\$582	\$2,725	\$3,472	\$610	\$2,862
Adult County - ACA	\$38,919	\$1,681	\$37,238	\$40,865	\$1,765	\$39,100
Compassionate Release	\$20	\$10	\$10	\$22	\$11	\$11
Juvenile	\$260	\$67	\$193	\$273	\$71	\$202
Total Retroactive Payments	\$0	\$0	\$0	\$15,000	\$0	\$15,000
Retro ACA	\$0	\$0	\$0	\$7,102	\$0	\$7,102
Retro Non-ACA	\$0	\$0	\$0	\$7,898	\$0	\$7,898
<b>Grand Total</b>	<b>\$42,506</b>	<b>\$2,340</b>	<b>\$40,166</b>	<b>\$59,632</b>	<b>\$2,457</b>	<b>\$57,175</b>

\*Difference in totals is due to rounding.

#### Funding:

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

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

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

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDI-CAL COUNTY INMATE REIMBURSEMENT

**REGULAR POLICY CHANGE NUMBER:** 13  
**IMPLEMENTATION DATE:** 2/2018  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2029

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 from the prior estimate, for FY 2020-21, is a decrease due to actual payment data from FY 2018-19 quarter 4 and FY 2019-20 quarters 1, 2, and 3 being used to project payments. Additionally, the FY 2020-21 reimbursement is further reduced by the availability of the COVID-19 Increased FMAP which reduces the GF liability in the Medi-Cal County Inmate

## MEDI-CAL COUNTY INMATE REIMBURSEMENT

### REGULAR POLICY CHANGE NUMBER: 13

Programs. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to projected growth in the program.

#### 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, and as a result the GF impact and reimbursement per FY will not match.
3. The Department estimates payments of \$42,506,000 TF (\$40,166,000 FF) and \$59,632,000 TF (\$57,175,000 FF) will be paid in FY 2020-21 and FY 2021-22, respectively. The FY 2021-22 estimated payment amount includes retroactive federal fund payments for \$15,000,000 which do not have a GF share of medical costs, therefore the GF will not be collected from the counties for this amount.
4. The total estimated GF reimbursement in FY 2020-21 and FY 2021-22 will be:

<b>FY 2020-21</b>	<b>GF</b>	<b>Reimbursement</b>
Non ACA	\$545,000	\$520,000
ACA	\$1,681,000	\$1,680,000
Juvenile	\$67,000	\$58,000
Compassionate Release	\$10,000	\$12,000
<b>Total</b>	<b>\$2,303,000</b>	<b>\$2,270,000</b>

<b>FY 2021-22</b>	<b>GF</b>	<b>Reimbursement</b>
Non ACA	\$610,000	\$603,000
ACA	\$1,765,000	\$1,744,000
Juvenile	\$71,000	\$70,000
Compassionate Release	\$11,000	\$11,000
<b>Total</b>	<b>\$2,457,000</b>	<b>\$2,428,000</b>

\*Totals may differ due to rounding.

#### Funding:

100% GF (4260-101-0001)

Reimbursement GF (4260-610-0995)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

**NON-OTLICP CHIP**

**REGULAR POLICY CHANGE NUMBER:** 14  
**IMPLEMENTATION DATE:** 12/1998  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 13

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$99,627,380	-\$83,603,400
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$99,627,380	-\$83,603,400
<b>FEDERAL FUNDS</b>	\$99,627,380	\$83,603,400

**Purpose:**

This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

**Authority:**

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

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate. The other CHIP eligibility categories are budgeted in this policy change.

- **Resource Disregard Program:** Prior to the implementation of the Affordable Care Act (ACA), Medi-Cal had asset limitations where families that exceeded it were eligible through the CHIP Resource Disregard Program. However, the ACA requires that states raise the minimum income level to at least 133 percent of the federal poverty level (FPL) and remove the Medicaid asset test for children, effective January 1, 2014. These changes allow certain children who would not have been eligible for Medicaid under the State Plan in effect on March 31, 1997, to now be eligible for Medicaid. Until these children transition out of the associated aid codes, the Department continues to budget the adjustment in this policy change (aid codes 8N, 8P, 8R, 8T).
- **Medicaid Expansion:** This CHIP population exceeds the Medicaid FPL limit and are below the OTLICP FPL (aid codes M5, M6).

**NON-OTLICP CHIP**  
**REGULAR POLICY CHANGE NUMBER: 14**

- 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).

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a General Fund (GF) increase due to a decrease in estimated expenditures for the Resource Disregard and Medicaid Expansion populations. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a GF increase due to the reduction in the Title XXI Federal Medical Assistance Percentage (FMAP), beginning October 2020.

**Methodology:**

1. It is assumed the estimated costs of the HPE, Medicaid Expansion, and Resource Disregard aid codes will be \$557,356,000 TF in FY 2020-21 and FY 2021-22.
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. Beginning October 1, 2020, estimated costs are eligible for Title XXI 65/35 FMAP.
3. Total estimated costs for FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>
Resource Disregard	\$259	(\$46)
HPE	\$7,604	(\$1,359)
Medicaid Expansion	\$549,493	(\$98,222)
<b>Total Cost</b>	<b>\$557,356</b>	<b>(\$99,627)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>
Resource Disregard	\$259	(\$39)
HPE	\$7,604	(\$1,141)
Medicaid Expansion	\$549,493	(\$82,423)
<b>Total Cost</b>	<b>\$557,356</b>	<b>(\$83,603)</b>

**NON-OTLIP CHIP**  
**REGULAR POLICY CHANGE NUMBER: 14**

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$557,356)	(\$278,678)	(\$278,678)
76.5 % Title XXI / 23.5 % GF	4260-113-0890/0001	\$139,339	\$32,745	\$106,594
65 % Title XXI / 35 % GF	4260-113-0890/0001	\$418,017	\$146,306	\$271,711
<b>Net Impact (rounded)</b>		<b>\$0</b>	<b>(\$99,627)</b>	<b>\$99,627</b>

<b>FY 2021-22</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50 % Title XIX / 50 % GF	4260-101-0890/0001	(\$557,356)	(\$278,678)	(\$278,678)
65 % Title XXI / 35 % GF	4260-113-0890/0001	\$557,356	\$195,075	\$362,281
<b>Net Impact (rounded)</b>		<b>\$0</b>	<b>(\$83,603)</b>	<b>\$83,603</b>

\*COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

\*\*COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## NON-EMERGENCY FUNDING ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 15  
**IMPLEMENTATION DATE:** 12/1997  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 15

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$1,008,412,530	\$1,007,093,250
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$1,008,412,530	\$1,007,093,250
<b>FEDERAL FUNDS</b>	-\$1,008,412,530	-\$1,007,093,250

**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), undocumented children and adults.

**Authority:**

HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)  
 Welfare & Institutions Code 14007.5  
 SB 75 (Chapter 18, Statutes of 2015)  
 SB 104 (Chapter 67, Statutes of 2019)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 and young adults. FFP was available, regardless of immigration status, for emergency and pregnancy related services. Effective May 16, 2016, for individuals under age 19, and effective January 1, 2020, for individuals 19 through 25 years of age, who did not have satisfactory immigration status or were unable to verify satisfactory immigration status or citizenship became 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: 15

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase due to an increase in managed care expenditures. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight decrease due to changes in the FMAP for Title XXI expenditures.

#### Methodology:

1. Based on updated July 2019 through June 2020 Fee-for-Service (FFS) expenditure reports of non-emergency services provided to this population, the Department estimates non-emergency FFS costs will be \$354,552,000 TF in FY 2020-21 and FY 2021-22.
2. Based on July 2019 through June 2020 managed care reports of non-emergency services provided to this population, the Department estimates non-emergency managed care capitation costs for the Affordable Care Act (ACA) Optional Expansion population will be \$456,113,000 TF in FY 2020-21 and FY 2021-22. The repayment for this group will be 90% FFP.
3. Based on July 2019 through June 2020 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 \$707,672,000 TF in FY 2020-21 and FY 2021-22. The repayment for this group is at 50/50 FMAP, 76.5/23.5 FMAP, and 65/35 FMAP.
4. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified immigrants is included in the SCHIP Funding for the Prenatal Care policy change.
5. The estimated FFP Repayment in FY 2020-21 and FY 2021-22:

(Dollars in Thousands)

FFS and MC costs	FY 2020-21		FY 2021-22	
	TF	FF Repayment	TF	FF Repayment
All Others (50% FF / 50% GF)	\$865,302	\$432,651	\$865,302	\$432,651
All Others (65% FF / 35% GF)	\$7,269	\$4,725	\$7,269	\$4,725
All Others (Title XXI)	\$45,888	\$31,146	\$45,888	\$29,827
ACA	\$599,878	\$539,890	\$599,878	\$539,890
<b>Total</b>	<b>\$1,518,337</b>	<b>\$1,008,412</b>	<b>\$1,518,337</b>	<b>\$1,007,093</b>

#### Funding:

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

65% Title XIX FF / 35% GF (4260-101-0890/0001)

100% GF (4260-101-0001)

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## SCHIP FUNDING FOR PRENATAL CARE

**REGULAR POLICY CHANGE NUMBER:** 16  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1007

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$95,528,900	-\$71,624,150
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$95,528,900	-\$71,624,150
<b>FEDERAL FUNDS</b>	\$95,528,900	\$71,624,150

**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)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase in general fund savings due to the increased FMAP for the FFCRA. Additionally, one adjustment quarter is slipping from FY 2019-20 into FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in general fund savings due to an extra quarterly adjustment in FY 2020-21, as well as the Title XXI FMAP decreases through FY 2020-21, and due to a reduction of FY 2021-22 quarters eligible for the increased FMAP for the FFCRA.

## SCHIP FUNDING FOR PRENATAL CARE

### REGULAR POLICY CHANGE NUMBER: 16

**Methodology:**

1. 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.
2. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. The total fund cost of prenatal care for undocumented and legal immigrant women is estimated to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>\$129,198</b>
<b>FY 2021-22</b>	<b>\$110,191</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
100% State GF	4260-101-0001	(\$129,198)	(\$129,198)	\$0
Title XXI 76.5% FF / 23.5% GF	4260-113-0890/0001	\$51,680	\$12,145	\$39,535
Title XXI 65% FF / 35% GF	4260-113-0890/0001	\$77,518	\$27,131	\$50,387
FFCRA 4.34% Increased FFP	4260-113-0890/0001	\$0	(\$5,607)	\$5,607
<b>Net Impact</b>		<b>\$0</b>	<b>(\$95,529)</b>	<b>\$95,529</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
100% State GF	4260-101-0001	(\$110,191)	(\$110,191)	\$0
Title XXI 65% FF / 35% GF	4260-113-0890/0001	\$110,191	\$38,567	\$71,624
<b>Net Impact</b>		<b>\$0</b>	<b>(\$71,624)</b>	<b>\$71,624</b>

\* COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CDCR RETRO REPAYMENT

**REGULAR POLICY CHANGE NUMBER:** 17  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2109

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$410,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$410,000	\$0
<b>FEDERAL FUNDS</b>	-\$410,000	\$0

**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:**

The change from the prior estimate, for FY 2020-21, is an increase due to a shift in final payments from FY 2019-20 to FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease as all payments are expected to be completed in FY 2020-21.

**CDCR RETRO REPAYMENT**  
**REGULAR POLICY CHANGE NUMBER: 17**

**Methodology:**

1. Approximately \$410,000 will be returned to the appropriate federal fund sources below.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX ACA Recoupment	\$0	\$376,000	(\$376,000)
Title XIX Recoupment	\$0	\$34,000	(\$34,000)
<b>Total FY 2020-21</b>	<b>\$0</b>	<b>\$410,000</b>	<b>(\$410,000)</b>

**Funding:**

100% GF (4260-101-0001)

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

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

## CS3 PROXY ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 18  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2155

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$155,547,330	-\$57,816,200
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$155,547,330	-\$57,816,200
<b>FEDERAL FUNDS</b>	\$155,547,330	\$57,816,200

**Purpose:**

This policy change estimates the technical adjustment in funding for the Non-Optional Targeted Low Income Children's Program (OTLICP) population of the Children's Health Insurance Program (CHIP) as described below. Expenditures are adjusted from Title XIX 50% federal financial participation (FFP) to enhanced Title XXI FFP.

**Authority:**

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

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

Medi-Cal has multiple CHIP eligibility categories. The largest is OTLICP which is budgeted throughout the Estimate.

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. Due to the modified asset test rules, the State cannot determine which children are only eligible for Medicaid 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 for FY 2020-21, from the prior estimate, is a General Fund (GF) decrease due to a shift in some FY 2019-20 memos being processed in FY 2020-21.

The change from FY 2020-21 to FY 2021-2022, in the current estimate, is a GF increase due to the reduction in the Title XXI Federal Medical Assistance Percentage in FY 2020-21. Also, the Department will process additional claiming memos in FY 2020-21 in order to reduce the current adjustment lag.

## CS3 PROXY ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 18

**Methodology:**

1. The Department started claiming under the CS3-Proxy in March 2016 with a two-year adjustment lag. Starting in FY 2019-20, the Department began to accelerate the claiming schedule for the CS3-Proxy in order to begin claiming the adjustments within a two-quarter lag by FY 2020-21.
2. This adjustment shifts funding from Title XIX federal funds with a 50% GF match to Title XXI federal funds with a 12% GF match for claims dated before October 1, 2019. Beginning October 1, 2019, the Title XXI GF match will be 23.5%. Beginning October 1, 2020, the Title XXI GF match will be 35%.
3. Previously, the CS3 Proxy adjustments were budgeted in the Non-OTLICP CHIP policy change.
4. Total estimated costs for FY 2020-21 and FY 2021-22 are:

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX /50 % GF	4260-101-0890/0001	(\$399,600)	(\$199,800)	(\$199,800)
88% Title XXI / 12% GF	4260-113-0890/0001	\$68,333	\$8,200	\$60,133
76.5% Title XXI / 23.5% GF	4260-113-0890/0001	\$265,276	\$62,340	\$202,936
65% Title XXI / 35% GF	4260-113-0890/0001	\$65,991	\$23,097	\$42,894
Title XIX FF	4260-101-0890	(\$65,527)	\$0	(\$65,527)
Title XIX GF	4260-101-0001	\$65,527	\$65,527	\$0
Title XXI FF	4260-113-0890	\$114,911	\$0	\$114,911
Title XXI GF	4260-113-0001	(\$114,911)	(\$114,911)	\$0
<b>Net Impact (rounded)</b>		<b>\$0</b>	<b>(\$155,547)</b>	<b>\$155,547</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Fund Number</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX /50 % GF	4260-101-0890/0001	(\$263,968)	(\$131,984)	(\$131,984)
65% Title XXI / 35% GF	4260-113-0890/0001	\$263,968	\$92,388	\$171,580
Title XIX FF	4260-101-0890	(\$60,737)	\$0	(\$60,737)
Title XIX GF	4260-101-0001	\$60,737	\$60,737	\$0
Title XXI FF	4260-113-0890	\$78,958	\$0	\$78,958
Title XXI GF	4260-113-0001	(\$78,958)	(\$78,958)	\$0
<b>Net Impact (rounded)</b>		<b>\$0</b>	<b>(\$57,817)</b>	<b>\$57,817</b>

\* Totals may differ due to rounding

\*\*COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

\*\*\* COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## REFUGEE MEDICAL ASSISTANCE

**REGULAR POLICY CHANGE NUMBER:** 19  
**IMPLEMENTATION DATE:** 11/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2237

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the refugees' medical expenditures to be reimbursed by the California Department of Public Health (CDPH).

**Authority:**

Interagency Agreement (IA) 17-94042

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Full federal funding is available through the Refugee Resettlement Program (RRP) for medical services provided to refugees in Refugee Medical Assistance (aid code 02) during their first 8 months in the United States. The RRP federal grant is administered by CDPH, which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department invoices the CDPH through an IA for refugee expenditure reimbursement, which is originally paid with General Fund (GF) dollars. There is \$600,000 annual reimbursement cap under the grant for these services.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. The Department provides CDPH with the number of RMA individuals in aid code 02 and the associated medical expenditures for each Federal Fiscal Year.
2. The current claiming periods for FY 2020-21 are October 1, 2018, through June 30, 2019, for a total reimbursable amount of \$206,000, and July 1, 2019, through September 30, 2019, for a total reimbursable amount of \$170,000. The current claiming periods for FY 2021-22 are October 1, 2019, through June 30, 2020, for a total estimated reimbursable amount of \$282,000.



**REFUGEE MEDICAL ASSISTANCE**  
REGULAR POLICY CHANGE NUMBER: 19

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>GF Reimbursement</b>
<b>FY 2020-21</b>	<b>\$0</b>	<b>(\$376,000)</b>	<b>\$376,000</b>
<b>FY 2021-22</b>	<b>\$0</b>	<b>(\$282,000)</b>	<b>\$282,000</b>

**Funding:**

100% GF (4260-101-0001)

Reimbursement GF (4260-610-0995)

## CCHIP DELIVERY SYSTEM

**REGULAR POLICY CHANGE NUMBER:** 20  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2122

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$3,936,000	\$0
<b>- STATE FUNDS</b>	-\$1,264,440	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	90.81 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$361,700	\$0
<b>STATE FUNDS</b>	-\$116,200	\$0
<b>FEDERAL FUNDS</b>	-\$245,520	\$0

**Purpose:**

This policy change estimates the savings achieved resulting from integrating County Children's Health Initiative Program (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. Effective October 1, 2019, the Department integrated CCHIP beneficiaries into the Medi-Cal Managed Care delivery system. In compliance with Maintenance of Efforts requirements, the CCHIP program is provided through the three county plans: San Francisco, Santa Clara, and San Mateo.

Effective October 1, 2019, the Department transitioned all administrative functions, such as premium collection and case management, for CCHIP to MAXIMUS, the current administrator vendor for the Medi-Cal Access Program (MCAP) and the Optional Targeted Low Income Program (OTLICP). The costs for the administrative functions are budgeted in the OTLICP, MCAP, Special Populations Admin Costs policy change.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase in savings due to updated enrollment data. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in savings due to assuming this policy change will transition into the base data by FY 2021-22, which is reflected in the Children's Health Insurance Program policy change.

**Methodology:**

1. Assume the transition occurred in October 2019.
2. As a result of the transition, **\$3,936,000** in **FY 2020-21** is expected to be saved.

**CCHIP DELIVERY SYSTEM**  
**REGULAR POLICY CHANGE NUMBER: 20**

**Funding:**

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

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

## CHIP PREMIUMS

**REGULAR POLICY CHANGE NUMBER:** 21  
**IMPLEMENTATION DATE:** 7/2014  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1879

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$64,198,000	-\$64,270,000
<b>- STATE FUNDS</b>	-\$20,623,660	-\$22,494,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$64,198,000	-\$64,270,000
<b>STATE FUNDS</b>	-\$20,623,660	-\$22,494,500
<b>FEDERAL FUNDS</b>	-\$43,574,340	-\$41,775,500

**Purpose:**

This policy change estimates the premium revenue associated with the Medicaid Children's Health Insurance Program (MCHIP).

**Authority:**

AB 1494 (Chapter 28, Statutes of 2012)  
 SPA 17-043  
 SPA 17-044

**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 Optional Targeted Low Income Children's Program (OTLICP), an MCHIP program that 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 2020-21, is an increase in premium revenue due to an estimated increase in member months subject to the monthly premiums.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase in premium revenue due to an estimated increase of average monthly eligibles. The change in general fund expenditures is due to the change in the Title XXI FMAP.

**Methodology:**

- The Department estimates in FY 2020-21 there will be 906,491 average monthly OTLICP eligibles and 907,490 in FY 2021-22. Based on FY 2018-19 data, 60.02% of the OTLICP population has family incomes over 160% of the FPL.

## CHIP PREMIUMS

### REGULAR POLICY CHANGE NUMBER: 21

2. In FY 2020-21, the Department estimates there are 6,528,911 member months subject to monthly premiums and 6,536,106 in FY 2021-22.

FY 2020-21:  $906,491 \times 12 \text{ months} \times 60.02\% = \mathbf{6,528,911}$  member months

FY 2021-22:  $907,490 \times 12 \text{ months} \times 60.02\% = \mathbf{6,536,106}$  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 2020-21	FY 2021-22
Total Exempt Member Months	89,028	89,028

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 2020-21	FY 2021-22
Discount Program	848,728	849,663
Delinquent Premiums	652,868	653,587
<b>Total Loss of Premium Member Months</b>	<b>1,501,596</b>	<b>1,503,250</b>

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

Member Months	FY 2020-21	FY 2021-22
Eligible Member Months	6,528,911	6,536,106
Exempt Member Months	(89,028)	(89,028)
Loss Member Months	(1,501,596)	(1,503,250)
<b>Net Member Months</b>	<b>4,938,287</b>	<b>4,943,828</b>

6. Premium requirement for children with incomes between 160-266% FPL is \$13 per month. Premium projections include reductions from waiving premiums due to statewide disasters such as the COVID-19 PHE and California wildfire season.
7. Beginning October 1, 2019, assume estimated costs are eligible for Title XXI 76.5/23.5 FMAP. Beginning October 1, 2020, assume estimated costs are eligible for Title XXI 65/35 FMAP.

**CHIP PREMIUMS**  
**REGULAR POLICY CHANGE NUMBER: 21**

The total estimated premium revenue for OTLICP are:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$64,198</b>	<b>\$20,624</b>	<b>\$43,574</b>
<b>FY 2021-22</b>	<b>\$64,270</b>	<b>\$22,494</b>	<b>\$41,776</b>

**Funding:**

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

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

## MINIMUM WAGE INCREASE - CASELOAD SAVINGS

**REGULAR POLICY CHANGE NUMBER:** 22  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1979

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$542,006,000	-\$887,216,000
<b>- STATE FUNDS</b>	-\$113,509,000	-\$206,430,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	71.97 %	44.57 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$151,924,300	-\$491,783,800
<b>STATE FUNDS</b>	-\$31,816,570	-\$114,424,150
<b>FEDERAL FUNDS</b>	-\$120,107,710	-\$377,359,680

**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:**

COVID-19 Caseload Impact  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 (GF) 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.

## MINIMUM WAGE INCREASE - CASELOAD SAVINGS

### REGULAR POLICY CHANGE NUMBER: 22

#### Reason for Change:

The change for FY 2020-21, in the current estimate, is a decrease in GF savings due to utilizing more recent caseload data which impacts the GF and federal fund splits. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to caseload reduction and an increase in incremental savings as a result of the minimum wage increasing.

#### Methodology:

1. Minimum wage was increased to \$11.00 as of January 1, 2018, to \$12 as of January 1, 2019, and to \$13.00 as of January 1, 2020. The implementation date for the increase to \$14.00 is January 1, 2021. The implementation date for the increase to \$15.00 is January 1, 2022.
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 67,500 caseload reduction in FY 2020-21 and a 90,000 caseload reduction in FY 2021-22.
4. Assume 54% 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 18% Fee-for-Service and 82% Managed Care. Corresponding payment lags are applied accordingly to calculate the estimated savings.
6. On a cash basis, savings are estimated to be:

(Dollars in Thousands)

FISCAL YEAR	TF	GF	FF
<b>FY 2020-21</b>	<b>(\$542,006)</b>	<b>(\$113,509)</b>	<b>(\$428,497)</b>
<b>FY 2021-22</b>	<b>(\$887,216)</b>	<b>(\$206,430)</b>	<b>(\$680,786)</b>

#### Funding:

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

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

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

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## COMMUNITY FIRST CHOICE OPTION

**REGULAR POLICY CHANGE NUMBER:** 23  
**IMPLEMENTATION DATE:** 12/2012  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 1595

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$5,620,436,000	\$5,587,467,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$5,620,436,000	\$5,587,467,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$5,620,436,000	\$5,587,467,000

**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  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 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, which updated 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar

## COMMUNITY FIRST CHOICE OPTION

### REGULAR POLICY CHANGE NUMBER: 23

quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change for FY 2020-21, from the previous estimate, is an increase due to updated expenditure data provided by CDSS that includes increased FMAP for COVID-19. The change from FY 2020-21 to 2021-22, in the current estimate, is a decrease due to updated expenditure data provided by CDSS and due to the COVID-19 increased FMAP ending on June 30, 2021.

#### Methodology:

1. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced FMAP rate of 6.2%. The CFCO policy change includes 56% Federal Financial Participation.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021, in this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. The estimated costs are provided by CDSS on a cash basis. In FY 2020-21, the estimated costs are \$5,620,436,000, which includes \$568,289,000 of increased FMAP at 6.2% for COVID-19 through June 30, 2021. In FY 2021-22, the estimated costs are \$5,933,890,000, which includes \$346,432,000 of payment lags for increased FMAP at 6.2% for COVID-19.

#### Funding:

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

FFCRA 6.2% Increased FMAP (4260-101-0890)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## HEALTH INSURER FEE

**REGULAR POLICY CHANGE NUMBER:** 24  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1831

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$284,312,000	\$0
<b>- STATE FUNDS</b>	\$97,410,090	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$284,312,000	\$0
<b>STATE FUNDS</b>	\$97,410,090	\$0
<b>FEDERAL FUNDS</b>	\$186,901,910	\$0

**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), Section 9010

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Effective January 1, 2014, the ACA placed an \$8 billion fee on the health insurance industry nationwide. The fee grew to \$14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The applicable fee amount estimated for the 2020 fee year is \$15.5 billion. 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 on 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 calendar year (CY) 2017 fee year, the tax on CY 2016 (data year) revenues. This moratorium precluded collection of the HIPF as required under the ACA for this period. The moratorium eliminated the CY 2016 data year HIPF payments. Subsequently, additional federal legislation was signed on January 22, 2018, that suspended the HIPF for the CY 2019 fee year (the tax to be paid on CY 2018 data year). Recent federal legislative changes have indefinitely repealed HIPF, beginning in CY 2021 fee year (CY 2020 data year). Therefore, no provider fee payments will occur post fee year CY 2020 (data year 2019).

**Reason for Change:**

There is no change in total funds from the prior estimate for FY 2020-21. Funding levels were updated with more recent member mix data.

## HEALTH INSURER FEE

### REGULAR POLICY CHANGE NUMBER: 24

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the suspension placed on the CY 2020 revenue year/CY 2021 fee year and going forward.

#### Methodology:

1. This fee applies to Medi-Cal premiums for existing Medi-Cal beneficiaries and the ACA expansion population.
2. Payments for CY 2018 data year have been suspended due to the federal budget moratorium.
3. CY 2019 estimated payments are expected to occur in FY 2020-21.
4. Assume the following amounts:

(Dollars in Thousands)

HIPF	FY 2020-21	FY 2021-22
CY 2019 (data year) Payments	\$284,312	\$0
<b>Total</b>	<b>\$284,312</b>	<b>\$0</b>

4. The Internal Revenue Service determines the effective rate and amount of tax on each plan for each taxable year. The total tax will be assessed on the plan's net premium.

#### Funding:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX FF/ 50% GF (4260-101-0001/0890)	\$177,640	\$88,820	\$88,820
93% Title XIX ACA / 7% GF (4260-101-0890)	\$84,211	\$5,895	\$78,316
88% Title XXI FF/ 12% GF (4260-101-0001/0890)	\$22,461	\$2,695	\$19,766
<b>Total</b>	<b>\$284,312</b>	<b>\$97,410</b>	<b>\$186,902</b>

## HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 25  
**IMPLEMENTATION DATE:** 2/2016  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1967

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$22,231,000	\$14,820,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$22,231,000	\$14,820,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$22,231,000	\$14,820,000

**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 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 change from the prior estimate, for FY 2020-21, is an increase due to reducing the adjustment lag by capturing 6 quarters in the current estimate instead of 4 quarters as previously estimated. The change from FY 2020-21 to 2021-22, in the current estimate, is a decrease due to FY 2020-21 capturing 6 quarters of expenditures, while FY 2021-22 is only capturing 4 quarters of expenditures.

## HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 25

#### 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 \$3,705,000 for FY 2020-21 and FY 2021-22.
3. The Department will also claim the enhanced Title XIX ACA FMAP for beneficiaries receiving services in DPHs and estimates to pay DPHs \$22,231,000 in FY 2020-21 and \$14,820,000 in FY 2021-22. The estimated pass-through costs are included in the chart below.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>
FY 2019-20 Q1	\$3,343	\$3,343
FY 2019-20 Q2	\$4,298	\$4,298
FY 2019-20 Q3	\$3,475	\$3,475
FY 2019-20 Q4	\$3,705	\$3,705
FY 2020-21 Q1	\$3,705	\$3,705
FY 2020-21 Q2	\$3,705	\$3,705
<b>Net Impact</b>	<b>\$22,231</b>	<b>\$22,231</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
FY 2020-21 Q3	\$3,705	\$3,705
FY 2020-21 Q4	\$3,705	\$3,705
FY 2021-22 Q1	\$3,705	\$3,705
FY 2021-22 Q2	\$3,705	\$3,705
<b>Net Impact</b>	<b>\$14,820</b>	<b>\$14,820</b>

## HOSPITAL PRESUMPTIVE ELIGIBILITY DPH PAYMENTS

REGULAR POLICY CHANGE NUMBER: 25

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>
93% Title XIX ACA FF / 7% GF (4260-101-0890/0001)	\$7,641	\$7,641
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	\$14,590	\$14,590
<b>Net Impact</b>	<b>\$22,231</b>	<b>\$22,231</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
90% Title XIX ACA FF / 10% GF (4260-101-0890/0001)	\$14,820	\$14,820
<b>Net Impact</b>	<b>\$14,820</b>	<b>\$14,820</b>

**HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.**

**REGULAR POLICY CHANGE NUMBER:** 26  
**IMPLEMENTATION DATE:** 1/2014  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1821

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$44,084,820	-\$43,987,480
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$44,084,820	-\$43,987,480
<b>FEDERAL FUNDS</b>	\$44,084,820	\$43,987,480

**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 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 change in FY 2020-21, from the prior estimate, is a slight decrease due to updated expenditure data. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight decrease due to the enhanced ACA FMAP changing from 93% in 2019 to 90% in 2020 for enhanced ACA FMAP.



## HOSPITAL PRESUMPTIVE ELIGIBILITY FUNDING ADJUST.

### REGULAR POLICY CHANGE NUMBER: 26

**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 2018 Q1 through FY 2018 Q4, the estimated average quarterly adjustment for FY 2020-21 is \$25,203,000. Using claims from the four most recent quarterly adjustments, the estimated average quarterly adjustment for FY 2021-22 is \$26,010,000.
4. The Department estimates to adjust \$100,813,000 TF claims from Title XIX 50/50 FMAP to claim the enhanced Title XIX ACA FMAP in FY 2020-21 and \$104,040,000 TF in FY 2021-22. The estimated funding adjustment is included in the chart below.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% GF	(\$100,813)	(\$50,406)	(\$50,406)
94% Title XIX FF / 6% GF	\$73,566	\$4,414	\$69,152
93% Title XIX FF / 7% GF	\$27,246	\$1,907	\$25,339
<b>Net Impact</b>	<b>\$0</b>	<b>(\$44,085)</b>	<b>\$44,085</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% GF	(\$104,040)	(\$52,020)	(\$52,020)
93% Title XIX FF / 7% GF	\$79,036	\$5,533	\$73,503
90% Title XIX FF / 10% GF	\$25,005	\$2,500	\$22,504
<b>Net Impact</b>	<b>\$0</b>	<b>(\$43,987)</b>	<b>\$43,987</b>

**Funding:**

- 94% Title XIX FF/6% GF (4260-101-0890/0001)
- 93% Title XIX FF/7% GF (4260-101-0890/0001)
- 90% Title XIX FF/10% GF (4260-101-0890/0001)
- 50% Title XIX FF/50% GF (4260-101-0890/0001)

## 1% FMAP INCREASE FOR PREVENTIVE SERVICES

**REGULAR POLICY CHANGE NUMBER:** 27  
**IMPLEMENTATION DATE:** 1/2016  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1791

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$5,250,000	-\$3,568,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$5,250,000	-\$3,568,000
<b>FEDERAL FUNDS</b>	\$5,250,000	\$3,568,000

**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: 27

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is due to the following:

- For FFS, the updated savings data for FY 2019-20 to be paid in FY 2020-21 is higher compared to the previous year.
- For managed care, the increase is due to the Department claiming the full Bridge Period (July 1, 2019 – December 31, 2020) savings amount which includes six additional months of savings.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2020-21 including six more months of managed care savings than FY 2021-22.

#### Methodology:

1. The 1% FMAP savings will include the following periods of savings in FY 2020-21:
  - FFS – July 1, 2019 through June 30, 2020
  - Managed care – July 1, 2019 through December 31, 2020.
2. FY 2021-22 will include the following periods of savings:
  - FFS – July 1, 2020 through June 30, 2020
  - Managed care – January 1, 2021 through December 31, 2021.
3. Total savings for the 1% FMAP increase for preventive services are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS:			
FY 2019-20 Savings	\$0	(\$206,000)	\$206,000
Total FFS	\$0	(\$206,000)	\$206,000
Managed Care:			
FY 2019-20 Savings	\$0	(\$3,363,000)	\$3,363,000
FY 2020-21 Savings	\$0	(\$1,681,000)	\$1,681,000
Total Managed Care	\$0	(\$5,044,000)	\$5,044,000
<b>Total FY 2020-21</b>	<b>\$0</b>	<b>(\$5,250,000)</b>	<b>\$5,250,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS:			
FY 2020-21 Savings	\$0	(\$206,000)	\$206,000
Total FFS	\$0	(\$206,000)	\$206,000
Managed Care:			
FY 2020-21 Savings	\$0	(\$1,681,000)	\$1,681,000
FY 2021-22 Savings	\$0	(\$1,681,000)	\$1,681,000
Total Managed Care	\$0	(\$3,362,000)	\$3,362,000
<b>Total FY 2021-22</b>	<b>\$0</b>	<b>(\$3,568,000)</b>	<b>\$3,568,000</b>

**1% FMAP INCREASE FOR PREVENTIVE SERVICES**  
REGULAR POLICY CHANGE NUMBER: 27

**Funding:**

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

## PAYMENTS TO PRIMARY CARE PHYSICIANS

**REGULAR POLICY CHANGE NUMBER:** 28  
**IMPLEMENTATION DATE:** 11/2013  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1659

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$32,000	-\$32,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$32,000	-\$32,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$32,000	-\$32,000

**Purpose:**

This policy change estimates the recoupment of the overpayment 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 attested as one of the specified primary care specialists, regardless of whether furnished by the physician directly or under the physician's personal supervision.

## PAYMENTS TO PRIMARY CARE PHYSICIANS

### REGULAR POLICY CHANGE NUMBER: 28

The Department continues the process to recoup the overpayments paid to primary care physician providers who received payments they were not eligible for. The period for which the overpayments occurred are for the dates of service from January 1, 2013 through December 31, 2014. The Department will continue recouping by implementing withholds from providers' weekly check writes until the Accounts Receivable for the overpayment is satisfied. The recoupments are expected to continue through FY 2021-22.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is due to lower estimated recoupments based on actual recoupment data from March 2020 to August 2020.

There is no change estimated from FY 2020-21 to FY 2021-22 in the current estimate.

#### **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. A total of \$32,000 TF is estimated to be recouped in FY 2020-21 and FY 2021-22.

Recoupments	TF	FF
FY 2020-21	(\$32,000)	(\$32,000)
FY 2021-22	(\$32,000)	(\$32,000)

#### **Funding:**

100% Title XIX (4260-101-0890)

## ACA DSH REDUCTION

**REGULAR POLICY CHANGE NUMBER:** 29  
**IMPLEMENTATION DATE:** 12/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2105

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$640,068,000	-\$1,568,421,000
<b>- STATE FUNDS</b>	-\$252,927,000	-\$711,005,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$640,068,000	-\$1,568,421,000
<b>STATE FUNDS</b>	-\$252,927,000	-\$711,005,500
<b>FEDERAL FUNDS</b>	-\$387,141,000	-\$857,415,500

**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), HR 3590, Section 2551  
 HR 2 (2015)  
 HR 1892 (2018)  
 HR 4378 (2019)  
 HR 3055 (2019)  
 HR 1865 (2019)  
 HR 748 (2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

The federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The Affordable Care Act (ACA) requires the aggregate, nationwide reduction of DSH allotments in the amount of \$4 billion in Federal Fiscal Year (FFY) 2021 and \$8 billion annually through FFY 2025, for a total aggregate reduction of \$36 billion. The distribution of the aggregate reductions is determined by the Centers for Medicare & Medicaid Services (CMS).

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 postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the FFY 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020.

## **ACA DSH REDUCTION**

### **REGULAR POLICY CHANGE NUMBER: 29**

In October 2017, CMS released a simulated California DSH reduction amount of \$166 million, which represented 8.35% of the total national reduction. In October 2019, CMS released a preliminary California DSH reduction amount of \$389.5 million for FFY 2020, representing 9.74% of that year's total national reduction of \$4 billion. Although the FFY 2020 reduction was eliminated, for estimation purposes for FFY 2021 and going forward, California's percent share of the national reduction is assumed to be 9.74%.

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, with the federal share of the \$160.00 from the annual DSH allotment and the non-federal share from the General Fund. The \$160.00 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from FY 2020-21, from the prior estimate, is due to the inclusion of the FFCRA increased FMAP which increased the NDPH DSH FFP available and subsequently decreased the DPH DSH FFP available, which resulted in decreased ACA DSH reduction amounts.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to an increased ACA DSH reduction in FFY 2022.

#### **Methodology:**

1. California's DSH allotment is estimated to be \$1.308 billion for FY 2020-21 and \$1.334 billion for FY 2021-22.
2. California's reduction results in a total reduction of \$390 million FF for FY 2020-21, and \$779 million FF for FY 2021-22 for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs). The DSH allotment reduction will offset DSH payments for NDPHs, University of California (UC) DPHs in the DSH Payment policy change, and the remaining DPHs in the Global Payment Program (GPP) policy change.
3. The DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated aggregate Private DSH replacement funding. The amounts are estimated to be \$101 million FF for FY 2020-21 and \$182 million FF for FY 2021-22. The Private DSH replacement reduction will offset Private DSH replacement payments in the Private Hospital DSH Replacement policy change.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased



## ACA DSH REDUCTION

### REGULAR POLICY CHANGE NUMBER: 29

FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

5. Assume the following DSH reduction on an accrual basis:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>IGT</b>	<b>FF</b>	<b>FFCRA</b>
Private DSH Replacement	(\$181,564)	(\$80,464)	\$0	(\$89,947)	(\$11,153)
DSH NDPH	(\$14,896)	(\$6,601)	\$0	(\$7,380)	(\$915)
DSH UC	(\$83,477)	\$0	\$0	(\$74,268)	(\$9,209)
GPP	(\$546,255)	\$0	(\$248,490)	(\$264,916)	(\$32,849)
<b>Total Reduction FY 2020-21</b>	<b>(\$826,192)</b>	<b>(\$87,065)</b>	<b>(\$248,490)</b>	<b>(\$436,511)</b>	<b>(\$54,126)</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>IGT</b>	<b>FF</b>
Private DSH Replacement	(\$364,762)	(\$182,381)	\$0	(\$182,381)
DSH NDPH	(\$29,206)	(\$14,603)	\$0	(\$14,603)
DSH UC	(\$167,388)	\$0	\$0	(\$167,388)
GPP	(\$1,194,160)	\$0	(\$597,080)	(\$597,080)
<b>Total Reduction FY 2021-22</b>	<b>(\$1,755,516)</b>	<b>(\$196,984)</b>	<b>(\$597,080)</b>	<b>(\$961,452)</b>

6. For Private Hospital DSH Replacement and DSH NDPH:

- Assume 11/12 of the FY 2020-21 DSH payment reduction will occur in FY 2020-21 and 1/12 will occur in FY 2021-22.
- Assume 11/12 of the FY 2021-22 DSH payment reduction will occur in FY 2021-22 and 1/12 will occur in FY 2022-23.

7. For GPP and UC DSH:

- Assume 3/4 of the FY 2020-21 DSH payment reduction will occur in FY 2020-21 and 1/4 will occur in FY 2021-22.
- Assume 3/4 of the FY 2021-22 DSH payment reduction will occur in FY 2021-22 and 1/4 will occur in FY 2022-23.

The aggregate DSH reduction is as follows on a cash basis:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF***</b>	<b>IGT</b>	<b>FF</b>	<b>FFCRA</b>
FY 2020-21 Private DSH Replacement	(\$166,434)	(\$72,898)	\$0	(\$83,217)	(\$10,319)
FY 2020-21 DSH NDPH	(\$13,655)	(\$5,980)	\$0	(\$6,828)	(\$847)
FY 2020-21 DSH UC*	(\$62,607)	\$0	\$0	(\$55,700)	(\$6,907)
FY 2020-21 GPP**	(\$397,372)	\$0	(\$174,049)	(\$198,686)	(\$24,637)
<b>Total Reduction FY 2020-21</b>	<b>(\$640,068)</b>	<b>(\$78,878)</b>	<b>(\$174,049)</b>	<b>(\$344,431)</b>	<b>(\$42,710)</b>

**ACA DSH REDUCTION**  
REGULAR POLICY CHANGE NUMBER: 29

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF***</b>	<b>IGT</b>	<b>FF</b>
FY 2020-21 Private DSH Replacement	(\$15,130)	(\$7,565)	\$0	(\$7,565)
FY 2020-21 DSH NDPH	(\$1,241)	(\$621)	\$0	(\$621)
FY 2020-21 DSH UC*	(\$20,869)	\$0	\$0	(\$20,869)
FY 2020-21 GPP**	(\$148,882)	\$0	(\$74,441)	(\$74,441)
FY 2021-22 Private DSH Replacement	(\$334,365)	(\$167,183)	\$0	(\$167,182)
FY 2021-22 DSH NDPH	(\$26,772)	(\$13,386)	\$0	(\$13,386)
FY 2021-22 DSH UC*	(\$125,541)	\$0	\$0	(\$125,541)
FY 2021-22 GPP**	(\$895,620)	\$0	(\$447,810)	(\$447,810)
<b>Total Reduction FY 2021-22</b>	<b>(\$1,568,421)</b>	<b>(\$188,755)</b>	<b>(\$522,251)</b>	<b>(\$857,415)</b>

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

6.2% FFCRA GF (4260-101-0001)

6.2% FFCRA Increased FFP (4260-101-0890)

## BEHAVIORAL HEALTH TREATMENT

**REGULAR POLICY CHANGE NUMBER:** 30  
**IMPLEMENTATION DATE:** 10/2016  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1855

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$936,977,000	\$1,118,481,000
<b>- STATE FUNDS</b>	\$392,132,820	\$537,337,350
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$936,977,000	\$1,118,481,000
<b>STATE FUNDS</b>	\$392,132,820	\$537,337,350
<b>FEDERAL FUNDS</b>	\$544,844,180	\$581,143,650

**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), or Behavioral Intervention Services (BIS) for the same age group who do not have an ASD diagnosis.

**Authority:**

Social Security Act Section 1905(a)(13)  
 SB 870 (Chapter 40, Statutes of 2014)  
 State Plan Amendment (SPA) 14-026  
 Welfare & Institutions (W&I) Code 14132.56  
 Interagency Agreement (IA) 15-92451  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension - DHCS

**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 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: 30

The Department, in collaboration with DDS, began transitioning responsibility for BHT services starting February 1, 2016 in both Medi-Cal Fee-for-Service (FFS) and managed care. The transition was completed in September 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.

Additional RC clients, without an ASD diagnosis, have been receiving BHT Behavioral Intervention Services (BIS) through the RCs. On March 1, 2018, the Department transitioned these additional RC clients enrolled in FFS Medi-Cal to Medi-Cal coverage for BHT/BIS. The transition of Medi-Cal managed care clients began on July 1, 2018 and was completed by December 1, 2018.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to the following:

- FFS – The net decrease is due to the following:
  - A portion of FY 2018-19 claims, previously budgeted in FY 2019-20, is now expected to be paid in FY 2020-21.
  - FY 2019-20 claims previously projected to be paid in FY 2020-21 decreased due to a portion of the claims getting processed in FY 2019-20.
  - FY 2020-21 claims estimate decreased due to updated actuals and revised payment lag.
- For managed care – The decrease is due to the following:
  - The number of FY 2019-20 and FY 2020-21 supplemental capitation payments is expected to decrease due to decreases in BHT utilization.
  - Bridge Period rate for January 2021 through June 2021 decreased.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is a net increase due to the following:

- FFS - The decrease is due to more prior year payments estimated for FY 2020-21.
- Managed care – Utilization for BHT services (capitation payments) is expected to increase for FY 2020-21, along with an assumed rate increase.

#### 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. On March 1, 2018, an additional 461 RC clients enrolled in BHT/BIS transitioned from DDS.

## BEHAVIORAL HEALTH TREATMENT

### REGULAR POLICY CHANGE NUMBER: 30

4. The IA contract between the Department and DDS was executed in July 2017, with a retroactive effective date of February 1, 2016.
5. The Department amended the BHT IA contract to include BHT/BIS. The amended contract was executed on October 29, 2018 and DDS began submitting claims starting April 2019.
6. The estimate includes the rate increases to RC providers authorized by ABX2 1 (Chapter 3, Statutes of 2016), effective July 1, 2016.
7. The FFS cost reimbursement estimates were provided by DDS. The estimated annual cost on an accrual basis is \$13,806,000 TF.
8. On a cash basis, FFS reimbursements are estimated to be paid as follows:

<b>Fee-for-Service Claims</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
FY 2018-19 claims	\$13,531,000	\$916,000	\$0
FY 2019-20 claims	\$13,821,000	\$8,287,000	\$559,000
FY 2020-21 claims	\$13,806,000	\$11,505,000	\$2,301,000
FY 2021-22 claims	\$13,806,000	\$0	\$11,505,000
<b>Total</b>		<b>\$20,708,000</b>	<b>\$14,365,000</b>

#### Managed Care

9. Managed care payments began in October 2016 for BHT services based on a supplemental capitation payment methodology, retroactive to the implementation date.
10. For BHT/BIS clients, a total of 4,729 managed care beneficiaries transitioned on a phase-in basis starting July 1, 2018 through December 1, 2018.
11. Capitation rates are typically rebased annually. However, the Department has implemented a one-time 18-month rating period for the period of July 1, 2019 through December 31, 2020 (Bridge Period) to aid in future prospective rate development as federally required. Similar to the corresponding base capitation rates, the BHT supplemental rate will be developed and rebased annually on a calendar year (CY) basis thereafter.
12. Beginning January 2021, managed care rates will be updated on a calendar year basis.
13. Assume 45,502 members received 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 326,169.

$$\text{FY 2019-20: } 326,169 \times \$2,468.19 = \$805,047,000 \text{ TF}$$

14. Assume 53,914 members received BHT services in FY 2020-21; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2020-21 is 390,456.

$$\text{FY 2020-21 (Jul 20 – Dec 20): } 187,026 \times \$2,468.19 = \$461,616,000 \text{ TF}$$

## BEHAVIORAL HEALTH TREATMENT

### REGULAR POLICY CHANGE NUMBER: 30

FY 2020-21 (Jan 21 – Jul 21): 203,430 x \$2,491.18 = \$506,781,000 TF

15. Assume 62,326 members received BHT services in FY 2021-22; not all members received BHT services each month. The estimated number of supplemental capitation payments for FY 2021-22 is 456,070.

FY 2021-22 (Jul 21 – Dec 21): 219,833 x \$2,491.18 = \$547,644,000 TF

FY 2021-22 (Jan 22 – Jul 22): 236,237 x \$2,565.92 = \$606,165,000 TF

16. Due to the supplemental capitation payment methodology, assume the following payment lags:
- For FY 2019-20, assume 75% of payments was paid in the same fiscal year and the remaining 25% of payments will be paid in the following fiscal year, due to a delay in supplemental capitation payments.
  - For FY 2020-21 and FY 2021-22, assume 74% of payments will be paid in the same fiscal year and 26% of payments will be paid the following fiscal year.
17. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

(Dollars in Thousands)

Rate Year	Accrual	FY 2020-21	FY 2021-22
FY 2018-19 - FFS	\$13,531	\$916	\$0
FY 2018-19 - Managed Care	\$664,103	\$0	\$0
FY 2019-20 - FFS	\$13,821	\$8,287	\$559
FY 2019-20 - Managed Care	\$805,047	\$201,262	\$0
FY 2020-21 - FFS	\$13,806	\$11,505	\$2,301
FY 2020-21 - Managed Care	\$968,397	\$715,007	\$253,390
FY 2021-22 – FFS	\$13,806	\$0	\$11,505
FY 2021-22 - Managed Care	\$1,153,809	\$0	\$850,726
Total		\$936,977	\$1,118,481

(Dollars in Thousands)

FY 2020-21	TF	GF	FF	FFCRA
Fee-for-Service	\$20,708	\$8,666	\$10,838	\$1,204
Managed Care	\$916,269	\$383,467	\$479,516	\$53,286
<b>Total</b>	<b>\$936,977</b>	<b>\$392,133</b>	<b>\$490,354</b>	<b>\$54,490</b>

FY 2021-22	TF	GF	FF	FFCRA
Fee-for-Service	\$14,365	\$6,901	\$7,464	\$0
Managed Care	\$1,104,116	\$530,436	\$573,680	\$0
<b>Total</b>	<b>\$1,118,481</b>	<b>\$537,337</b>	<b>\$581,144</b>	<b>\$0</b>

## BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 30

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$814,652	\$407,326	\$407,326
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$30,582	\$7,187	\$23,395
65% Title XXI / 35% GF (4260-113-0001/0890)	\$91,743	\$32,110	\$59,633
FFCRA 6.2% Increased FFP (4260-101-0001/0890)	\$0	(\$50,508)	\$50,508
FFCRA 4.34% Increased FFP (4260-113-0001/0890)	\$0	(\$3,982)	\$3,982
<b>Total</b>	<b>\$936,977</b>	<b>\$392,133</b>	<b>\$544,844</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$972,460	\$486,230	\$486,230
65% Title XXI / 35% GF (4260-113-0001/0890)	\$146,021	\$51,107	\$94,914
<b>Total</b>	<b>\$1,118,481</b>	<b>\$537,337</b>	<b>\$581,144</b>

## ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

**REGULAR POLICY CHANGE NUMBER:** 31  
**IMPLEMENTATION DATE:** 5/2013  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 1476

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$568,296,000	\$445,897,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$568,296,000	\$445,897,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$568,296,000	\$445,897,000

**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  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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: 31

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to increased expenditures related to COVID-19, and a number of invoices that were anticipated to be paid in FY 2019-20 were paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, is a decrease due to FY 2021-22 anticipated decreases in COVID-related expenditures, and that FY 2020-21 invoices will not be paid in FY 2021-22.

#### Methodology:

- The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures paid through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	FFCRA
FY 2020-21	\$1,005,512	\$437,216	\$495,118	\$73,178
FY 2021-22	\$864,720	\$418,823	\$432,360	\$13,537

#### Funding:

100% Title XIX FFP (4260-101-0890)  
FFCRA 6.2% Increased FFP (4260-101-0890)

## FAMILY PACT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 32  
**IMPLEMENTATION DATE:** 1/1997  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$354,323,000	\$379,437,000
<b>- STATE FUNDS</b>	\$84,403,500	\$90,386,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$354,323,000	\$379,437,000
<b>STATE FUNDS</b>	\$84,403,500	\$90,386,000
<b>FEDERAL FUNDS</b>	\$269,919,500	\$289,051,000

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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, 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.

This policy change is inclusive of CMS approved, time-limited supplemental payments, at a rate equal to 150 percent of the current Family PACT rates, to Family PACT providers for specific family planning services. Expenditures for these services are delineated in the Proposition 56-Women's Health Supplemental Payments policy change.

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

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is decrease due to a reduction in clients utilizing the Family PACT services during the coronavirus disease 2019 national public health

## FAMILY PACT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 32

emergency and updated actual expenditure data. The change from FY 2020-21 to 2021-22, in the current estimate, is an increase due to a slight increase in projected users of Family PACT services in FY 2021-22.

#### Methodology:

1. The Department used linear regressions based upon the most recent 36 months of actual data 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 2020-21		FY 2021-22	
	TF	GF	TF	GF
Physicians	\$57,101	\$13,602	\$62,324	\$14,846
Other Medical	\$273,923	\$65,251	\$291,610	\$69,465
Co. & Comm. Outpatient	\$1,201	\$286	\$1,265	\$301
Pharmacy	\$22,098	\$5,264	\$24,238	\$5,774
<b>Total</b>	<b>\$354,323</b>	<b>\$84,404</b>	<b>\$379,437</b>	<b>\$90,386</b>

\*Totals may differ due to rounding.

#### Funding:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$11,215	\$5,608	\$5,608
100% GF (4260-101-0001)	\$49,428	\$49,428	\$0
90% Family Planning / 10% GF (4260-101-0890/0001)	\$293,680	\$29,368	\$264,312
<b>Total</b>	<b>\$354,323</b>	<b>\$84,403</b>	<b>\$269,920</b>

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0890/0001)	\$12,010	\$6,005	\$6,005
100% GF (4260-101-0001)	\$52,931	\$52,931	\$0
90% Family Planning / 10% GF (4260-101-0890/0001)	\$314,495	\$31,450	\$283,046
<b>Total</b>	<b>\$379,437</b>	<b>\$90,386</b>	<b>\$289,051</b>

\*Totals may differ due to rounding.

**FAMILY PACT PROGRAM**  
**REGULAR POLICY CHANGE NUMBER: 32**

\*\* COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

\*\*\*COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## LOCAL EDUCATION AGENCY (LEA) PROVIDERS

**REGULAR POLICY CHANGE NUMBER:** 33  
**IMPLEMENTATION DATE:** 7/2000  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 25

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$106,617,000	\$113,749,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$106,617,000	\$113,749,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$106,617,000	\$113,749,000

**Purpose:**

This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services through the LEA Medi-Cal Billing Option Program (LEA BOP).

**Authority:**

Welfare & Institutions Code 14132.06 and 14115.8  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

LEA Expansion  
COVID-19 Increased FMAP Extension – DHCS

**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 BOP. Through the program, LEAs receive federal reimbursement for certified public expenditures (CPEs) incurred while providing specific eligible health services to Medi-Cal enrolled students to the extent federal financial participation (FFP) is available. LEAs receive interim payments based on interim reimbursement rates, which are calculated using a Cost and Reimbursement Comparison Schedule (CRCS) that is submitted to the Department annually for the preceding fiscal year. Final payment reconciliations based on actual CPEs for a given year are completed when the Department has audited the LEAs' CRCS. If interim payments exceed the audited CPEs, the Department recovers and returns the excess federal match from the LEA to the federal government. If interim payments are less than the audited CPEs, the Department draws additional federal funds to reimburse the LEA.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health

## LOCAL EDUCATION AGENCY (LEA) PROVIDERS

### REGULAR POLICY CHANGE NUMBER: 33

and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a net decrease due to:

- Estimating a decrease for the FY 2020-21 interim payments as a result of the COVID-19 impact,
- Including adjustments for rate inflation, ACA newly funding, Children's Health Insurance Program (CHIP) funding, and FFCRA increased FFP, and
- Including estimates for recoupments from reconciliations due to the state.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net increase due to:

- Increased FY 2021-22 interim payments based on the average estimated expenditures from the last three fiscal years,
- Updated ACA newly and CHIP funding adjustments, and
- No FFCRA increased FFP assumed in FY 2021-22 in this policy change.

#### Methodology:

1. The estimate is based on the preceding three state fiscal years of actual paid claims data.
2. The FY 2020-21 and FY 2021-22 interim payments are adjusted based on the Implicit Price Deflator for Gross Domestic Products through an Erroneous Payment Correction (EPC).
3. Assume a 25 percent claim reduction for FY 2020-21 for averaged claims per year and rate inflation due to school closures resulting from COVID-19.
4. State Plan Amendment 13-005 authorized the Optional Targeted Low Income Children (OTLIC) population to be Medi-Cal eligible, and allowable under the LEA Program to receive Title XXI federal financial reimbursement. Based on historical paid claims data, 81% of the adjudicated LEA payments were from Title XIX Medi-Cal population, and 19% from Title XXI OTLIC population.
5. The FY 2020-21 and FY 2021-22 estimates include payment and FFP adjustments for ACA newly aid codes and CHIP aid codes allowable under the LEA Program through an EPC.
6. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**LOCAL EDUCATION AGENCY (LEA) PROVIDERS**  
REGULAR POLICY CHANGE NUMBER: 33

7. Assume adjustments for cost report reconciliations due back to the State will be received in FY 2020-21 and FY 2021-22.

<b>FY 2020-21</b>	<b>TF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>	<b>FFCRA</b>
FY 2020-21 Interim Payments	\$94,114,000	\$94,114,000	\$0	\$0
FY 2020-21 Rate Inflation	\$1,705,000	\$1,705,000	\$0	\$0
ACA Adjustment	\$12,000	\$12,000	\$0	\$0
CHIP Adjustment	\$19,095,000	\$0	\$19,095,000	\$0
COVID-19 6.2% Increase	\$2,080,000	\$0	\$0	\$2,080,000
COVID-19 4.34% Increase	\$2,452,000	\$0	\$0	\$2,452,000
FY 2020-21 Reconciliation due to State	(\$12,841,000)	(\$12,841,000)	\$0	\$0
<b>Total</b>	<b>\$106,617,000</b>	<b>\$82,990,000</b>	<b>\$19,095,000</b>	<b>\$4,532,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>	<b>FFCRA</b>
FY 2021-22 Interim Payments	\$116,364,000	\$116,364,000	\$0	\$0
FY 2021-22 Rate Inflation	\$3,250,000	\$3,250,000	\$0	\$0
ACA Adjustment	\$168,000	\$168,000	\$0	\$0
CHIP Adjustment	\$6,808,000	\$0	\$6,808,000	\$0
FY 2021-22 Reconciliation due to State	(\$12,841,000)	(\$12,841,000)	\$0	\$0
<b>Total</b>	<b>\$113,749,000</b>	<b>\$106,941,000</b>	<b>\$6,808,000</b>	<b>\$0</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)

## LEA EXPANSION

**REGULAR POLICY CHANGE NUMBER:** 34  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2136

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$64,911,000	\$60,489,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$64,911,000	\$60,489,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$64,911,000	\$60,489,000

**Purpose:**

This policy change estimates the expenditures to Local Educational Agencies (LEAs) for Medi-Cal eligible services as a result of State Plan Amendment (SPA) 15-021.

**Authority:**

Welfare & Institutions Code 14132.06 and 14115.8  
 SPA 15-021  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

SPA 15-021 will add new assessment/treatment services, new practitioner types, and lift the claiming limitation of 24 services in a 12 month period for beneficiaries without an Individualized Education Plan or Individualized Family Services Plan, effective July 1, 2015.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.



## LEA EXPANSION

### REGULAR POLICY CHANGE NUMBER: 34

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- Decreased estimate of the retroactive and ongoing impact, and
- Including adjustments for rate inflation, ACA newly funding, Children's Health Insurance Program (CHIP) funding, and FFCRA increased FFP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Updated rate inflation, ACA newly, and CHIP funding adjustments, and
- No FFCRA increased FFP assumed in FY 2021-22 in this policy change.

**Methodology:**

1. LEAs will be able to claim for expanded services authorized by SPA 15-021 retroactive to July 1, 2015.
1. Assume payments will start in January FY 2020-21 representing 50% of allowable claims and 50% for FY 2021-22.
2. Retroactive claims are assumed to be 20% of the amount claimed in FY 2015-16, FY 2016-17, FY 2017-18 and FY 2018-19. Of these claims it is assumed that 50 percent of LEA BOP participants will submit claims with an estimated retroactive impact of \$54,358,000 federal funds, of which 50% is assumed to be paid in FY 2020-21 and the remaining 50% assumed to be paid in FY 2021-22.
3. The estimated ongoing impact assumes LEA claims will increase by 20% from the total amount claimed under LEA Billing Option Program. The impact for FFY 2020-21 is \$18,823,000. The ongoing impact is estimated to be \$18,823,000 in FY 2021-22.
4. The estimate includes retroactive and ongoing payments associated with the ACA enhanced payments under Title XIX for FY 2020-21 and FY 2021-22. The FY 2020-21 and FY 2021-22 estimates include payment adjustments to ACA related aid codes allowable under the LEA Program through an Erroneous Payment Correction (EPC).
5. The FY 2020-21 and FY 2021-22 interim payments are adjusted based on the Implicit Price Deflator for Gross Domestic Products through an EPC.
6. SPA 13-005 authorized the Optional Targeted Low Income Children (OTLIC) population to be Medi-Cal eligible, and allowable under the LEA Program to receive Title XXI federal financial reimbursement. Based on historical paid claims data, 81% of the adjudicated LEA payments were from Title XIX Medi-Cal population, and 19% from Title XXI OTLIC population. The FY 2020-21 and FY 2021-22 estimates include payment adjustments to CHIP related aid codes allowable under the LEA Program through an EPC.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**LEA EXPANSION**  
REGULAR POLICY CHANGE NUMBER: 34

<b>FY 2020-21</b>	<b>TF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>	<b>FFCRA</b>
SPA 15-021 Retroactive Impact	\$27,179,000	\$27,179,000	\$0	\$0
SPA 15-021 Ongoing Impact	\$18,823,000	\$18,823,000	\$0	\$0
FY 2020-21 Rate Inflation	\$341,000	\$341,000	\$0	\$0
ACA Adjustment	\$137,000	\$137,000	\$0	\$0
CHIP Adjustment	\$17,311,000	\$0	\$17,311,000	\$0
COVID-19 6.2% Increase	\$962,000	\$0	\$0	\$962,000
COVID-19 4.34% Increase	\$158,000	\$0	\$0	\$158,000
<b>Total</b>	<b>\$64,911,000</b>	<b>\$46,480,000</b>	<b>\$17,311,000</b>	<b>\$1,120,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>	<b>FFCRA</b>
SPA 15-021 Retroactive Impact	\$27,179,000	\$27,179,000	\$0	\$0
SPA 15-021 Ongoing Impact	\$18,823,000	\$18,823,000	\$0	\$0
FY 2021-22 Rate Inflation	\$1,217,000	\$1,217,000	\$0	\$0
ACA Adjustment	\$12,197,000	\$12,197,000	\$0	\$0
CHIP Adjustment	\$1,073,000	\$0	\$1,073,000	\$0
<b>Total</b>	<b>\$60,489,000</b>	<b>\$59,416,000</b>	<b>\$1,073,000</b>	<b>\$0</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)

## RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS

**REGULAR POLICY CHANGE NUMBER:** 35  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2121

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$35,481,000	\$35,481,000
<b>- STATE FUNDS</b>	\$12,814,500	\$12,814,500
<b>PAYMENT LAG</b>	0.9850	1.0000
<b>% REFLECTED IN BASE</b>	19.78 %	19.48 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$28,035,900	\$28,569,300
<b>STATE FUNDS</b>	\$10,125,600	\$10,318,240
<b>FEDERAL FUNDS</b>	\$17,910,320	\$18,251,070

**Purpose:**

This policy change estimates the Fee-for-Service (FFS) cost of restoring optician and optical lab services for individuals age 21 and over.

**Authority:**

SB 97 (Chapter 52, Statute of 2017)  
 SB 78 (Chapter 38 Statutes of 2019)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

ABX3 5 (Chapter 20, Statutes of 2009) excluded several optional benefits, including optician and optical lab services, from coverage under the Medi-Cal program for beneficiaries 21 years of age and older, effective July 1, 2009.

SB 97 restored the provision of optician services including services provided by a fabricating optical laboratory effective January 1, 2020, contingent upon an act from the Legislature. This allowed for the provision of eyeglasses, contact lenses, low vision devices and materials to correct visual impairments for individuals over the age of 21.

SB 78 reinstated coverage for audiology, optician and optical lab, incontinence cream and washes, podiatry, and speech therapy in the Medi-Cal program, on January 1, 2020. See the Optional Benefits Restoration policy change for the audiology, incontinence creams and washes, podiatry, and speech therapy restoration costs.

While SB 78 suspends these adult optional benefits on January 1, 2022, the Department assumes the suspension for these adult optional benefits to be delayed to January 1, 2023.

**Reason for Change:**

There is no change to the total funds estimate from the prior estimate for FY 2020-21. However, the funding assumptions have been updated based on more recent data.

## RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS

### REGULAR POLICY CHANGE NUMBER: 35

There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

#### Methodology:

- Adult optician and optical lab services were restored, effective January 1, 2020.
- The estimated FFS and managed care costs for the restoration of adult optician and optical lab services on a cash basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Total</b>	<b>FFS</b>	<b>Managed Care*</b>
Total	\$68,521	\$35,481	\$33,040

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Total</b>	<b>FFS</b>	<b>Managed Care*</b>
Total	\$76,420	\$35,481	\$40,939

\*Managed care costs are budgeted in the managed care base capitation rates; display is for informational purposes only.

- FFS costs include the managed care costs for fabricating lenses which are carved-out and paid in FFS.
- This policy change budgets the restoration of adult optician and optical lab services for FFS only. The FY 2020-21 and FY 2021-22 FFS costs are estimated to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50%	\$23,166	\$11,583	11,583
90% Title XIX/ 10% GF	\$12,315	\$1,232	\$11,083
<b>Total</b>	<b>\$35,481</b>	<b>\$12,815</b>	<b>\$22,666</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50%	\$23,166	\$11,583	\$11,583
90% Title XIX/ 10% GF	\$12,315	\$1,232	\$11,083
<b>Total</b>	<b>\$35,481</b>	<b>\$12,815</b>	<b>\$22,666</b>

#### Funding:

- 50% Title XIX / 50% GF (4260-101-0001/0890)  
 90% Title XIX / 10% GF (4260-101-0001/0890)

**RESTORATION OF ADULT OPTICIAN & OPTICAL LAB SVCS**  
**REGULAR POLICY CHANGE NUMBER: 35**

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

## MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 36  
 IMPLEMENTATION DATE: 7/2019  
 ANALYST: Kalandie Coleman  
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$20,232,000	\$20,232,000
<b>- STATE FUNDS</b>	\$9,489,000	\$10,116,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$20,232,000	\$20,232,000
<b>STATE FUNDS</b>	\$9,489,000	\$10,116,000
<b>FEDERAL FUNDS</b>	\$10,743,000	\$10,116,000

### 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)  
 Families First Coronavirus Response Act (FFCRA)

### Interdependent Policy Changes:

COVID-19 Increased FMAP Extension – DHCS

### 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 waiver. Subject to approval from the Centers for Medicare and Medicaid Services, the Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit effective January 1, 2021. This proposed carve out has been delayed due to the Coronavirus disease 2019 (COVID-19) public health emergency.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

The total MSSP reimbursement (both for fee-for-service and managed care) is budgeted in this policy change. The total MSSP cost is \$39,422,000 in FY 2020-21 and FY 2021-22. The reimbursement for CCI activities are budgeted in the CCI-Administrative Costs policy change.

## MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

### REGULAR POLICY CHANGE NUMBER: 36

**Reason for Change:**

The change for FY 2020-21, from the prior estimate, is an increase in federal funds (FF) due to the availability of the FFCRA 6.2% increased FMAP through June 30, 2021.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight decrease in FFs due to the FFCRA increased FMAP ending on June 30, 2021 in this policy change.

**Methodology:**

1. Assume the total MSSP reimbursement is \$20,232,000 TF for FY 2020-21 and FY 2021-22.
2. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through June 30, 2021, in this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. The estimates below were provided by CDA on a cash basis.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>GF Reimb.</b>
MSSP in this PC	\$18,978,000	\$9,489,000	\$9,489,000	\$0
Total Reimbursement	\$1,254,000	(\$18,978,000)	\$0	\$20,232,000
FFCRA 6.2% Increase FMAP	\$0	\$0	\$1,254,000	(\$1,254,000)
<b>Total</b>	<b>\$20,232,000</b>	<b>(\$9,489,000)</b>	<b>\$10,743,000</b>	<b>\$18,978,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>GF Reimb.</b>
MSSP in this PC	\$19,605,000	\$9,802,000	\$9,803,000	\$0
Total Reimbursement	\$627,000	(\$19,605,000)	\$0	\$20,232,000
FFCRA 6.2% Increase FMAP	\$0	\$0	\$627,000	(\$627,000)
<b>Total</b>	<b>\$20,232,000</b>	<b>(\$9,803,000)</b>	<b>\$10,430,000</b>	<b>\$19,605,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

Reimbursement (4260-610-0995)

FFCRA 6.2% Increased FMAP (4260-101-0890)

FFCRA 6.2% GF (4260-101-0001)

FFCRA 6.2% Reimbursement (4260-601-0995)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CCS DEMONSTRATION PROJECT

**REGULAR POLICY CHANGE NUMBER:** 37  
**IMPLEMENTATION DATE:** 4/2013  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1775

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$11,306,000	\$6,908,000
<b>- STATE FUNDS</b>	\$5,347,420	\$3,303,850
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$11,306,000	\$6,908,000
<b>STATE FUNDS</b>	\$5,347,420	\$3,303,850
<b>FEDERAL FUNDS</b>	\$5,958,580	\$3,604,150

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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.

Rady Children's Hospital – San Diego (RCHSD) demonstration project was implemented effective July 1, 2018. RCHSD acts as an Accountable Care Organization in providing services to CCS-eligible Medi-Cal beneficiaries 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. The Department entered into a risk corridor arrangement for the first 2.5 years of the program and retains the option to extend the risk corridor arrangement if actuarially appropriate. Due to the COVID-19 impact, the Department requested an extension of the 1115 Waiver, which is set to expire on December 31, 2020. If the request for extension is approved, the RCHSD demonstration project would be extended through December 31, 2021.



## CCS DEMONSTRATION PROJECT

### REGULAR POLICY CHANGE NUMBER: 37

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase due to the program extending from its original December 31, 2020 sunset date to December 31, 2021. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the program ending effective January 1, 2022.

#### Methodology:

1. The RCHSD demonstration project implemented in July 2018 and FY 2018-19 payments began in November 2018, retroactive back to July 1, 2018.
2. Assume one month of the FY 2019-20 RCHSD rate will pay in FY 2020-21.
3. The Department implemented a onetime 18-month rating period for the period of July 1, 2019 through December 31, 2020, which is referred to as the Bridge Period.
4. Assume seven months of the Bridge Period RCHSD rate will pay in FY 2020-21.
5. Assume five months of the CY 2021 RCHSD rate will pay in FY 2020-21.
6. Assume seven months of the CY 2021 RCHSD rate will pay in FY 2021-22.
7. The final Bridge Period RCHSD rate and estimated monthly enrollment on an accrual basis are expected to be:

Fiscal Year	Average Monthly Enrollment	Capitation Rate	Average Monthly Payment	RCHSD Annual Payment
FY 2019-20	346	\$2,427.02	\$839,749	\$10,077,000
FY 2020-21 (July-Dec 2020)	380	\$2,427.02	\$922,267	\$5,534,000
FY 2020-21 (Jan-June 2021)	380	\$2,596.85	\$986,800	\$5,921,000
FY 2021-22 (July-Dec 2021)	380	\$2,596.85	\$986,800	\$5,921,000

8. Assume the June 2020 capitation payment will be deferred to July 2020.
9. Assume the final capitation payment will occur in January 2022.
10. The FY 2018-19 risk corridor data is estimated to be collected in FY 2020-21, as outlined within the RCHSD contract. Final risk corridor calculations for FY 2018-19 and any associated repayments or recoupments are expected to occur in FY 2021-22. An estimate is not available at this time.
11. Bridge Period risk corridor data is estimated to be collected on December 31, 2021, as outlined in the RCHSD contract. Bridge Period risk corridor calculations and any associated repayments or recoupments are expected to occur in FY 2022-23. An estimate is not available at this time.

**CCS DEMONSTRATION PROJECT**  
**REGULAR POLICY CHANGE NUMBER: 37**

12. Total estimated costs for FY 2020-21 and FY 2021-22 on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$9,669,000	\$4,834,000	\$4,835,000
76.5% Title XXI / 23.5% GF (4260-113-0001/0890)	\$522,000	\$123,000	\$399,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$1,115,000	\$390,000	\$725,000
<b>Total</b>	<b>\$11,306,000</b>	<b>\$5,347,000</b>	<b>\$5,959,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$5,906,000	\$2,954,000	\$2,953,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$1,002,000	\$351,000	\$651,000
<b>Total</b>	<b>\$6,908,000</b>	<b>\$3,304,000</b>	<b>\$3,604,000</b>

**Funding:**

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CALIFORNIA COMMUNITY TRANSITIONS COSTS

**REGULAR POLICY CHANGE NUMBER:** 38  
**IMPLEMENTATION DATE:** 12/2008  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1228

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$10,020,000	\$13,798,000
<b>- STATE FUNDS</b>	\$2,272,000	\$5,907,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$10,020,000	\$13,798,000
<b>STATE FUNDS</b>	\$2,272,000	\$5,907,000
<b>FEDERAL FUNDS</b>	\$7,748,000	\$7,891,000

### Purpose:

This policy change estimates the costs of providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project who will transition to the community and receive qualified home and community-based services for up to 365 days following their transition.

### Authority:

Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071  
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403  
 Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2  
 Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5  
 Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4  
 Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205  
 Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811  
 SB 214 (Chapter 300, Statutes of 2020)

### Interdependent Policy Changes:

CCT Fund Transfer to CDSS

### Background:

In January 2007, the Centers for Medicare and Medicaid Services (CMS) 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 was extended by the ACA.

On April 18, 2018, the federal Medicaid Services Investment and Accountability Act of 2019 was signed into law and appropriated additional federal funding for CMS to allocate state grantees for FY 2019-20.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new

## CALIFORNIA COMMUNITY TRANSITIONS COSTS

### REGULAR POLICY CHANGE NUMBER: 38

funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020, to May 22, 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The increased FMAP for this particular program is 3.1 percentage points. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

On March 27, 2020, H.R. 748, the CARES Act was passed. Section 3811 of the CARES Act extends the end date of the MFP grant from May 22, 2020, to November 30, 2020, and appropriates \$337,500,000 for January to October 2020. CMS has not awarded funding appropriated under the CARES Act to state grantees; however, the new appropriation ensures states will receive an award in 2021.

Beginning January 1, 2021, SB 214 creates a temporary program that revises the current requirement for individuals residing in an inpatient facility from 90 days and longer to less than 90 days. The temporary program requires the Department to end enrolling specified individuals by the end of December 31, 2022 and end providing services at the end of December 31, 2023.

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.

Currently, CCT Medi-Cal estimates are based on the average cost of services provided to the projected number of CCT enrollees and participants each fiscal year. However, the 2-year claiming period and the process to draw enhanced matching funds from CMS, which is based on the date of payment, has created an ongoing misalignment between the amounts included in the Medi-Cal estimate and actual payments every quarter. As a result, California must pay for service costs generated in previous years and draw down enhanced federal financial participation (FFP) for those costs.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the extension of the grant, which increased the number of projected transitions, the delay in payment of DDS invoices that were shifted from FY 2019-20 to FY 2020-21, and the implementation of SB 214 which increased the number of eligible participants. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to an increase in the number of eligible participants due to SB 214.

## CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 38

**Methodology:**

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be \$85,782 in FY 2020-21 and FY 2021-22. 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 \$696 per month; reimbursed at 75% MFP and 25% GF. Due to the temporary FMAP increase to MFP services, reimbursement will be at 78.1% MFP and 21.9% GF in FY 2020-21.
3. Assume the Department will pay 100% GF for pre-transition services and unsuccessful pre-transition services and 50% FF / 50% GF for post-transition services for the newly CCT population.
4. Assume the newly CCT population will begin transitioning to the CCT program on January 1, 2021.
5. Assume 172 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2020-21 and 158 in FY 2021-22 cost \$1,509 annually; reimbursed at 100% MFP.
6. Of the newly CCT population, assume 60 pre-transitions that are unsuccessful for non-DD beneficiaries in FY 2020-21 and 132 in FY 2021-22 cost \$1,509 annually; reimbursed at 100% GF.
7. Assume non-DD beneficiaries, upon transitioning into CCT, cost \$18,000 annually in FY 2020-21 and FY 2021-22; reimbursed at 75% MFP and 25% GF. Due to the temporary FMAP increase to MFP services, reimbursement will be at 78.1% MFP and 21.9% GF in FY 2020-21.
8. Due to the temporary FMAP increase to MFP services, assume the Department will be reimbursed \$57,000 TF for CCT pre- and post-transitions from January through June 2020.
9. Assume 600 individuals will transition from an inpatient facility to the CCT program in Calendar Year (CY) 2021. Of the 600 individuals, assume 300 are from the newly CCT population and 300 are from current CCT program.
10. Assume 720 individuals will transition from an inpatient facility to the CCT program in CY 2022. Of the 720 individuals, assume 420 are from the newly CCT population and 300 are from current CCT program.
11. Assume \$22,836,000 has been awarded for calendar year (CY) 2020.
12. Assume \$22,836,000 will be awarded for CY 2021, which will allow CCT transitions to continue through December 31, 2021.
13. Assume the federal government will issue a new grant award in CY 2022 at least equal to the current grant awarded, which will allow CCT transitions to continue through December 31, 2022.
14. Assume the Department will pay the DDS invoices for DD transitions, and CCT accounting memos for Demonstration services in FY 2020-21.

## CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 38

15. Below is the overall impact of the CCT Demonstration project in FY 2020-21 and FY 2021-22.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>CCT Costs (PC 38):</b>			
Non-DD GF costs and Total FFP	\$6,750,000	\$1,623,000	\$5,128,000
Newly CCT Population	\$1,483,000	\$1,089,000	\$394,000
FFCRA 3.1% Increased FFP	\$0	(\$284,000)	\$284,000
Accounting Memos and DDS Invoices	\$1,787,000	(\$155,000)	\$1,942,000
<b>Total Costs</b>	<b>\$10,020,000</b>	<b>\$2,273,000</b>	<b>\$7,748,000</b>
<b>CCT Savings:</b>			
Total Non-DD GF savings and Total FFP	(\$27,936,000)	(\$13,102,000)	(\$14,834,000)
<b>CCT Fund Transfer to CDSS (PC 44):</b>			
CCT Fund Transfer Costs	\$235,000	\$0	\$235,000
FFCRA 3.1% Increased FFP	\$32,000	\$0	\$32,000
<b>Total Costs</b>	<b>\$267,000</b>	<b>\$0</b>	<b>\$267,000</b>
CCT Outreach - Admin costs (OA 43)	\$360,000	\$0	\$360,000
<b>Total of CCT PCs including pass through</b>	<b>(\$17,289,000)</b>	<b>(\$10,829,000)</b>	<b>(\$6,459,000)</b>

\*The savings are included in the total, however, they are fully reflected in the base estimates.

**CALIFORNIA COMMUNITY TRANSITIONS COSTS**  
REGULAR POLICY CHANGE NUMBER: 38

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>CCT Costs (PC 38):</b>			
Non-DD GF costs and Total FFP	\$6,992,000	\$1,678,000	\$5,314,000
Newly CCT Population	\$6,806,000	\$4,229,000	\$2,577,000
<b>Total Cost</b>	<b>\$13,798,000</b>	<b>\$5,907,000</b>	<b>\$7,891,000</b>
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$51,362,000)	(\$25,681,000)	(\$25,681,000)
CCT Fund Transfer to CDSS (PC 44)	\$196,000	\$0	\$196,000
CCT Outreach - Admin costs (OA 43)	\$360,000	\$0	\$360,000
Total of CCT PCs including pass through	(\$37,008,000)	(\$19,774,000)	(\$17,234,000)

\*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)

FFCRA 3.1% GF (4260-101-0001)

FFCRA 3.1% Increased FFP (4260-106-0890)

## MSSP SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 39  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2142

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$4,933,000	\$4,933,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$4,933,000	\$4,933,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$4,933,000	\$4,933,000

**Purpose:**

This policy change estimates the cost of a one-time-only supplemental funding to the Multipurpose Senior Services Program (MSSP).

**Authority:**

Budget Act of 2019 (AB 74)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 waiver for up to 11,370 participants in 9,283 participant slots in FY 2019-20 and FY 2020-21. The Coordinated Care Initiative (CCI) was previously scheduled to transition MSSP to a managed care benefit, effective January 1, 2021. The proposed carve out has been delayed due to the Coronavirus disease 2019 (COVID-19) public health emergency.

The Legislature approved a one-time appropriation, spread over a three-year period, to allow for a rate increase for MSSP Care Management and Care Management Support services, effective July 1, 2019.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.



## MSSP SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 39

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease in general funds due to the temporary increase in federal funding from the national public health emergency. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in general funds due to the temporary increase in federal funding ending June 30, 2021.

**Methodology:**

1. Assume the supplemental funding will be available over a three-year period.
2. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS.
3. On a cash basis, the estimated expenditures for FY 2020-21 and FY 2021-22 are:

Fiscal Year	TF	Title XIX FF	FFCRA	GF	GF Reimbursement
FY 2020-21	\$4,933,000	\$4,627,000	\$306,000	(\$4,627,000)	\$4,627,000
FY 2021-22	\$4,933,000	\$4,933,000	\$0	(\$4,933,000)	\$4,933,000

**Funding:**

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

Reimbursement (4260-601-0995)

FFCRA 6.2% Increased FMAP (4260-101-0890)

FFCRA 6.2% GF (4260-101-0001)

FFCRA 6.2% Reimbursement (4260-601-0995)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## OPTIONAL BENEFITS RESTORATION

**REGULAR POLICY CHANGE NUMBER:** 40  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2150

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$17,519,000	\$17,519,000
<b>- STATE FUNDS</b>	\$6,327,100	\$6,327,100
<b>PAYMENT LAG</b>	0.9958	1.0000
<b>% REFLECTED IN BASE</b>	69.10 %	91.19 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$5,390,600	\$1,543,400
<b>STATE FUNDS</b>	\$1,946,860	\$557,420
<b>FEDERAL FUNDS</b>	\$3,443,770	\$986,010

**Purpose:**

This policy change estimates the Fee-for-Service (FFS) costs for the optional benefits restoration for audiology, incontinence creams and washes, podiatry and speech therapy.

**Authority:**

State Plan Amendment (SPA) 19-0046  
SB 78 (Chapter 38 Statutes of 2019)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

ABX3 5 (Chapter 20, Statutes of 2009), excluded specified optional benefits from coverage under the Medi-Cal program, effective July 1, 2009.

SB 78 reinstated coverage for audiology, optician and optical lab, incontinence creams and washes, podiatry, and speech therapy in the Medi-Cal program, no sooner than January 1, 2020. The optional benefits restoration for optician and optical lab is budgeted in the Restoration of Adult Optician and Optical Lab Svcs policy change. Managed care costs are budgeted in the managed care base capitation rates.

While SB 78 suspends these adult optional benefits on January 1, 2022, the Department assumes the suspension for these adult optional benefits to be delayed to January 1, 2023.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is due to an increase in the estimated Fee-for-Service (FFS) caseload projection.

There is no change in the current estimate from FY 2020-21 to FY 2021-22 for FFS.

**Methodology:**

1. The specified optional benefits were reinstated effective January 1, 2020.

## OPTIONAL BENEFITS RESTORATION

### REGULAR POLICY CHANGE NUMBER: 40

2. The estimated FFS and managed care costs for the audiology, incontinence creams and washes, podiatry, and speech therapy restoration, on cash basis, are:

<b>FY 2020-21 – Cash Basis</b>	<b>Total: FFS + Managed Care</b>	<b>FFS</b>	<b>Managed Care*</b>
Audiology	\$10,001,000	\$5,068,000	\$4,933,000
Incontinence Cream and Washes	\$12,503,000	\$9,330,000	\$3,173,000
Podiatry	\$10,521,000	\$2,799,000	\$7,722,000
Speech Therapy	\$1,461,000	\$322,000	\$1,139,000
<b>Total</b>	<b>\$34,486,000</b>	<b>\$17,519,000</b>	<b>\$16,967,000</b>

<b>FY 2021-22 – Cash Basis</b>	<b>Total: FFS + Managed Care</b>	<b>FFS</b>	<b>Managed Care*</b>
Audiology	\$10,428,000	\$5,068,000	\$5,360,000
Incontinence Cream and Washes	\$12,370,000	\$9,330,000	\$3,040,000
Podiatry	\$12,433,000	\$2,799,000	\$9,634,000
Speech Therapy	\$1,445,000	\$322,000	\$1,123,000
<b>Total</b>	<b>\$36,676,000</b>	<b>\$17,519,000</b>	<b>\$19,157,000</b>

\*Managed care costs are budgeted in the managed care base capitation rates; display is for informational purposes only.

3. This policy change budgets optional benefits restoration only for FFS.

<b>FY 2020-21 – FFS</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Audiology	\$5,068,000	\$1,830,000	\$3,238,000
Incontinence Cream and Washes	\$9,330,000	\$3,370,000	\$5,960,000
Podiatry	\$2,799,000	\$1,011,000	\$1,788,000
Speech Therapy	\$322,000	\$116,000	\$206,000
<b>Total</b>	<b>\$17,519,000</b>	<b>\$6,327,000</b>	<b>\$11,192,000</b>

<b>FY 2021-22 – FFS</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Audiology	\$5,068,000	\$1,830,000	\$3,238,000
Incontinence Cream and Washes	\$9,330,000	\$3,370,000	\$5,960,000
Podiatry	\$2,799,000	\$1,011,000	\$1,788,000
Speech Therapy	\$322,000	\$116,000	\$206,000
<b>Total</b>	<b>\$17,519,000</b>	<b>\$6,327,000</b>	<b>\$11,192,000</b>

**OPTIONAL BENEFITS RESTORATION**  
REGULAR POLICY CHANGE NUMBER: 40

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$11,438,000	\$5,719,000	\$5,719,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$6,081,000	\$608,000	\$5,473,000
<b>Total</b>	<b>\$17,519,000</b>	<b>\$6,327,000</b>	<b>\$11,192,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$11,438,000	\$5,719,000	\$5,719,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$6,081,000	\$608,000	\$5,473,000
<b>Total</b>	<b>\$17,519,000</b>	<b>\$6,327,000</b>	<b>\$11,192,000</b>

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change  
 COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDICALLY TAILORED MEALS PILOT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 41  
**IMPLEMENTATION DATE:** 4/2018  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2046

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,600,000	\$1,300,000
<b>- STATE FUNDS</b>	\$1,600,000	\$1,300,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,600,000	\$1,300,000
<b>STATE FUNDS</b>	\$1,600,000	\$1,300,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the contract cost to provide the Medically Tailored Meals Pilot Program (Pilot) and its evaluation.

**Authority:**

Welfare & Institutions Code 14042.1  
 AB 80 (Chapter 12, Statutes of 2020)

**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 congestive heart failure. 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. In February 2020, the Department executed a contract to evaluate the Pilot's impact on hospital readmissions, decreased admissions to long-term care facilities, and emergency room utilization. The Department will submit the evaluation report to the Legislature by December 2023.

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

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to increased participants and the extension of the Pilot. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to remaining program funds being utilized through June 2023.

**Methodology:**

1. The Pilot began in April 2018.

**MEDICALLY TAILORED MEALS PILOT PROGRAM**  
**REGULAR POLICY CHANGE NUMBER: 41**

2. Assume the cost for **FY 2020-21** is **\$1,600,000 TF** and **\$1,300,000 TF** for **FY 2021-22**.

**Funding:**

100% GF (4260-101-0001)

## EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

**REGULAR POLICY CHANGE NUMBER:** 42  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2158

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,874,000	\$1,729,000
<b>- STATE FUNDS</b>	\$673,800	\$621,700
<b>PAYMENT LAG</b>	0.8358	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,566,300	\$1,729,000
<b>STATE FUNDS</b>	\$563,160	\$621,700
<b>FEDERAL FUNDS</b>	\$1,003,130	\$1,107,300

**Purpose:**

This policy change estimates the cost to provide screenings for additional substances in primary care settings to beneficiaries over 21 years of age.

**Authority:**

Affordable Care Act (ACA), Section 4106

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

The Department currently screens Medi-Cal beneficiaries for alcohol misuse per the United States Preventive Services Task Force (USPSTF) recommendation. The Department is adding screening for additional substances (i.e., drug use and abuse) as a Medi-Cal benefit for beneficiaries over age 21. Medi-Cal children, ages 0-21 years old, are screened for alcohol and drug use under the American Academy of Pediatrics (AAP) Bright Futures Health tobacco, alcohol, and drug use assessments.

Effective June 9, 2020, the USPSTF assigned a “B” rating to “Unhealthy Drug Use Screening” for adults ages 18 and older, making it a mandatory benefit under the Preventive Services component (Item 13(c)) of the Department’s approved Medicaid State Plan. Adding this benefit will identify, reduce, and prevent problematic use, abuse, and dependence on drugs.

Managed care costs for the screenings 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.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the following:

- Fee-for-Service (FFS) caseload projection increased from the prior estimate.
- Estimated retroactive claims for FY 2019-20 will be paid in FY 2020-21.

## EXPANSION TO SCREENING FOR ADDITIONAL SUBSTANCES

### REGULAR POLICY CHANGE NUMBER: 42

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2020-21 including retroactive payments for dates of service between June 9, 2020 and June 30, 2020.

#### Methodology:

1. Assume expansion to screening for additional substances effective June 9, 2020, will be implemented January 1, 2021.
2. The Erroneous Payment Correction for the period from June 9, 2020 to December 31, 2020 is estimated to occur in May 2021. The EPC costs are included in the FY 2020-21 totals.
3. Total estimated payments for the screenings are:

<b>Additional Substances Screening</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$1,874,000</b>	<b>\$674,000</b>	<b>\$1,200,000</b>
<b>FY 2021-22</b>	<b>\$1,729,000</b>	<b>\$622,000</b>	<b>\$1,107,000</b>

#### Funding:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$1,216,000	\$608,000	\$608,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$658,000	\$66,000	\$592,000
<b>Total</b>	<b>\$1,874,000</b>	<b>\$674,000</b>	<b>\$1,200,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$1,122,000	\$561,000	\$561,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$607,000	\$61,000	\$546,000
<b>Total</b>	<b>\$1,729,000</b>	<b>\$622,000</b>	<b>\$1,107,000</b>

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.



## MEDICAL INTERPRETERS PILOT PROJECT

**REGULAR POLICY CHANGE NUMBER:** 43  
**IMPLEMENTATION DATE:** 4/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1989

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,000,000	\$2,000,000
<b>- STATE FUNDS</b>	\$1,000,000	\$2,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,000,000	\$2,000,000
<b>STATE FUNDS</b>	\$1,000,000	\$2,000,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the costs for establishing a medical interpreters pilot project.

**Authority:**

SB 165 (Chapter 365, Statutes of 2019)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

SB 165 appropriated \$5 million General Fund (GF) for the support of medical interpreters pilot projects through June 30, 2024. Funding will be awarded for pilot projects in up to four pilot sites to deliver language assistance services to patients/clients who are unserved or underserved because they are limited English proficient (LEP).

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the following:

- Shift in payments from FY 2019-20 to FY 2020-21, due to implementation delays.
- The prior estimate assumed a one-time lump-sum payment for the pilot project. This estimate assumes that quarterly payments will be made on a reimbursement basis.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to a full year of estimated costs included in FY 2021-22.

**Methodology:**

1. Assume the Medical Interpreters Pilot Project will be effective January 1, 2021.
2. On an accrual basis, assume \$2,000,000 GF annually will be reimbursements to contractors for the pilot project. An estimated \$500,000 quarterly reimbursement is expected to begin in April 2021.

**MEDICAL INTERPRETERS PILOT PROJECT**  
**REGULAR POLICY CHANGE NUMBER: 43**

3. Total estimated reimbursement for FY 2020-21 and FY 2021-22, on a cash basis, are:

(Dollars in Thousands)

<b>Medical Interpreters Pilot Project</b>	<b>TF</b>	<b>GF</b>
<b>FY 2020-21</b>	<b>\$1,000</b>	<b>\$1,000</b>
<b>FY 2021-22</b>	<b>\$2,000</b>	<b>\$2,000</b>

**Funding:**

100% General Fund (4260-101-0001)

## CCT FUND TRANSFER TO CDSS

**REGULAR POLICY CHANGE NUMBER:** 44  
**IMPLEMENTATION DATE:** 10/2011  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1562

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$267,000	\$196,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$267,000	\$196,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$267,000	\$196,000

**Purpose:**

This policy change estimates the enhanced federal funding associated with providing the 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 (P.L. 109-171), Section 6071  
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403)  
 Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2  
 Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5  
 Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4  
 Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205  
 IA 10-87274 (CDSS)  
 Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811

**Interdependent Policy Changes:**

Not Applicable

**Background:**

In January 2007, the Centers for Medicare and Medicaid Services (CMS) awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. The CCT demonstration is authorized under Section 6071 of the Federal DRA of 2005 and was extended by the ACA.

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

## **CCT FUND TRANSFER TO CDSS**

### **REGULAR POLICY CHANGE NUMBER: 44**

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020, to May 22, 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 Home and Community-Based Services (HCBS).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The increased FMAP for this particular program is 3.1 percentage points. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

On March 27, 2020, H.R. 748, the CARES Act was passed. Section 3811 of the CARES Act extends the end date of the MFP grant from May 22, 2020, to November 30, 2020, and appropriates \$337,500,000 for January to October 2020. CMS has not awarded funding appropriated under the CARES Act to state grantees; however, the new appropriation ensures states will receive an award in 2021.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to increased FMAP due to the FFCRA and a grant extension, which increased the number of projected transitions and the transfer amount to CDSS. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the increased FMAP funding ending in FY 2020-21.

#### **Methodology:**

1. The Department provides HCBS to CCT participants who are receiving IHSS. The Department provides federal funding to CDSS as the base federal match through HCBS policy changes.
2. CCT services are reimbursed at 75% FFP and 25% GF. 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 10-87274 with CDSS. The IA transfers the additional 25% FFP for HCBS provided to CCT participants who are receiving IHSS services during their 365 days of participation in the CCT demonstration.
4. It is assumed that 24% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs \$10,877 in FY 2020-21 and FY 2021-22. The Department will provide 25% of these costs to CDSS. Due to the temporary FMAP increase to MFP services, the Department will reimburse CDSS an additional 3.1% of costs in FY 2020-21.
5. Assume the Department will reimburse an additional \$3,000 TF for services provided by CDSS from January through June 2020.
6. Assume 360 non-DD beneficiaries will transition in FY 2020-21 and 300 in FY 2021-22.

## CCT FUND TRANSFER TO CDSS

### REGULAR POLICY CHANGE NUMBER: 44

7. Assume the federal government will issue a new grant award for \$22,836,000 TF in CY 2020, based on federal projections, which will allow CCT transitions to continue through December 31, 2021.
8. Assume the federal government will issue a new grant award for \$22,836,000 TF in CY 2021, based on federal projections, which will allow CCT transitions to continue through December 31, 2022.
9. Below is the overall impact of the CCT Demonstration project in FY 2020-21 and FY 2021-22.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>CCT Costs (PC 38):</b>			
Non-DD GF costs and Total FFP	\$6,750,000	\$1,623,000	\$5,128,000
Newly CCT Population	\$1,483,000	\$1,089,000	\$394,000
FFCRA 3.1% Increased FFP	\$0	(\$284,000)	\$284,000
Accounting Memos and DDS Invoices	\$1,787,000	(\$155,000)	\$1,942,000
<b>Total Costs</b>	<b>\$10,020,000</b>	<b>\$2,273,000</b>	<b>\$7,748,000</b>
<b>CCT Savings:</b>			
Total Non-DD GF savings and Total FFP	(\$27,936,000)	(\$13,102,000)	(\$14,834,000)
<b>CCT Fund Transfer to CDSS (PC 44):</b>			
CCT Fund Transfer Costs	\$235,000	\$0	\$235,000
FFCRA 3.1% Increased FFP	\$32,000	\$0	\$32,000
<b>Total Costs</b>	<b>\$267,000</b>	<b>\$0</b>	<b>\$267,000</b>
CCT Outreach - Admin costs (OA 43)	\$360,000	\$0	\$360,000
<b>Total of CCT PCs including pass through</b>	<b>(\$17,289,000)</b>	<b>(\$10,829,000)</b>	<b>(\$6,459,000)</b>

\*The savings are included in the total, however, they are fully reflected in the base estimates.

**CCT FUND TRANSFER TO CDSS**  
REGULAR POLICY CHANGE NUMBER: 44

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCT Costs (PC 38):			
Non-DD GF costs and Total FFP	\$6,992,000	\$1,678,000	\$5,314,000
Newly CCT Population	\$6,806,000	\$4,229,000	\$2,577,000
Total Cost	\$13,798,000	\$5,907,000	\$7,891,000
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$51,362,000)	(\$25,681,000)	(\$25,681,000)
<b>CCT Fund Transfer to CDSS (PC 44)</b>	<b>\$196,000</b>	<b>\$0</b>	<b>\$196,000</b>
CCT Outreach - Admin costs (OA 43)	\$360,000	\$0	\$360,000
Total of CCT PCs including pass through	(\$37,008,000)	(\$19,774,000)	(\$17,234,000)

\*The savings are included in the total, however, they are fully reflected in the base estimates.

**Funding:**

MFP Federal Grant (4260-106-0890)

FFCRA 3.1% Increased FFP (4260-106-0890)

## DIABETES PREVENTION PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 45  
**IMPLEMENTATION DATE:** 12/2020  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2056

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$276,000	\$1,358,000
<b>- STATE FUNDS</b>	\$98,000	\$480,850
<b>PAYMENT LAG</b>	0.7349	0.9401
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$202,800	\$1,276,700
<b>STATE FUNDS</b>	\$72,020	\$452,050
<b>FEDERAL FUNDS</b>	\$130,810	\$824,610

**Purpose:**

This policy change estimates the Fee-for-Service (FFS) costs 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 & Institutions Code, Section 14149.9

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

AB 1810 required the Department to establish the DPP as a Medi-Cal covered benefit in FFS and managed care. The new DPP benefit was established on January 1, 2019 consistent with the Centers for Disease Control and Prevention's (CDC) guidelines. The program incorporated many components of the Centers for Medicare and Medicaid Services' (CMS) DPP in Medicare. The DPP is an evidence-based, lifestyle change program designed to prevent or delay Type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes.

Medi-Cal providers choosing to offer DPP services must comply with CDC guidance and obtain CDC recognition in connection with the National Diabetes Prevention Recognition Program (DPRP). DPP services will be provided through trained peer coaches who use a CDC-approved curriculum. The CDC's DPP curriculum promotes realistic lifestyle changes, emphasizing weight loss through exercise, healthy eating and behavior modification.

Medi-Cal's DPP benefit consists of the following:

- Core Sessions (Months 1-6) – The Core Sessions consist of at least 16 sessions over the first six months. Payments for the core sessions are attendance and performance based.

## DIABETES PREVENTION PROGRAM

### REGULAR POLICY CHANGE NUMBER: 45

- 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.
- 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.

Managed care costs for DPP 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.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to no expected payments until December 2020 due to provider enrollment delays.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to no Ongoing Maintenance costs incurring in FY 2020-21. Costs for Core Sessions and Core Maintenance Sessions will increase in FY 2021-22 due to phased-in beneficiary participation.

#### **Methodology:**

1. Assume DPP payments will start December 1, 2020.
2. Total annual cost for the Core Sessions is estimated to be \$1,017,000 TF.
 

Core Sessions – Attendance:	\$711,000 TF
Core Sessions – Performance:	\$306,000 TF
3. Assume a six-month phase-in for beneficiary participation in the Core Sessions beginning December 1, 2020. Assume Performance payments will be phased-in over a six-month period and will be paid at the end of Core Sessions, beginning June 1, 2021, on a six-month phase in basis.
4. Total annual cost for the Core Maintenance Sessions is estimated to be \$362,000 TF.
5. Assume Core Maintenance Sessions will start June 1, 2021, and will be phased-in over a six-month period.
6. Total annual cost for the Ongoing Maintenance Sessions is estimated to be \$190,000 TF.
7. Assume Ongoing Maintenance Sessions will start December 1, 2021, and will be phased-in over a six-month period.



**DIABETES PREVENTION PROGRAM**  
REGULAR POLICY CHANGE NUMBER: 45

8. Total estimated payments are:

<b>DPP</b>	<b>Annual Cost</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
Core Sessions - Attendance	\$711,000	\$267,000	\$711,000
Core Sessions - Performance	\$306,000	\$4,000	\$264,000
Core Maintenance	\$362,000	\$5,000	\$312,000
Ongoing Maintenance	\$190,000	\$0	\$71,000
<b>Total</b>	<b>\$1,569,000</b>	<b>\$276,000</b>	<b>\$1,358,000</b>

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$176,000	\$88,000	\$88,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$100,000	\$10,000	\$90,000
<b>Total</b>	<b>\$276,000</b>	<b>\$98,000</b>	<b>\$178,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$862,000	\$431,000	\$431,000
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$1,000	\$0	\$1,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$495,000	\$50,000	\$445,000
<b>Total</b>	<b>\$1,358,000</b>	<b>\$481,000</b>	<b>\$877,000</b>

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## HEARING AID COVERAGE

**REGULAR POLICY CHANGE NUMBER:** 46  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2189

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$10,000,000
<b>- STATE FUNDS</b>	\$0	\$10,000,000
<b>PAYMENT LAG</b>	1.0000	0.8830
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$8,830,000
<b>STATE FUNDS</b>	\$0	\$8,830,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the cost of providing hearing aids and associated services to non-Medi-Cal children who otherwise do not have health insurance coverage for these services and are at or below 600% Federal Poverty Level (FPL).

**Authority:**

FY 2020-21 Budget Bill

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Some children with private health insurance do not have coverage or cannot afford hearing aids and hearing aid supplies. Without this benefit, children are at high risk for developmental and educational delays. It is especially important to make this benefit available, given the current pandemic that has resulted in school closures and distance learning. Children who are deaf and hard of hearing must be able to utilize every medical assistance/device available to ensure continued learning.

Coverage for hearing aids and associated services is proposed to be offered to non-Medi-Cal children, who otherwise do not have health insurance coverage for these services and are at or below 600% FPL, beginning July 1, 2021. Funding for this program will be provided with 100% General Fund (GF).

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume the effective date is July 1, 2021.
2. Annual costs are estimated to be \$10,000,000 TF/GF.

**HEARING AID COVERAGE**  
**REGULAR POLICY CHANGE NUMBER: 46**

3. FY 2021-22 payments for hearing aids to these non-Medi-Cal children are estimated to be:

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Hearing Aid	\$10,000,000	\$10,000,000	\$0
<b>Total</b>	<b>\$10,000,000</b>	<b>\$10,000,000</b>	<b>\$0</b>

**Funding:**

100% GF (4260-101-0001)

## MEDI-CAL DRUG REBATE FUND

**REGULAR POLICY CHANGE NUMBER:** 48  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2124

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the transfer of drug rebate collections from the Medi-Cal Drug Rebate Fund to the General Fund (GF).

**Authority:**

SB 78 (Chapter 38, Statutes of 2019)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

SB 78 established the Medi-Cal Drug Rebate 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 Rebate Fund to offset the GF.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

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.

## **MEDI-CAL DRUG REBATE FUND**

### **REGULAR POLICY CHANGE NUMBER: 48**

**Reason for Change:**

The change for FY 2020-21, from the prior estimate, is a decrease in the GF transfer due to:

- Updated rebate collection projections based on actual rebate collections through June 2020, and
- Including FFCRA increased FMAP, shifting rebate savings from the state to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in the GF transfer due to:

- An increase in the estimated rebate collections expected in FY 2021-22, and
- No FFCRA increased FMAP is estimated in FY 2021-22.

**Methodology:**

1. In FY 2020-21, it is estimated that \$1.49 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF and \$1.54 billion will be transferred from the Medi-Cal Drug Rebate Fund to the GF in FY 2021-22.
2. An estimated balance of \$175.36 million was in the Medi-Cal Drug Rebate Fund as of July 2020. In FY 2020-21 and FY 2021-22, due to the severe State budget shortfall related to the COVID-19 pandemic, all rebate collections will be transferred to the GF leaving no reserve in the Medi-Cal Drug Rebate Fund.
3. FY 2020-21 includes an additional \$6.2 million in the Medi-Cal Drug Rebate Fund to repay manufacturers for the California Children's Services (CCS) Healthy Families blood factor rebates. The CCS Healthy Families program was authorized under the CHIP State Plan and was not eligible for Medicaid rebates. The Department plans to provide reimbursement to the manufacturers.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**MEDI-CAL DRUG REBATE FUND**  
REGULAR POLICY CHANGE NUMBER: 48

5. The summary of the non-federal share and federal share of the estimated FY 2020-21 and FY 2021-22 rebates and the estimated reserve for each respective fiscal year are:

(Dollars in Thousands)

<b>Summary of Drug Rebates</b>	<b>TF</b>	<b>Fund 3331</b>	<b>FF</b>
Federal Drug Rebates	(\$2,246,609)	(\$676,463)	(\$1,570,146)
State Supplemental Drug Rebates	(\$158,307)	(\$38,736)	(\$119,571)
Managed Care Drug Rebates	(\$2,108,472)	(\$603,557)	(\$1,504,915)
Family PACT Drug Rebates	(\$11,692)	(\$1,195)	(\$10,497)
BCCTP Drug Rebates	(\$6,465)	(\$1,783)	(\$4,682)
Subtotal Rebates	(\$4,531,545)	(\$1,321,734)	(\$3,209,811)
Estimated FY 2019-20 Balance		(\$175,365)	
CCS HF Blood Factor GF Adjustments		\$6,200	
<b>Medi-Cal Drug Rebate Fund Transfer</b>		<b>(\$1,490,899)</b>	

(Dollars in Thousands)

<b>Summary of Drug Rebates</b>	<b>TF</b>	<b>Fund 3331</b>	<b>FF</b>
Federal Drug Rebates	(\$2,395,828)	(\$818,487)	(\$1,577,341)
State Supplemental Drug Rebates	(\$160,265)	(\$42,023)	(\$118,242)
Managed Care Drug Rebates	(\$2,094,173)	(\$678,271)	(\$1,415,902)
Family PACT Drug Rebates	(\$12,747)	(\$1,315)	(\$11,432)
BCCTP Drug Rebates	(\$6,680)	(\$2,102)	(\$4,578)
Subtotal Rebates	(\$4,669,693)	(\$1,542,198)	(\$3,127,495)
Estimated FY 2020-21 Reserve to transfer		\$0	
Estimated FY 2021-22 Reserve		\$0	
<b>Medi-Cal Drug Rebate Fund Transfer</b>		<b>(\$1,542,198)</b>	

**MEDI-CAL DRUG REBATE FUND**  
REGULAR POLICY CHANGE NUMBER: 48

4. The estimated transfers from the Medi-Cal Drug Rebate Fund to GF are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>
<b>Drug Rebates Transfer</b>	<b>\$0</b>	<b>(\$1,490,899)</b>	<b>\$1,490,899</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>
<b>Drug Rebates Transfer</b>	<b>\$0</b>	<b>(\$1,542,198)</b>	<b>\$1,542,198</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,490,899	\$0	\$1,490,899
100% GF (4260-101-0001)	(\$1,656,345)	(\$1,656,545)	\$0
FFCRA 6.2% GF (4260-101-0001)	\$154,676	\$154,676	\$0
FFCRA 4.34% GF (4260-113-0001)	\$10,770	\$10,770	\$0
<b>Total</b>	<b>\$0</b>	<b>(\$1,490,899)</b>	<b>\$1,490,899</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>
Medi-Cal Drug Rebate Fund (4260-601-3331)	\$1,542,198	\$0	\$1,542,198
100% GF (4260-101-0001)	(\$1,542,198)	(\$1,542,198)	\$0
<b>Total</b>	<b>\$0</b>	<b>(\$1,542,198)</b>	<b>\$1,542,198</b>

**BCCTP DRUG REBATES**

**REGULAR POLICY CHANGE NUMBER:** 49  
**IMPLEMENTATION DATE:** 1/2010  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 1433

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$4,682,000	-\$4,578,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$4,682,000	-\$4,578,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$4,682,000	-\$4,578,000

**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  
 SB 78 (Chapter 38, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Medi-Cal Drug Rebate Fund  
 COVID-19 Increased FMAP Extension – DHCS

**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.

SB 78 established 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 Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health



## BCCTP DRUG REBATES

### REGULAR POLICY CHANGE NUMBER: 49

and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2020,
- A decrease in estimated BCCTP pharmacy expenditures for the applicable expenditure period, and
- Including FFCRA increased FFP in FY 2020-21, resulting in rebate savings shifting from the GF to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in rebate savings due to the assumption that FFCRA increased FFP is not included for FY 2021-22 in this policy change, although there is a TF increase for BCCTP drug rebates for FY 2021-22.

#### Methodology:

1. Payments began in January 2010.
2. Rebates are invoiced quarterly.
3. The 4.34% Title XIX FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
4. The estimated rebates to collect are \$6,465,000 in FY 2020-21 and \$6,680,000 in FY 2021-22.
5. Assume, of the total BCCTP rebates collected, the ACA offset for BCCTP is \$652,000 TF in FY 2020-21 and \$674,000 TF in FY 2021-22.
6. The Department estimates \$1,783,000 and \$2,102,000 BCCTP drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2020-21 and FY 2021-22, respectively.

(Dollars in Thousands)

FY 2020-21	TF	FF	Fund 3331 Transfer*
100% Title XIX FF	(\$3,778)	(\$3,778)	(\$2,035)
FFCRA 4.34% Increased FFP	(\$252)	(\$252)	\$252
ACA Offset	(\$652)	(\$652)	\$0
<b>Total</b>	<b>(\$4,682)</b>	<b>(\$4,682)</b>	<b>(\$1,783)</b>

**BCCTP DRUG REBATES**  
REGULAR POLICY CHANGE NUMBER: 49

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$3,904)	(\$3,904)	(\$2,102)
ACA Offset	(\$674)	(\$674)	\$0
<b>Total</b>	<b>(\$4,578)</b>	<b>(\$4,578)</b>	(\$2,102)

\*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

**Funding:**

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

FFCRA 4.34% Increased FFP (4260-101-0890)

## LITIGATION SETTLEMENTS

**REGULAR POLICY CHANGE NUMBER:** 50  
**IMPLEMENTATION DATE:** 8/2009  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1449

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$19,201,000	\$0
<b>- STATE FUNDS</b>	-\$19,201,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$19,201,000	\$0
<b>STATE FUNDS</b>	-\$19,201,000	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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 2020-21, is an increase in the amount of settlement payments the Department expects to receive.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to only being able to budget for current year settlement amounts.

**LITIGATION SETTLEMENTS**  
**REGULAR POLICY CHANGE NUMBER: 50****Methodology:**

The following settlements are expected to be received in FY 2020-21:

<b>Settlement Name</b>	<b>FY 2020-21</b>
ResMed	(\$33,000)
National Cornerstone Health Services, Inc.	(\$350,000)
Novartis Pharmaceuticals Corporation	(\$5,905,000)
Progenity Inc.	(\$53,000)
Memorial Health Services	(\$12,613,000)
Royal Pharmaceuticals, LLC	(\$3,000)
Seton Pharmaceuticals, LLC	(\$244,000)
<b>Total GF Savings</b>	<b>(\$19,201,000)</b>

**Funding:**

100% GF (4260-101-0001)

## FAMILY PACT DRUG REBATES

**REGULAR POLICY CHANGE NUMBER:** 51  
**IMPLEMENTATION DATE:** 12/1999  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 51

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$10,497,000	-\$11,432,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$10,497,000	-\$11,432,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$10,497,000	-\$11,432,000

**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  
 SB 78 (Chapter 38, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Medi-Cal Drug Rebate Fund  
 COVID-19 Increased FMAP Extension – DHCS

**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.

SB 78 established 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 Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34

## **FAMILY PACT DRUG REBATES**

### **REGULAR POLICY CHANGE NUMBER: 51**

percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2020,
- Decreased estimated FPACT pharmacy expenditures for the applicable expenditure period,
- Updated non-family planning and family planning funding splits applied to FPACT rebates, resulting in higher rebate collections claimed at the 90%/10% FMAP, and
- Including FFCRA increased FFP in FY 2020-21, resulting in rebate savings shifting from the GF to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in rebate savings due to:

- Increased estimated FPACT pharmacy expenditures for the applicable expenditure period, and
- FFCRA increased FFP is not assumed for FY 2021-22 in this policy change.

#### **Methodology:**

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 1.56% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 98.44% of the FPACT rebates.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. Assume the ACA offset is \$340,000 TF for FY 2020-21 and \$370,000 TF for FY 2021-22.
4. Actual data from July 2013 to June 2020 is used to project rebates.

**FAMILY PACT DRUG REBATES**  
REGULAR POLICY CHANGE NUMBER: 51

5. The Department estimates \$1,195,000 and \$1,315,000 FFACT rebate collections to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2020-21 and FY 2021-22, respectively.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$10,146)	(\$10,146)	(\$1,206)
FFCRA 6.2% Increased FFP	(\$11)	(\$11)	\$11
ACA Offset	(\$340)	(\$340)	\$0
<b>Total</b>	<b>(\$10,497)</b>	<b>(\$10,497)</b>	<b>(\$1,195)</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$11,062)	(\$11,062)	(\$1,315)
ACA Offset	(\$370)	(\$370)	\$0
<b>Total</b>	<b>(\$11,432)</b>	<b>(\$11,432)</b>	<b>(\$1,315)</b>

\*The Fund 3331 Transfer column is for informational purposes only. See Methodology #5.

**Funding:**

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS

**REGULAR POLICY CHANGE NUMBER:** 52  
**IMPLEMENTATION DATE:** 5/2020  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2234

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$21,000,000	-\$21,000,000
<b>- STATE FUNDS</b>	-\$7,777,200	-\$7,777,200
<b>PAYMENT LAG</b>	0.9980	1.0000
<b>% REFLECTED IN BASE</b>	32.28 %	36.19 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$14,192,800	-\$13,400,100
<b>STATE FUNDS</b>	-\$5,256,190	-\$4,962,630
<b>FEDERAL FUNDS</b>	-\$8,936,570	-\$8,437,470

**Purpose:**

This policy change estimates the savings for the permanent reinstatement of over-the-counter (OTC) adult acetaminophen and cough/cold products as Medi-Cal covered benefits.

**Authority:**

State Plan Amendment (SPA) 20-0024  
Proposed Trailer Bill Language

**Interdependent Policy Change:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

Welfare and Institutions Code (WIC) 14132 states that OTC adult acetaminophen and antitussive cough and cold products are not Medi-Cal covered benefits.

The Centers for Medicare and Medicaid Services approved the temporary reinstatement of OTC adult acetaminophen and cough/cold products in the Disaster Relief SPA 20-0024. The SPA 20-0024 authorized the implementation of temporary policies in response to the 2019 Novel Coronavirus (COVID-19) public health emergency (PHE).

Proposed trailer bill language will permanently reinstate OTC adult acetaminophen and cough/cold products as Medi-Cal benefits.

The reinstatement of OTC adult acetaminophen and cough/cold products is a savings for the Department as these products are less costly than prescription opioids, prescription nonsteroidal anti-inflammatory analgesics, and stronger prescription strength cough treatments.

The May 2020 Estimate budgeted savings for the temporary reinstatement of OTC adult acetaminophen and cough/cold products in the COVID-19 Additional Impacts PC.



## OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS

### REGULAR POLICY CHANGE NUMBER: 52

#### Reason for Change:

The change in FY 2020-21 from the prior estimate is due to estimating a full year of savings in FY 2020-21. The prior estimate included savings only through June 30, 2020, budgeted in the COVID-19 Additional Impacts PC.

There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

#### Methodology:

1. The Department temporarily reinstated OTC adult acetaminophen and cough/cold products effective March 1, 2020, under the Disaster Relief SPA 20-0024 through the PHE period assumed to be extended until December 31, 2021.
2. Proposed trailer bill language will permanently reinstate OTC adult acetaminophen and cough/cold products beginning July 1, 2021.
3. Assume there is no lapse in coverage in the transition from the temporary reinstatement of OTC adult acetaminophen and cough/cold products under the emergency SPA to a permanent reinstatement with the amendment of WIC 14132.
4. The Fee-For-Service (FFS) annual savings are estimated at \$21 million TF (\$7.7 million GF):

Annual Savings	TF	GF	FF
	(\$21,000,000)	(\$7,777,000)	(\$13,223,000)

5. The FY 2020-21 and FY 2021-22 FFS savings are estimated to be:

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	(\$14,193,000)	(\$7,096,000)	(\$7,096,000)
90% Title XIX/ 10% GF	(\$6,807,000)	(\$681,000)	(\$6,127,000)
<b>Total</b>	<b>(\$21,000,000)</b>	<b>(\$7,777,000)</b>	<b>(\$13,223,000)</b>

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF	(\$14,193,000)	(\$7,096,000)	(\$7,096,000)
90% Title XIX/ 10% GF	(\$6,807,000)	(\$681,000)	(\$6,127,000)
<b>Total</b>	<b>(\$21,000,000)</b>	<b>(\$7,777,000)</b>	<b>(\$13,223,000)</b>

#### Funding:

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

90% Title XIX / 10% GF (4260-101-0001/890)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

**OTC ADULT ACETAMINOPHEN & COUGH/COLD PRODUCTS**  
**REGULAR POLICY CHANGE NUMBER: 52**

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

## BLOOD FACTOR REIMBURSEMENT METHODOLOGY

**REGULAR POLICY CHANGE NUMBER:** 53  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2164

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$37,797,000	-\$37,797,000
<b>- STATE FUNDS</b>	-\$13,478,010	-\$13,532,750
<b>PAYMENT LAG</b>	0.9500	1.0000
<b>% REFLECTED IN BASE</b>	9.79 %	8.82 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$32,391,800	-\$34,463,300
<b>STATE FUNDS</b>	-\$11,550,590	-\$12,339,160
<b>FEDERAL FUNDS</b>	-\$20,841,250	-\$22,124,140

**Purpose:**

This policy change estimates the savings related to the reimbursement methodology for blood factors.

**Authority:**

Federal Social Security Act 42 CFR Part 447 Part II  
SPA 19-0015

**Interdependent Policy Change:**

COVID Emergency FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

The Centers for Medicare and Medicaid (CMS) Final Rule for Covered Outpatient Drugs requires states to incorporate blood factor reimbursement methodology into their Medicaid State Plan and address ingredient cost, professional dispensing fees, and other associated services in the reimbursement methodology. Blood factor is used to treat hemophilia.

Previously, Medi-Cal reimbursed blood factor claims at the lower of the billed amount or Average Sales Price (ASP) + 20%. The ASP + 20% cap was set in the Welfare and Institutions Code 14105.86. The new Medi-Cal methodology for reimbursement is:

- Hemophilia Treatment Centers (HTC) = lower of acquisition cost + \$.14 per unit dispensing fee or ASP + 20%.
- Non-HTC = lower of actual acquisition cost + \$.04 per unit dispensing fee or ASP + 20%.

**Reason for Change:**

There is no change to the total funds estimate from the prior estimate for FY 2020-21. The funding assumptions, however, have been updated based on more recent data.

## BLOOD FACTOR REIMBURSEMENT METHODOLOGY

### REGULAR POLICY CHANGE NUMBER: 53

There is no change in the annual savings estimate from FY 2020-21 to FY 2021-22 in the current estimate. The funding in FY 2021-22, however, includes a full year of Title XXI funding at 65% FFP/ 35% GF.

#### Methodology:

1. The Department implemented the new reimbursement methodology on July 1, 2020.
2. The new blood factor reimbursement methodology is:
  - HTC = lower of acquisition cost + \$.14 per unit dispensing fee or ASP + 20%.
  - Non-HTC = lower of actual acquisition cost + \$.04 per unit dispensing fee or ASP + 20%.
3. Acquisition Cost is the invoice price less discounts, rebates, or chargebacks.
4. ASP is the price reported to CMS by the manufacturer pursuant to Section 1847A of the federal Social Security Act (42 U.S.C. Sec. 1395w-3a).
5. The estimated HTC and non-HTC savings are:

Annual Savings	TF	GF	FF
HTC	(\$10,000,000)	(\$3,566,000)	(\$6,434,000)
Non-HTC	(\$27,797,000)	(\$9,912,000)	(\$17,885,000)
<b>Total</b>	<b>(\$37,797,000)</b>	<b>(\$13,533,000)</b>	<b>(\$24,264,000)</b>

6. The estimated FY 2020-21 blood factor savings are:

FY 2020-21	TF	GF	FF
50% Title XIX / 50% GF	(\$23,192,000)	(\$11,596,000)	(\$11,596,000)
90% Title XIX/ 10% GF	(\$12,700,000)	(\$1,270,000)	(\$11,430,000)
76.5% Title XXI / 23.5% GF	(\$476,000)	(\$112,000)	(\$364,000)
65% Title XXI / 35% GF	(\$1,429,000)	(\$500,000)	(\$929,000)
<b>Total</b>	<b>(\$37,797,000)</b>	<b>(\$13,478,000)</b>	<b>(\$24,319,000)</b>

## BLOOD FACTOR REIMBURSEMENT METHODOLOGY

### REGULAR POLICY CHANGE NUMBER: 53

7. The estimated FY 2021-22 blood factor savings are:

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	(\$23,192,000)	(\$11,596,000)	(\$11,596,000)
90% Title XIX/ 10% GF	(\$12,700,000)	(\$1,270,000)	(\$11,430,000)
65% Title XXI / 35% GF	(\$1,905,000)	(\$667,000)	(\$1,238,000)
<b>Total</b>	<b>(\$37,797,000)</b>	<b>(\$13,533,000)</b>	<b>(\$24,264,000)</b>

**Funding:**

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

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

76.5% Title XXI / 23.5% GF (4260-113-0001/890)

90% Title XIX / 10% GF (4260-101-0001/890)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 increased FMAP Extension – DHCS policy change.

## MEDICAL SUPPLY REBATES

**REGULAR POLICY CHANGE NUMBER:** 54  
**IMPLEMENTATION DATE:** 10/2006  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 1181

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$22,271,000	-\$90,973,000
<b>- STATE FUNDS</b>	-\$11,135,500	-\$45,486,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$22,271,000	-\$90,973,000
<b>STATE FUNDS</b>	-\$11,135,500	-\$45,486,500
<b>FEDERAL FUNDS</b>	-\$11,135,500	-\$45,486,500

**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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

The Department negotiates Maximum Acquisition Cost (MAC) for diabetic test strips and lancets with manufacturers to make available the best price to all providers. The Department establishes the medical supply reimbursement rates for diabetic test strips and lancets, which are based on the contracted MAC. The Department also negotiates medical supply rebates with some manufacturers to provide savings to the Department. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

The medical supply rebate contract terms for diabetic test strips and lancets are effective January 1, 2019, through December 31, 2021.

In June 2020, the Department negotiated MACs with manufacturers of pen needles, an additional medical supply product necessary for use with pre-filled insulin cartridges. Rebates were also negotiated with some of these manufacturers. The rebates will be a percentage of the MAC per unit of services (quantity) reimbursed. The contract terms are effective January 1, 2021, through December 31, 2023.

Due to system limitations in the Rebate Accounting Information System, manually created invoices for the rebate amounts are sent to manufacturers.

## MEDICAL SUPPLY REBATES

### REGULAR POLICY CHANGE NUMBER: 54

On April 1, 2021, pharmacy services for managed care (MC) will transition to the Fee-for-Service (FFS) delivery system. This transition is referred to as Medi-Cal Rx. The Medi-Cal Rx contractor, Magellan Medicaid Administration, Inc. will also take over the rebate accounting operations. It is estimated that the takeover for rebate operations will occur on July 1, 2021. It is anticipated that the medical supply invoices will no longer be manually created beginning with FY 2020-21 Q4.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate is a decrease in savings due to the Medi-Cal Rx transition implementing on April 1, 2021, rather than the previously assumed date of January 1, 2021.

The change from FY 2020-21 to FY 2021-22, in the current estimate is an increase in savings due to estimating three quarters of increased rebates from the Medi-Cal Rx transition and three quarters of rebates from the addition of pen needles.

#### Methodology:

1. Assume the average quarterly collection is \$5,006,000 for test strips and lancets.
2. The transition of pharmacy benefits from MC to the FFS delivery system, or Medi-Cal Rx, will increase the FFS medical supply rebates, beginning April 1, 2021. Assume the average quarterly collection is \$28,079,000 for test strips and lancets with the increase due to Medi-Cal Rx.
3. Assume the average quarterly collection is \$2,246,000 for pen needles.
4. Assume there is a one quarter lag for medical supply rebate collections, and with the new contractor takeover of rebate operations starting with FY 2020-21 Q4 rebates, there will be an ongoing two quarter lag.
5. Assume the increase in quarterly rebate collection in proportion to the increased FFS population will be reflected beginning in the second quarter of FY 2021-22.
6. Assume the total rebates collected are \$22,271,000 in FY 2020-21 and \$90,973,000 in FY 2021-22.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	(\$22,271)	(\$11,135)	(\$11,136)
FY 2021-22	(\$90,973)	(\$45,486)	(\$45,487)

#### Funding:

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

## MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS

REGULAR POLICY CHANGE NUMBER: 55  
 IMPLEMENTATION DATE: 4/2021  
 ANALYST: Autumn Recce  
 FISCAL REFERENCE NUMBER: 2166

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$7,619,000	-\$37,818,000
<b>- STATE FUNDS</b>	-\$2,420,900	-\$13,540,550
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$7,619,000	-\$37,818,000
<b>STATE FUNDS</b>	-\$2,420,900	-\$13,540,550
<b>FEDERAL FUNDS</b>	-\$5,198,100	-\$24,277,450

### Purpose:

This policy change estimates the savings for Medi-Cal Rx from implementing a Maximum Allowable Ingredient Cost (MAIC) benchmark.

### Authority:

Social Security Act Section 1927 [42 U.S.C. 1396r-8]  
 Welfare & Institutions Code Section 14105  
 Executive Order N-01-19  
 Families First Coronavirus Response Act (FFCRA)

### Interdependent Policy Change:

Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS  
 COVID-19 Increased FMAP Extension – DHCS

### Background:

On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from managed care (MC) to Fee-for-Service (FFS). The transition of pharmacy services from MC to FFS will be implemented on April 1, 2021. Transitioning pharmacy services from managed care to FFS delivery system is referred to as Medi-Cal Rx.

Currently, Medi-Cal reimburses based on the lower of Actual Acquisition Cost (AAC) plus a professional dispensing fee, or usual and customary charges. AAC is determined as the lowest of:

- National Average Drug Acquisition Cost (NADAC), or Wholesale Acquisition Cost (WAC) + 0% if the NADAC is not available,
- Federal Upper Limit (FUL), or
- Maximum Allowable Ingredient Cost (MAIC).

MAICs are currently an optional benchmark for pharmacy claims. Part of the Medi-Cal Rx transition effort will include the implementation of MAICs, as calculated by the Medi-Cal Rx contractor, for drugs which have 3 or more generically equivalent options available. Utilizing the MAIC benchmark will result in savings.



## **MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS**

### **REGULAR POLICY CHANGE NUMBER: 55**

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

#### Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from MAIC in FFS
- Medi-Cal Rx- Additional Supplemental Rebates
- Medical Supply Rebates

#### Other Admin

- Medi-Cal Rx – Administrative Costs

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease in savings due to:

- The implementation date of Medi-Cal Rx changing from January 1, 2021, to April 1, 2021,
- Updated MAIC pricing received from MAIC vendor, Mercer Government Human Services, LLC, and
- Including FFCRA increased funding for the applicable periods in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to estimating a full year of MAIC implementation for Medi-Cal Rx in FY 2021-22 and no FFCRA increased funding is assumed in FY 2021-22.

#### **Methodology:**

1. The Department will begin reimbursing FFS pharmacy claims at the MAIC beginning April 1, 2021.
2. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS**  
REGULAR POLICY CHANGE NUMBER: 55

3. The estimated annual savings is \$37,856,000 TF.

(Dollars in Thousands)

<b>Annual</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Additional Savings from MAIC Implementation in FFS	(\$37,856)	(\$13,554)	(\$24,302)
<b>Total</b>	<b>(\$37,856)</b>	<b>(\$13,554)</b>	<b>(\$24,302)</b>

4. The estimated savings for FY 2020-21 and FY 2021-22 is:

(Dollars in Thousands)

<b>FY 2020-21 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Additional Savings from MAIC Implementation in FFS	(\$7,619)	(\$2,421)	(\$5,197)
<b>Total</b>	<b>(\$7,619)</b>	<b>(\$2,422)</b>	<b>(\$5,197)</b>

(Dollars in Thousands)

<b>FY 2021-22 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Additional Savings from MAIC Implementation in FFS	(\$37,818)	(\$13,541)	(\$24,277)
<b>Total</b>	<b>(\$37,818)</b>	<b>(\$13,541)</b>	<b>(\$24,277)</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$4,675)	(\$2,338)	(\$2,338)
FFCRA 6.2% Increased FFP (4260-101-0001 / 0890)	\$0	\$290	(\$290)
90% Title XIX / 10% GF (4260-101-0001/0890)	(\$2,560)	(\$256)	(\$2,304)
65% Title XXI / 35% GF (4260-113-0001/0890)	(\$384)	(\$135)	(\$250)
FFCRA 4.34% Increased FFP (4260-113-0001 / 0890)	\$0	\$17	(\$17)
<b>Total</b>	<b>(\$7,619)</b>	<b>(\$2,422)</b>	<b>(\$5,197)</b>

**MEDI-CAL RX - ADDITIONAL SAVINGS FROM MAIC IN FFS**  
REGULAR POLICY CHANGE NUMBER: 55

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$23,205)	(\$11,603)	(\$11,603)
90% Title XIX / 10% GF (4260-101-0001/0890)	(\$12,706)	(\$1,271)	(\$11,435)
65% Title XXI / 35% GF (4260-113-0001/0890)	(\$1,907)	(\$667)	(\$1,240)
<b>Total</b>	<b>(\$37,818)</b>	<b>(\$13,541)</b>	<b>(\$24,277)</b>

## STATE SUPPLEMENTAL DRUG REBATES

**REGULAR POLICY CHANGE NUMBER:** 56  
**IMPLEMENTATION DATE:** 1/1991  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 54

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$119,571,000	-\$118,242,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$119,571,000	-\$118,242,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$119,571,000	-\$118,242,000

**Purpose:**

This policy change estimates the revenues collected from the State Supplemental Drug rebates.

**Authority:**

Welfare & Institutions Code 14105.33  
 SB 78 (Chapter 38, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Medi-Cal Drug Rebate Fund  
 COVID-19 Increased FMAP Extension – DHCS

**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).

SB 78 established 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 Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## STATE SUPPLEMENTAL DRUG REBATES

### REGULAR POLICY CHANGE NUMBER: 56

#### Reason for Change:

The change from the prior estimate, for FY 2020-21 is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2020,
- Updated FFS pharmacy expenditure data through June 2020,
- Projecting an increase in rebate collections based on the historical trend, and
- Including FFCRA increased FFP in FY 2020-21, resulting in rebate savings shifting from the GF to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in rebate savings due to:

- FFCRA increased FFP is not assumed for FY 2021-22 resulting in a decrease to federal funds (FF) although there is a TF increase for state supplemental drug rebates for FY 2021-22, and
- Assuming CHIP rebates are funded in full at 65% FF/ 35% GF and no longer include CHIP funding at 76.5% FF/23.5% GF resulting in a decrease in FF.

#### 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 0.21% of the regular federal drug rebates and are funded with 90% FF and 10% GF.
3. The 6.2% Title XIX FFCRA increased FMAP and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
4. CHIP rebates are funded at 88% FF/ 12% GF through September 30, 2019, 76.5% FF/ 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebates collections are \$6,537,000 FF and \$6,044,000 FF in FY 2020-21 and FY 2021-22, respectively.
5. The optional expansion ACA population collections are estimated to be \$85,940,000 TF for FY 2020-21, of which \$77,346,000 FF is budgeted in this policy change. The amount of \$8,594,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2020-22, the ACA collections are estimated to be \$91,663,000 TF, of which \$82,497,000 FF is budgeted in this policy change. The amount of \$9,166,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

**STATE SUPPLEMENTAL DRUG REBATES**  
REGULAR POLICY CHANGE NUMBER: 56

6. The Department estimates to transfer \$38,736,000 and \$42,023,000 state supplemental rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2020-21 and FY 2021-22, respectively.

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$31,389,000)	(\$31,389,000)	(\$34,441,000)
FFCRA 6.2% Increased FFP	(\$3,878,000)	(\$3,878,000)	\$3,878,000
100% Title XIX ACA	(\$77,346,000)	(\$77,346,000)	(\$8,594,000)
100% Title XXI FF	(\$6,537,000)	(\$6,537,000)	\$0
FFCRA 4.34% Increased FFP	(\$421,000)	(\$421,000)	\$421,000
<b>Total</b>	<b>(\$119,571,000)</b>	<b>(\$119,571,000)</b>	<b>(\$38,736,000)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$29,701,000)	(\$29,701,000)	(\$32,857,000)
100% Title XIX ACA	(\$82,497,000)	(\$82,497,000)	(\$9,166,000)
100% Title XXI FF	(\$6,044,000)	(\$6,044,000)	\$0
<b>Total</b>	<b>(\$118,242,000)</b>	<b>(\$118,242,000)</b>	<b>(\$42,023,000)</b>

\*The Fund 3331 Transfer column is for informational purposes only. See Methodology #6.

**Funding:**

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

100% Title XXI (4260-113-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)

## MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

**REGULAR POLICY CHANGE NUMBER:** 57  
**IMPLEMENTATION DATE:** 4/2021  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2165

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$174,437,000	-\$297,336,000
<b>- STATE FUNDS</b>	\$49,267,750	-\$125,031,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$174,437,000	-\$297,336,000
<b>STATE FUNDS</b>	\$49,267,750	-\$125,031,300
<b>FEDERAL FUNDS</b>	\$125,169,250	-\$172,304,700

### Purpose:

This policy change estimates the net cost for Medi-Cal Rx by transitioning the Medi-Cal pharmacy services from Managed Care (MC) to Fee-For Service (FFS) delivery system.

### Authority:

Executive Order N-01-19  
Families First Coronavirus Response Act (FFCRA)

### Interdependent Policy Changes:

Medi-Cal Rx – Additional Savings from MAIC in FFS  
COVID-19 Increased FMAP Extension – DHCS

### Background:

On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from MC to FFS. The transition of pharmacy services from MC to FFS will be implemented on April 1, 2021. Transitioning pharmacy services from MC to FFS delivery system is referred to as Medi-Cal Rx.

The Department estimates total savings from Medi-Cal Rx will be approximately \$419 million GF annually. This figure takes into consideration many factors including, but not limited to the following:

- Increases in FFS Medi-Cal drug spending and other-related supplies provided by a pharmacy.
- New pharmacy administrative costs in FFS for claims payment and utilization management.
- Reductions in MC related administrative costs when compared to what would have been paid by the Department under existing managed care rates.
- Additional savings from implementation of a Maximum Allowable Ingredient Cost (MAIC) policy in FFS.
- Non-hospital 340B clinic savings based on data received from those facilities.
- Additional supplemental rebate savings for the MC utilization shift to FFS and existing FFS.

## **MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS**

### **REGULAR POLICY CHANGE NUMBER: 57**

Medi-Cal Rx includes the following when billed by a pharmacy on a pharmacy claim:

- Covered Outpatient Drugs, including Physician Administered Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

This policy change is part of the carve-out effort transitioning MC pharmacy services to the FFS delivery system for all MC contracts except for the Cal Medi Connect (CMC) dual contracts. The Centers for Medicare and Medicaid Services has required the CMC dual program to continue to cover this benefit for their enrolled members until the Coordinate Care Initiative ends December 31, 2022. The PCs related to Medi-Cal Rx are:

#### Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from MAIC in FFS
- Medi-Cal Rx- Additional Supplemental Rebates
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments

#### Other Admin

- Medi-Cal Rx – Administrative Costs

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate for FY 2020-21 is an increase in costs due to:

- The implementation date of Medi-Cal Rx changing from January 1, 2021, to April 1, 2021,
- An increase in the estimated annual managed care pharmacy savings and related MC administration,
- An increase in estimated annual FFS pharmacy costs, and
- Including FFCRA increased funding in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- An increase in savings due to estimating a full year of the net impact for Medi-Cal Rx in FY 2021-22, and
- FFCRA increased funding is not assumed in FY 2021-22.

#### **Methodology:**

1. The Department will transition MC pharmacy costs beginning April 1, 2021.



## MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS

### REGULAR POLICY CHANGE NUMBER: 57

2. The Department expects savings related to Medi-Cal Rx will be phased-in gradually, reaching approximately \$419 million in General Fund savings.
3. The estimated MC pharmacy savings and the related MC administration savings is \$6,396,077,000 TF annually.
4. Costs for FFS pharmacy costs are estimated to be \$6,251,993,000 TF annually.
5. The Department expects saving related to non-hospital 340B clinics to be \$147,000,000 TF annually.
6. The 6.2% Title XIX FFCRA increased FMAP and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
7. The estimated annual savings is:

(Dollars in Thousands)

<b>Annual</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Estimated Managed Care Pharmacy Savings	(\$6,134,338)	(\$2,102,697)	(\$4,031,641)
Managed Care Related Administrative Cost Savings	(\$261,739)	(\$89,718)	(\$172,021)
Net Managed Care Savings	(\$6,396,077)	(\$2,192,415)	(\$4,203,662)
Estimated Fee-For-Service Pharmacy Costs	\$6,251,993	\$2,143,027	\$4,108,966
Estimated Non-Hospital 340B Savings	(\$147,000)	(\$73,500)	(\$73,500)
Total MC to FFS	(\$291,084)	(\$122,888)	(\$168,196)

**MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS**  
REGULAR POLICY CHANGE NUMBER: 57

8. The estimated cost for FY 2020-21 and FY 2021-22 is:

(Dollars in Thousands)

<b>FY 2020-21 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Estimated Managed Care Pharmacy Savings	(\$1,022,390)	(\$311,734)	(\$710,656)
Managed Care Related Administrative Cost Savings	(\$43,623)	(\$14,856)	(\$28,767)
Net Managed Care Savings	(\$1,066,013)	(\$326,590)	(\$739,423)
Estimated Fee-For-Service Pharmacy Costs	\$1,258,214	\$383,639	\$874,575
Estimated Non-Hospital 340B Savings	(\$17,764)	(\$7,781)	(\$9,983)
<b>Total MC to FFS</b>	<b>\$174,437</b>	<b>\$49,268</b>	<b>\$125,169</b>

(Dollars in Thousands)

<b>FY 2021-22 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Estimated Managed Care Pharmacy Savings	(\$6,134,338)	(\$2,102,697)	(\$4,031,641)
Managed Care Related Administrative Cost Savings	(\$261,739)	(\$89,718)	(\$172,021)
Net Managed Care Savings	(\$6,396,077)	(\$2,192,415)	(\$4,203,662)
Estimated Fee-For-Service Pharmacy Costs	\$6,245,741	\$2,140,884	\$4,104,857
Estimated Non-Hospital 340B Savings	(\$147,000)	(\$73,500)	(\$73,500)
<b>Total MC to FFS</b>	<b>(\$297,336)</b>	<b>(\$125,031)</b>	<b>(\$172,305)</b>

**MEDI-CAL RX - MANAGED CARE PHARMACY BENEFIT TO FFS**  
REGULAR POLICY CHANGE NUMBER: 57

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$92,752	\$46,376	\$46,376
FFCRA 6.2% Increased FFP (4260-101-0001 / 0890)	\$0	(\$7,306)	\$7,306
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$71,864	\$7,187	\$64,677
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$9,821	\$3,437	\$6,384
FFCRA 4.34% Increased FFP (4260-113-0001 / 0890)	\$0	(\$426)	\$426
<b>Total</b>	<b>\$174,437</b>	<b>\$49,268</b>	<b>\$125,169</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001 / 0890)	(\$233,443)	(\$116,722)	(\$116,772)
90% Title XIX / 10% GF (4260-101-0001 / 0890)	(\$56,211)	(\$5,621)	(\$50,590)
65% Title XXI / 35% GF (4260-113-0001 / 0890)	(\$7,682)	(\$2,689)	(\$4,993)
<b>Total</b>	<b>(\$297,336)</b>	<b>(\$125,031)</b>	<b>(\$172,305)</b>

## FEDERAL DRUG REBATES

**REGULAR POLICY CHANGE NUMBER:** 58  
**IMPLEMENTATION DATE:** 7/1990  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 55

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$1,570,146,000	-\$1,577,341,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$1,570,146,000	-\$1,577,341,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$1,570,146,000	-\$1,577,341,000

**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.  
 SB 78 (Chapter 38, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Medi-Cal Drug Rebate Fund  
 COVID-19 Increased FMAP Extension – DHCS

**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.

SB 78 established 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 Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Beginning with the April 2020 through June 2020 quarterly drug rebates, County Organized Health System (COHS) rebates are now reported with managed care rebates. COHS rebates were previously reported with Fee-for-Service (FFS) rebates. Rebates for COHS will continue to be reported with managed care rebates until the COHS and managed care pharmacy claims are transitioned to Medi-Cal Rx on January 1, 2021. Furthermore, after the Medi-Cal Rx transition on January 1, 2021, a majority of the rebates currently reported as managed care rebates will be reported as FFS federal rebates. Until more data is available for these transitions, this policy

## **FEDERAL DRUG REBATES**

### **REGULAR POLICY CHANGE NUMBER: 58**

change does not include changes to the rebate reporting categories related to the COHS rebates to managed care transition or Medi-Cal Rx transition.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2020,
- Updated FFS pharmacy expenditure data through June 2020, and
- Including FFCRA increased FFP in FY 2020-21, resulting in rebate savings shifting from the GF to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in rebate savings due to:

- An increase in estimated FFS pharmacy expenditures for the applicable expenditure period and,
- FFCRA increased FFP is not assumed for FY 2021-22.

#### **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 0.21% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.
3. The 6.2% Title XIX FFCRA increased FMAP and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. CHIP rebates are funded at 88% FF / 12% GF through September 30, 2019, 76.5% FF / 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are \$81,711,000 FF and \$75,547,000 FF in FY 2020-21 and FY 2021-22, respectively.
4. The optional expansion ACA population collections are estimated to be \$693,213,000 TF for FY 2020-21, of which \$623,892,000 FF is budgeted in this policy change. The amount of \$69,321,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For FY 2021-22, a total of \$739,378,000 TF is estimated for the optional expansion population,

## FEDERAL DRUG REBATES

### REGULAR POLICY CHANGE NUMBER: 58

of which \$655,440,000 FF is budgeted in this policy change. The amount of \$73,938,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

5. The ongoing additional FF claimed by CMS (ACA Offset) is reflected in this policy change. The additional FF is \$122,012,000 TF for FY 2020-21 and \$130,116,000 TF for FY 2021-22.
6. The Department estimates \$676,463,000 and \$818,487,000 federal drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2020-21 and FY 2021-22, respectively.

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$656,209,000)	(\$656,209,000)	(\$693,464,000)
FFCRA 6.2% Increased FFP	(\$81,063,000)	(\$81,063,000)	\$81,063,000
100% Title XIX ACA FF	(\$623,892,000)	(\$623,892,000)	(\$69,321,000)
100% Title XXI FF	(\$81,711,000)	(\$81,711,000)	\$0
FFCRA 4.34% Increased FFP	(\$5,259,000)	(\$5,259,000)	\$5,259,000
ACA Offset	(\$122,012,000)	(\$122,012,000)	\$0
<b>Total</b>	<b>(\$1,570,146,000)</b>	<b>(\$1,570,146,000)</b>	(\$676,463,000)

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$706,238,000)	(\$706,238,000)	(\$744,549,000)
100% Title XIX ACA FF	(\$655,440,000)	(\$655,440,000)	(\$73,938,000)
100% Title XXI FF	(\$75,547,000)	(\$75,547,000)	\$0
ACA Offset	(\$130,116,000)	(\$130,116,000)	\$0
<b>Total</b>	<b>(\$1,577,341,000)</b>	<b>(\$1,577,341,000)</b>	(\$818,487,000)

\*The Fund 3331 Transfer column is for informational purposes only. See Methodology #7.

#### **Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)

## DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

**REGULAR POLICY CHANGE NUMBER:** 59  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2012

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$419,478,000	\$404,190,000
<b>- STATE FUNDS</b>	\$41,639,150	\$44,646,700
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$419,478,000	\$404,190,000
<b>STATE FUNDS</b>	\$41,639,150	\$44,646,700
<b>FEDERAL FUNDS</b>	\$377,838,850	\$359,543,300

**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  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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

## DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

### REGULAR POLICY CHANGE NUMBER: 59

continue to 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 RTS
- 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).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

This change from the prior estimate, for FY 2020-21, is a net increase due to the following:

- Updated claims data reimbursements for 30 counties were higher compared to the previous projection, and as a result, the overall estimate increased.
- Prior year claims – A portion of unpaid claims for FY 2017-18 and FY 2018-19, previously projected to be paid through cost report settlements, are now estimated to be paid in FY 2020-21.
- Updated payment lag – Based on more recent claims data, payment lags for 27 counties increased overall resulting in more payments included in FY 2021-22.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is a net decrease due to the following:

- FY 2020-21 includes more unpaid claims for prior years than FY 2021-22.
- Updated approved interim county rates - Overall rates for FY 2021-22 are higher compared to FY 2020-21, due to eight counties updating their rates for FY 2021-22.



## DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

### REGULAR POLICY CHANGE NUMBER: 59

- FFCRA Increased FMAP are not assumed for payments in FY 2021-22 in this policy change.

#### Methodology:

1. DMC-ODS waiver services for opt-in counties began in February 2017 on a phase-in basis.
2. Four counties implemented the waiver in FY 2016-17.
  - For FY 2017-18, seven additional counties (for a total of 11 counties) began providing waiver services.
  - For FY 2018-19, 16 additional counties (for a total of 27 counties) began providing waiver services.
  - For FY 2019-20, three additional counties (for a total of 30 counties) began providing waiver services.
3. In FY 2020-21, the remaining seven opt-in counties (for a total of 37 counties) began providing waiver services under the PHP. Implementation for the seven PHP counties occurred in July 2020.
4. A total of 21 counties have not opted-in to implement DMC-ODS waiver services.
5. 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. 19 counties have revised rates for FY 2020-21 that will be implemented in July 2020. Costs for rate adjustments are included in this estimate.

#### Net DMC-ODS Waiver Costs

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

(Dollars in Thousands)

DMC-ODS Waiver Net Cost	FY 2020-21	FY 2021-22
Required Services	\$46,376	\$44,011
Optional Services	\$1,689	\$1,852
Existing Services	\$472,532	\$466,777
PHP Counties	\$7,335	\$14,669
<b>Total</b>	<b>\$527,932</b>	<b>\$527,309</b>

#### Claims Payment Error

7. 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 Affordable Care Act (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, with completion in FY 2020-21.

**DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER**  
REGULAR POLICY CHANGE NUMBER: 59

Claims Payment Error	GF Cost	GF Recoupment
FY 2017-18	\$655,000	\$0
FY 2018-19	\$6,000	(\$554,000)
FY 2019-20	\$0	(\$101,000)
FY 2020-21	\$0	(\$6,000)
<b>Total</b>	<b>\$661,000</b>	<b>(\$661,000)</b>

8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
9. On a cash basis, the total costs for the claims payment error and waiver services costs are estimated to be \$434,102,000 TF and \$411,481,000 TF in FY 2020-21 and FY 2021-22 respectively.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>CF</b>
Regular					
Current	\$111,396,000	\$20,099,000	\$56,042,000	\$6,871,000	\$28,384,000
ACA Optional	\$172,935,000	\$14,370,000	\$155,642,000	\$0	\$2,923,000
Perinatal					
Current	\$173,748,000	\$0	\$86,886,000	\$10,771,000	\$76,091,000
ACA Optional	\$62,518,000	\$6,252,000	\$56,266,000	\$0	\$0
<b>Claims Error</b>					
General Fund	\$0	(\$6,000)	\$0	\$0	\$6,000
<b>PHP Plans</b>					
PHP Counties	\$7,335,000	\$924,000	\$5,144,000	\$217,000	\$1,050,000
<b>Total</b>	<b>\$527,932,000</b>	<b>\$41,639,000</b>	<b>\$359,980,000</b>	<b>\$17,859,000</b>	<b>\$108,454,000</b>

**DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER**  
REGULAR POLICY CHANGE NUMBER: 59

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>CF</b>
Regular					
Current	\$109,405,000	\$22,259,000	\$54,986,000	\$0	\$32,160,000
ACA Optional	\$169,846,000	\$14,195,000	\$152,862,000	\$0	\$2,789,000
Perinatal					
Current	\$171,632,000	\$0	\$85,826,000	\$0	\$85,806,000
ACA Optional	\$61,757,000	\$6,176,000	\$55,581,000	\$0	\$0
<b>PHP Plans</b>					
PHP Plans	\$14,669,000	\$2,017,000	\$10,288,000	\$0	\$2,364,000
<b>Total</b>	<b>\$527,309,000</b>	<b>\$44,647,000</b>	<b>\$359,543,000</b>	<b>\$0</b>	<b>\$123,119,000</b>

**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)  
 90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)  
 76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)  
 65% Title XXI FF / 35% GF (4260-113-0001/0890)  
 50% Title XIX / 50% GF (4260-101-0001/0890)  
 FFCRA 6.2% Increased FFP (4260-101-0890)  
 FFCRA 6.2% GF (4260-101-0001)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 63  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1724

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,011,000	\$1,806,000
<b>- STATE FUNDS</b>	\$84,200	\$155,600
<b>PAYMENT LAG</b>	0.7500	0.8835
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$758,200	\$1,595,600
<b>STATE FUNDS</b>	\$63,150	\$137,470
<b>FEDERAL FUNDS</b>	\$695,100	\$1,458,130

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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
- RTS – Regular and Perinatal
- ODF Individual Counseling – Regular and Perinatal
- ODF Group Counseling – Regular and Perinatal

## DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 63

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a net decrease due to updated developed rates for FY 2020-21, and a significant decrease in estimated utilization due to more counties transitioning to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2021-22 reflecting changes for FY 2020-21 and FY 2021-22 rates.

#### Methodology:

- The FY 2019-20 developed rates, FY 2020-21 developed rates, and FY 2021-22 estimated rates for regular and perinatal services are:

Regular Services	FY 2019-20 Developed Rates	FY 2020-21 Developed Rates	FY 2021-22 Estimated Rates
NTP Methadone	\$13.93	\$14.20	\$14.71
NTP Individual Counseling	\$15.74	\$16.65	\$17.25
NTP Group Counseling	\$3.36	\$3.80	\$3.94
Intensive Outpatient Treatment	\$71.78	\$76.43	\$79.18
Residential Treatment - EPSDT	\$110.42	\$112.55	\$116.60
ODF Individual Counseling	\$78.69	\$83.30	\$86.30
ODF Group Counseling	\$30.22	\$33.90	\$35.12

Perinatal Services	FY 2019-20 Developed Rates	FY 2020-21 Developed Rates	FY 2021-22 Estimated Rates
NTP Methadone	\$15.00	\$15.29	\$15.84
NTP Individual Counseling	\$23.39	\$23.84	\$24.70
NTP Group Counseling	\$5.37	\$6.09	\$6.31
Intensive Outpatient Treatment	\$89.71	\$91.45	\$94.74
Residential Treatment Services	\$110.42	\$112.55	\$116.60
ODF Individual Counseling	\$116.97	\$119.23	\$123.52
ODF Group Counseling	\$48.36	\$54.25	\$56.20

- The incremental rate changes for FY 2020-21 and FY 2021-22 are shown below:

**DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT**  
REGULAR POLICY CHANGE NUMBER: 63

Incremental Difference	FY 2020-21 Regular	FY 2020-21 Perinatal	FY 2021-22 Regular	FY 2021-22 Perinatal
NTP Methadone	\$0.27	\$0.29	\$0.51	\$0.55
NTP Individual Counseling	\$0.91	\$0.45	\$0.60	\$0.86
NTP Group Counseling	\$0.44	\$0.72	\$0.14	\$0.22
Intensive Outpatient Treatment	\$4.65	\$1.74	\$2.75	\$3.29
Residential Treatment Services	\$2.13	\$2.13	\$4.05	\$4.05
ODF Individual Counseling	\$4.61	\$2.26	\$3.00	\$4.29
ODF Group Counseling	\$3.68	\$5.89	\$1.22	\$1.95

3. The cost estimate for FY 2020-21, based on the incremental rate changes for FY 2019-20 and FY 2020-21 are:

FY 2020-21 - Regular	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	1,132,703	\$0.27	\$306,000
NTP Individual Counseling	513,340	\$0.91	\$467,000
NTP Group Counseling	1,011	\$0.44	\$0
Intensive Outpatient Treatment	23,105	\$4.65	\$107,000
Residential Treatment - EPSDT	0	\$2.13	\$0
ODF Individual Counseling	17,538	\$4.61	\$81,000
ODF Group Counseling	87,347	\$3.68	\$321,000
Total for Regular Services			\$1,282,000

FY 2020-21 - Perinatal	Total Number of Units	Incremental Difference	Total Rate Adj. Cost
NTP Methadone	3,780	\$0.29	\$1,000
NTP Individual Counseling	1,510	\$0.45	\$1,000
NTP Group Counseling	4	\$0.72	\$0
Intensive Outpatient Treatment	982	\$1.74	\$2,000
Residential Treatment Services	3,354	\$2.13	\$7,000
ODF Individual Counseling	112	\$2.26	\$0
ODF Group Counseling	781	\$5.89	\$5,000
Total for Perinatal Services			\$16,000

## DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 63

4. The cost estimate for FY 2021-22, based on the incremental rate changes for FY 2020-21 and FY 2021-22 are:

<b>FY 2021-22 - Regular</b>	<b>Total Number of Units</b>	<b>Incremental Difference</b>	<b>Rate Adj. Cost</b>	<b>FY 2021-22 Rate Adj.</b>
NTP Methadone	1,132,703	\$0.51	\$578,000	\$884,000
NTP Individual Counseling	513,340	\$0.60	\$308,000	\$775,000
NTP Group Counseling	1,011	\$0.14	\$0	\$0
Intensive Outpatient Treatment	23,105	\$2.75	\$64,000	\$171,000
Residential Treatment - EPSDT	0	\$4.05	\$0	\$0
ODF Individual Counseling	17,538	\$3.00	\$53,000	\$134,000
ODF Group Counseling	87,347	\$1.22	\$107,000	\$428,000
<b>Total for Regular Services</b>			<b>\$1,110,000</b>	<b>\$2,392,000</b>

<b>FY 2021-22 - Perinatal</b>	<b>Total Number of Units</b>	<b>Incremental Difference</b>	<b>Total Rate Adj. Cost</b>	<b>FY 2021-22 Rate Adj.</b>
NTP Methadone	3,780	\$0.55	\$2,000	\$3,000
NTP Individual Counseling	1,510	\$0.86	\$1,000	\$2,000
NTP Group Counseling	4	\$0.22	\$0	\$0
Intensive Outpatient Treatment	982	\$3.29	\$3,000	\$5,000
Residential Treatment Services	3,354	\$4.05	\$14,000	\$21,000
ODF Individual Counseling	112	\$4.29	\$0	\$0
ODF Group Counseling	781	\$1.95	\$2,000	\$7,000
<b>Total for Perinatal Services</b>			<b>\$22,000</b>	<b>\$38,000</b>

5. Total estimated costs for the annual rate adjustments are:

<b>Annual Rate Adj. Cost</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
NTP	\$775,000	\$1,664,000
ODF	\$407,000	\$569,000
IOT	\$109,000	\$176,000
RTS	\$7,000	\$21,000
<b>Total</b>	<b>\$1,298,000</b>	<b>\$2,430,000</b>

## DRUG MEDI-CAL ANNUAL RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 63

FY 2020-21	TF	GF	FF	FFCRA	CF
<b>Regular</b>					
Current	\$705,000	\$26,000	\$353,000	\$44,000	\$282,000
ACA Optional	\$578,000	\$58,000	\$520,000	\$0	\$0
<b>Perinatal</b>					
Current	\$12,000	\$0	\$6,000	\$1,000	\$5,000
ACA Optional	\$3,000	\$0	\$3,000	\$0	\$0
<b>Total</b>	<b>\$1,298,000</b>	<b>\$84,000</b>	<b>\$882,000</b>	<b>\$45,000</b>	<b>\$287,000</b>

FY 2021-22	TF	GF	FF	FFCRA	CF
<b>Regular</b>					
Current	\$1,315,000	\$47,000	\$658,000	\$0	\$610,000
ACA Optional	\$1,078,000	\$108,000	\$970,000	\$0	\$0
<b>Perinatal</b>					
Current	\$29,000	\$0	\$15,000	\$0	\$14,000
ACA Optional	\$8,000	\$1,000	\$7,000	\$0	\$0
<b>Total</b>	<b>\$2,430,000</b>	<b>\$156,000</b>	<b>\$1,650,000</b>	<b>\$0</b>	<b>\$624,000</b>

- The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
- Assume DMC claims are paid 75% in the same year the services occur and the remaining 25% in the following year.

#### Funding:

100% Title XIX FF (4260-101-0890)  
 100% Title XXI FF (4260-113-0890)  
 90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)  
 76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)  
 65% Title XXI FF / 35% GF (4260-113-0001/0890)  
 50% Title XIX / 50% GF (4260-101-0001/0890)  
 FFCRA 6.2% Increased FFP (4260-101-0890)  
 FFCRA 6.2% GF (4260-101-0001)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)



**DRUG MEDI-CAL MAT BENEFIT**

**REGULAR POLICY CHANGE NUMBER:** 64  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2169

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$398,000	\$613,000
<b>- STATE FUNDS</b>	\$68,600	\$130,200
<b>PAYMENT LAG</b>	0.8750	0.5876
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$348,200	\$360,200
<b>STATE FUNDS</b>	\$60,020	\$76,510
<b>FEDERAL FUNDS</b>	\$288,220	\$283,690

**Purpose:**

This policy change estimates the cost of additional medication assisted treatment (MAT) drugs under the State Plan.

**Authority:**

Public Law 115-271  
H.R.6, Section 1006 (2018)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

Under the Medicaid State Plan, 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.

Beginning on October 1, 2020 and ending September 2025, Public Law 115-271, requires states to include MAT in its Medicaid State Plan. The MAT must include all drugs and biological products approved by the Food and Drug Administration (FDA) to treat opioid addiction. The FDA has approved the following four drugs and biological products to treat opioid addiction: methadone, buprenorphine, buprenorphine-naloxone combination, and naltrexone. California's State Plan currently covers MATs through NTP providers. However, the State Plan only covers the use of methadone and naltrexone in MAT. Effective July 1, 2020, under the State Plan, NTP and non-NTP certified providers will cover all drugs and biological products that the FDA has approved to treat opioid addiction, including buprenorphine and buprenorphine-naloxone combination products.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver already includes NTP MAT and Additional MAT. This fiscal impact only includes the costs to State Plan counties not participating in the DMC-ODS Waiver.

## DRUG MEDI-CAL MAT BENEFIT

### REGULAR POLICY CHANGE NUMBER: 64

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate for FY 2020-21, is a net decrease due to the following:

- Updated estimated caseload, for both NTP State Plan and non-NTP certified clinics, decreased due to more counties transitioning into the DMC-ODS Waiver.
- Updated developed MAT rates are higher than previously estimated.
- For non-NTP certified clinic settings, the prior estimate assumed reimbursement at the State Plan MAT rates. This estimate assumes reimbursements at the existing rates established for non-NTP settings, which are higher than the State Plan MAT rates.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to higher estimated rates for FY 2021-22, and FY 2021-22 including a full years cost.

#### Methodology:

1. Assume rates for the additional MATs will be implemented in January 1, 2021. Currently, the FDA-approved MAT drugs already in the State Plan are methadone and naltrexone. This fiscal assumes the addition of buprenorphine and buprenorphine-naloxone combination drugs to the State Plan effective July 1, 2020.
2. The additional MATs will be available to beneficiaries in both NTP and non-NTP certified clinic settings. MATs provided in a non-NTP certified clinic setting will be reimbursed as a separate encounter with the existing rate established for the non-NTP setting.
3. The 6.2% Title XIX FFCRA and 4.34% Title XXI increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
4. Total estimated costs are:

FY 2020-21	TF	GF	FF	FFCRA	CF
<b>Regular</b>					
Current	\$248,000	\$47,000	\$124,000	\$15,000	\$62,000
ACA Optional	\$204,000	\$20,000	\$184,000	\$0	\$0
<b>Perinatal</b>					
Current	\$8,000	\$2,000	\$3,000	\$1,000	\$2,000
ACA Optional	\$2,000	\$0	\$2,000	\$0	\$0
<b>Total</b>	<b>\$462,000</b>	<b>\$69,000</b>	<b>\$313,000</b>	<b>\$16,000</b>	<b>\$64,000</b>

**DRUG MEDI-CAL MAT BENEFIT**  
**REGULAR POLICY CHANGE NUMBER: 64**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>CF</b>
<b>Regular</b>					
Current	\$384,000	\$96,000	\$192,000	\$0	\$96,000
ACA Optional	\$314,000	\$31,000	\$283,000	\$0	\$0
<b>Perinatal</b>					
Current	\$11,000	\$3,000	\$5,000	\$0	\$3,000
ACA Optional	\$3,000	\$0	\$3,000	\$0	\$0
<b>Total</b>	<b>\$712,000</b>	<b>\$130,000</b>	<b>\$483,000</b>	<b>\$0</b>	<b>\$99,000</b>

**Funding:**

100% GF (4260-101-0001)

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

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## DRUG MEDI-CAL PROGRAM COST SETTLEMENT

**REGULAR POLICY CHANGE NUMBER:** 66  
**IMPLEMENTATION DATE:** 9/2019  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1723

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$46,000	\$0
<b>- STATE FUNDS</b>	-\$14,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$46,000	\$0
<b>STATE FUNDS</b>	-\$14,000	\$0
<b>FEDERAL FUNDS</b>	\$60,000	\$0

**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). The Department has the authority to audit the cost reports within three years of the cost settlement.

Cost settlements for non-NTP 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: 66

Cost settlements for NTP 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 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 2020-21, is due to additional audit settlements completed for FY 2013-14, FY 2014-15, and additional cost report completed for FY 2015-16.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to no cost settlement payments or recoupments in FY 2021-22.

#### 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 audit settlements for the annual cost reports will be recouped in FY 2020-21.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Title XIX</b>	<b>Title XXI</b>	<b>CF</b>
FY 2013-14 Settlements	(\$62,000)	\$0	(\$30,000)	(\$3,000)	(\$29,000)
FY 2014-15 Settlements	(\$50,000)	\$0	(\$35,000)	\$0	(\$15,000)
FY 2015-16 Settlements	\$114,000	(\$14,000)	\$133,000	(\$5,000)	\$0
<b>Total</b>	\$2,000	<b>(\$14,000)</b>	<b>\$68,000</b>	<b>(\$8,000)</b>	(\$44,000)

#### Funding:

100% General Fund

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

## MHP COSTS FOR CONTINUUM OF CARE REFORM

**REGULAR POLICY CHANGE NUMBER:** 69  
**IMPLEMENTATION DATE:** 1/2017  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1957

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$23,862,000	\$21,862,000
<b>- STATE FUNDS</b>	\$11,627,500	\$11,090,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$23,862,000	\$21,862,000
<b>STATE FUNDS</b>	\$11,627,500	\$11,090,500
<b>FEDERAL FUNDS</b>	\$12,234,500	\$10,771,500

**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)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension - DHCS

**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 CFTs 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.

## MHP COSTS FOR CONTINUUM OF CARE REFORM

### REGULAR POLICY CHANGE NUMBER: 69

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate for FY 2020-21, is a decrease due to:

- Updating the cost per hour to \$213.60 from \$244.60, based on median county interim rates for CFT;
- Updating placement assessment based on CDSS estimates;
- Updating the cost per hour for placement assessments, to \$245.40 from \$244.80, based on median county interim rates for STRTP assessments submitted for FY 2019-20; and
- The current estimate includes the estimated FFCRA increased FMAP for Continuum of Care Reform (CCR) expenditures through June 30, 2021.

The change from FY 2020-21 to FY 2021-22, in the current estimate is due to:

- Updating eligible child welfare cases for CFTs, that includes adding new CFT caseload type, Intensive Services Foster Care (ISFC); and
- Updating the discounted Federal Medical Assistance Percentages (FMAP) from 55% to 54%.

#### 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%, 11,737 are assumed to be open child welfare cases and currently receiving a CFT.

## MHP COSTS FOR CONTINUUM OF CARE REFORM

### REGULAR POLICY CHANGE NUMBER: 69

Caseload	42%	Less: Current Cases	CFT Cases (A)	Hours per Year (B)	CFT Case Hours (A x B)
Tier 1	1,448	682	766	12	9,192
Tier 2	2,655	1,251	1,404	10	14,040
Tier 3	9,511	4,477	5,034	8	40,272
Tier 4	9,888	4,656	5,232	4	20,928
Tier 5	1,423	671	752	4	3,008
Total	24,925	11,737	13,188	38	87,440

- 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 \$4.25 per minute or \$255.00 per hour for FY 2018-19, \$4.60 per minute or \$276.00 per hour for FY 2019-20, and \$3.56 per minute or \$213.60 per hour for FY 2020-21 and for FY 2021-22.
- The estimated FY 2021-22 caseload is updated based on CDSS' projections, and includes a new caseload, Intensive Services Foster Care (ISFC).
- The estimated annual costs for participation in a child and family team in FY 2018-19, FY 2019-20, FY 2020-21 and FY 2021-22 are estimated as:

(Rounded)

Caseload	CFT Case Hours	FY 2018-19 Cost (Case Hours x \$255.00/hr)	FY 2019-20 Cost (Case Hours x \$276.00/hr)	FY 2020-21 Cost (Case Hours x \$213.60/hr)	FY 2021-22 Cost (Case Hours x \$213.60/hr)
Tier 1	7,920	\$2,020,000	\$2,186,000	\$1,692,000	\$1,963,000
Tier 2	11,630	\$2,966,000	\$3,210,000	\$2,484,000	\$2,999,000
Tier 3	34,120	\$8,701,000	\$9,418,000	\$7,288,000	\$8,602,000
Tier 4	18,328	\$4,674,000	\$5,059,000	\$3,915,000	\$4,470,000
Tier 5	2,764	\$705,000	\$763,000	\$590,000	\$643,000
Total	74,762	\$19,066,000	\$20,636,000	\$15,969,000	\$18,677,000

#### Placement Assessments

- Based on CDSS' estimated number of children currently in a rate classification level (RCL) 10 to 12 residential group homes, assume 2,465 children would transition to an STRTP in FY 2018-19, 3,085 children in FY 2019-20, 3,085 children in FY 2020-21 and 3,085 in FY 2021-22.
- 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.



## MHP COSTS FOR CONTINUUM OF CARE REFORM

### REGULAR POLICY CHANGE NUMBER: 69

4. Based on based on median county interim rates for STRTP assessments, the average cost for is \$4.25 per minute or \$255.00 per hour for FY 2018-19, \$4.60 per minute or \$276.00 per hour for FY 2019-20, and \$4.06 per minute or \$245.40 per hour for FY 2020-21 and for FY 2021-22.

5. The assumed Placement Assessment costs are:

FY 2018-19:  $2,465 \times \$255.00 \times 4 = \$2,514,300$

FY 2019-20:  $3,085 \times \$276.00 \times 4 = \$3,405,840$

FY 2020-21:  $3,085 \times \$245.40 \times 4 = \$3,028,236$

FY 2021-22:  $3,085 \times \$245.40 \times 4 = \$3,028,236$

#### Training

1. Beginning FY 2018-19, CDSS is requesting funds through Federal Title IV-E authority to provide counties with CCR training. The total mental health staff training request is \$3,000,000 to be paid at 75% FMAP, and discounted to 55% for FY 2020-21 and 54% for FY 2021-22, 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 2020-21: Federal Share:  $\$3,000,000 \times 0.75 \times 0.55 = \$1,237,000$  (Rounded)

FY 2020-21: GF Match:  $\$3,000,000 \times (1 - (0.75 \times 0.55)) = \$1,763,000$  (Rounded)

FY 2021-22: Federal Share:  $\$3,000,000 \times 0.75 \times 0.54 = \$1,215,000$  (Rounded)

FY 2021-22: General Fund Match:  $\$3,000,000 \times (1 - (0.75 \times 0.54)) = \$1,785,000$  (Rounded)

#### Funding Summary

1. Based on Short Doyle/Medi-Cal paid claims data, on a cash basis for FY 2020-21, the Department will pay 1% of FY 2018-19 claims, and 61% of FY 2019-20 claims, and 38% of FY 2020-21 claims. On a cash basis for FY 2021-22, the Department will pay 1% of FY 2019-20 claims, and 61% of FY 2020-21 claims, and 38% of FY 2021-22 claims. There is no lag in payment for training costs. The estimated costs, on a cash basis, is:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>CFT</b>	<b>Placement Assessments</b>	<b>Training</b>
FY 2018-19	\$216	\$191	\$25	\$0
FY 2019-20	\$14,664	\$12,587	\$2,077	\$0
FY 2020-21	\$8,982	\$6,068	\$1,151	\$1,763
Total FY 2020-21	\$23,862	\$18,846	\$3,253	\$1,763

## MHP COSTS FOR CONTINUUM OF CARE REFORM

### REGULAR POLICY CHANGE NUMBER: 69

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>CFT</b>	<b>Placement Assessments</b>	<b>Training</b>
FY 2019-20	\$241	\$207	\$34	\$0
FY 2020-21	\$11,588	\$9,741	\$1,847	\$0
FY 2021-22	\$10,034	\$7,098	\$1,151	\$1,785
<b>Total FY 2021-22</b>	<b>\$21,863</b>	<b>\$17,046</b>	<b>\$3,032</b>	<b>\$1,785</b>

2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

<b>COVID-19 - FFCRA</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2020-21	\$0	(\$1,185,000)	\$1,185,000
FY 2021-22	\$0	(\$733,000)	\$733,000

3. The FY 2020-21 and FY 2021-22 estimate is:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CFT	\$18,846	\$9,423	\$9,423
Placement Assessments	\$3,253	\$1,626	\$1,627
Training	\$1,763	\$1,763	\$0
FFCRA 6.2% Increased FFP	\$0	(\$1,185)	\$1,185
<b>Total</b>	<b>\$23,862</b>	<b>\$11,627</b>	<b>\$12,235</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CFT	\$17,045	\$8,522	\$8,523
Placement Assessments	\$3,032	\$1,516	\$1,516
Training	\$1,785	\$1,785	\$0
FFCRA 6.2% Increased FFP	\$0	(\$733)	\$733
<b>Total</b>	<b>\$21,862</b>	<b>\$11,090</b>	<b>\$10,772</b>

**Funding:**

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

100% GF (4260-101-0001)

FFCRA 6.2% Increased FFP (4260-101-0001/0890)

## SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

**REGULAR POLICY CHANGE NUMBER:** 70  
**IMPLEMENTATION DATE:** 10/2017  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1458

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$9,861,000	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$9,861,000	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$9,861,000	\$0

**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 2020-21, is due to adding the estimated FY 2010-11 payments for San Mateo county and FY 2011-12 payments for San Francisco county.

The change from FY 2020-21 and FY 2021-22, in the current estimate, is due to no payments scheduled for FY 2021-22 at this time.

**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).

## SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 70

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. Counties submit the necessary county costs through a supplemental claiming process. It is expected that this process will continue in FY 2020-21 and FY 2021-22.
4. The estimates below were developed using actual costs from claims submitted by counties. The supplemental payments are estimated to be paid in FY 2020-21.
5. The Department anticipates supplemental claims to occur in FY 2021-22, however, these costs have not been determined and are not included in the estimate.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>FF</b>
FY 2010-11	\$5,683
FY 2011-12	\$4,178
<b>Total for FY 2020-21</b>	<b>\$9,861</b>

**Funding:**

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

## PATHWAYS TO WELL-BEING

**REGULAR POLICY CHANGE NUMBER:** 71  
**IMPLEMENTATION DATE:** 1/2013  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1718

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$961,000	\$1,006,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$961,000	\$1,006,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$961,000	\$1,006,000

**Purpose:**

This policy change estimates the costs for 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 in order to receive TFC services.

**Authority:**

SPA 09-004  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension - DHCS

**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, which include Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and TFC under the Specialty Mental Health Services (SMHS) waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. The parties met with the Special Master to develop a plan for settlement implementation.

As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive 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

## PATHWAYS TO WELL-BEING

### REGULAR POLICY CHANGE NUMBER: 71

Amendment (SPA) #09-004 for TFC. 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. Expenditures for ICC and IHBS are assumed to be fully reflected in the SMHS base policy change, SMHS for Children.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children’s Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is due to estimating an increase in the number of clients, and increase in the number of claims to be paid, based on updated actual claims paid for FY 2019-20. The current estimate includes the estimated FFCRA increased FMAP for TFC expenditures through June 30, 2021.

The change from FY 2020-21 and FY 2021-22, in the current estimate, is due to the addition of estimated TFC cost in FY 2021-22 based on the FY 2020-21 estimate including a three percent growth.

#### Methodology:

1. The cost estimate is based on an increase in the number of children receiving SMHS.
2. Actual claims for TFC services provided in FY 2018-19 were \$206,000 and were \$627,000 in FY 2019-20.
3. Assume claims for services provided in FY 2019-20 will be \$1,791,000 TF on an accrual basis.
4. Assume a 3% growth in claims for FY 2020-21 and FY 2021-22.
5. Assume the Department pays 35% of TFC claims in the year the services occur, and 65% is paid in the year after services occur.

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF (rounded)
FY 2019-20	TFC	\$1,790,774	0.65	\$1,164,000
FY 2020-21	TFC	\$1,844,497	0.35	\$646,000
Total FY 2020-21 Cash Estimate				\$1,810,000

**PATHWAYS TO WELL-BEING**  
REGULAR POLICY CHANGE NUMBER: 71

Fiscal Year	Service	Total Accrual	Payment Lag	Cash Estimate TF (rounded)
FY 2020-21	TFC	\$1,844,497	0.65	\$1,199,000
FY 2021-22	TFC	\$1,899,832	0.35	\$665,000
Total FY 2021-22 Cash Estimate				\$1,864,000

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2020-21	\$1,810	\$905	\$905
FY 2021-22	\$1,864	\$932	\$932

6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change. The total estimate for FY 2020-21 and FY 2021-22 is shown below:

(Dollars in Thousands)

Fiscal Year	TF	FF	FFCRA	CF
<b>FY 2020-21</b>	\$1,810	<b>\$905</b>	<b>\$56</b>	\$849
<b>FY 2021-22</b>	\$1,864	<b>\$932</b>	<b>\$74</b>	\$858

**Funding:**

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## LATE CLAIMS FOR SMHS

**REGULAR POLICY CHANGE NUMBER:** 72  
**IMPLEMENTATION DATE:** 7/2018  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1717

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$30,000	\$0
<b>- STATE FUNDS</b>	\$30,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$30,000	\$0
<b>STATE FUNDS</b>	\$30,000	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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 2020-21. The change from FY 2020-21 to FY 2021-22 is due to no additional late claims have been submitted for payment.

**Methodology:**

- Late claims are based on actual claims received from the counties.
- Assume GF will be used to pay claims in FY 2020-21 that exceed the federal claiming limit.

Cash Basis	TF	GF
FY 2020-21	\$30,000	\$30,000

**Funding:**

100% GF (4260-101-0001)



## SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

**REGULAR POLICY CHANGE NUMBER:** 73  
**IMPLEMENTATION DATE:** 1/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1660

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

### 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 nine payments totaling \$1,800,000.

### Reason for Change:

There is no change from the prior estimate for FY 2020-21. There is no change in the current estimate from FY 2020-21 to FY 2021-22.

### Methodology:

1. The Department began making repayments to CMS in January 2012 and 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.
2. Siskiyou County reimburses the GF \$200,000 annually. The county has submitted payments totaling \$1,800,000.

## SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

### REGULAR POLICY CHANGE NUMBER: 73

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	\$738,000	\$738,000	\$0
Subtotal	\$11,989,000	\$11,989,000	\$0
Repayments	(\$1,800,000)	\$0	\$0
Recoupments	(\$381,000)	\$0	\$0
Total	\$9,808,000	\$11,989,000	\$0

4. The estimate for FY 2020-21 and FY 2021-22 is as follows:

Fiscal Year	TF	GF	FF	Reimbursement
FY 2020-21	\$0	(\$200,000)	\$0	\$200,000
FY 2021-22	\$0	(\$200,000)	\$0	\$200,000

**Funding:**

100% GF (4260-101-0001)

Reimbursement GF (4260-601-0995)

## SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

**REGULAR POLICY CHANGE NUMBER:** 75  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2247

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$3,375,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$3,375,000
<b>FEDERAL FUNDS</b>	\$0	-\$3,375,000

**Purpose:**

This proposal estimates the ongoing costs resulting from Medi-Cal services provided to Medi-Cal beneficiaries while in Short-Term Residential Therapeutic Programs (STRTPs) that are classified as Institutions for Mental Diseases (IMD). This proposal estimates the amount of federal reimbursement the Department may need to return to the Centers for Medicare and Medicaid Services (CMS) in response to CMS guidance that STRTPs cannot be exempted from IMD determination.

**Authority:**

P.L. 115-123; 42 CFR 435.1009

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Congress enacted the Families First Prevention Services Act (FFPSA) on February 9, 2018. The intent of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care settings meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTPs) as a congregate care setting that may be used when specific criteria are met. In California, STRTPs are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs meet the requirements of QRTPs. The definition of a QRTP in Title IV-E overlaps with the definition of an IMD in Title XIX. Title XIX prohibits federal reimbursement for covered services provided to beneficiaries who are residents of an IMD.

On July 3, 2020, the Department sent a letter to CMS explaining why STRTPs do not meet the criteria to be classified as an IMD. CMS responded to the Department on July 30, 2020, and was unable to provide the Department with a blanket assurance that all STRTPs are not IMDs. As a result, the Department will need to assess each STRTP to determine whether or not the STRTP meets the criteria to be considered an IMD. Because federal regulations prohibit federal reimbursement for covered services provided to beneficiaries who are residents of an IMD, the Department will incur new costs for services provided to children and youth residing in STRTPs that would have been federally matchable prior to the IMD determination, including medically necessary services for physical health, mental health, dental, and substance use disorders.

## SHORT-TERM RESIDENTIAL THERAPEUTIC PROG / QRTPS

### REGULAR POLICY CHANGE NUMBER: 75

Although specialty mental health costs for beneficiaries in STRTP IMDs would be the responsibility of county mental health plans since the IMD exclusion pre-dates realignment, the Department would be responsible for costs associated with ancillary services provided to beneficiaries while a resident of an STRTP that is identified to be an IMD and will establish a process to repay federal funds on an ongoing basis.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. The Department will assess all STRTPs to determine which facilities are IMDs. This assessment will be completed by June 30, 2021.
2. This policy change estimates the ongoing cost of providing services to beneficiaries while residing in an STRTP that would have been Medicaid reimbursable prior to the IMD determination, beginning July 1, 2021.
3. All Medi-Cal costs, other than specialty mental health costs, are included in this estimate (Managed Care, Fee-for-Service, and Dental).
4. The Department determined the total cost of all Medi-Cal services provided to children and youth, and not claimed through the Short-Doyle Medi-Cal claiming system, while residing in an STRTP that could meet the criteria of an IMD.

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
<b>FY 2021-22</b>	\$0	<b>\$3,375</b>	<b>(\$3,375)</b>

#### Funding:

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

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

## CHART REVIEW

**REGULAR POLICY CHANGE NUMBER:** 76  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1714

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$41,000	-\$396,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$41,000	-\$396,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$41,000	-\$396,000

**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 2020-21, is a decreased recoupment estimate resulting from the postponement of FY 2019-20 chart reviews of four inpatient hospital reviews and nine outpatient county mental health provider reviews due to the COVID-19 Public Health Emergency (PHE). These are now rescheduled to take place in FY 2020-21, with estimated recoupments to occur in FY 2021-22.

The change from FY 2020-21 and FY 2021-22, in the current estimate, is an increase in recoupments due to accounting for the prior year postponed recoupments and additional FY 2020-21 recoupments in FY 2021-22.

**Methodology:**

1. The FY 2020-21 estimate includes actual and estimated recoupments from inpatient and outpatient chart reviews conducted for FY 2019-20.
2. The FY 2021-22 estimate includes estimated recoupments from inpatient and outpatient chart reviews to be conducted for FY 2019-20 that were postponed until FY 2020-21 due to the COVID-19 PHE, and includes recoupments for FY 2020-21.

**CHART REVIEW**  
**REGULAR POLICY CHANGE NUMBER: 76**

<b>Fiscal Year</b>	<b>TF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>(\$41,000)</b>	<b>(\$41,000)</b>
<b>FY 2021-22</b>	<b>(\$396,000)</b>	<b>(\$396,000)</b>

**Funding:**

100% Title XIX (4260-101-0890)

## INTERIM AND FINAL COST SETTLEMENTS - SMHS

**REGULAR POLICY CHANGE NUMBER:** 77  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1713

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$61,870,000	\$0
<b>- STATE FUNDS</b>	\$1,103,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$61,870,000	\$0
<b>STATE FUNDS</b>	\$1,103,000	\$0
<b>FEDERAL FUNDS</b>	-\$62,973,000	\$0

**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 2020-21 is due to:

- FY 2008-09, FY 2010-11, and FY 2011-12 audit settlements were updated, resulting in increased recoupments scheduled to be paid in FY 2020-21,
- FY 2012-13 and FY 2013-14 interim cost settlements were updated and resulted in increased recoupments, and
- FY 2014-15 interim cost settlements were included, decreasing the recoupments scheduled to be paid in FY 2020-21.

## INTERIM AND FINAL COST SETTLEMENTS - SMHS

### REGULAR POLICY CHANGE NUMBER: 77

The change in the current estimate for FY 2020-21 to FY 2021-22 is due to no underpayment or recoupments scheduled for FY 2021-22 at this time.

#### 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 2020-21 is:

(Dollars in Thousands)

<b>Interim Settlements</b>	<b>TF</b>	<b>GF</b>	<b>Title XIX</b>	<b>Title XXI</b>
FY 2011-12	(\$598)	\$0	(\$511)	(\$87)
FY 2012-13	(\$734)	\$0	(\$179)	(\$555)
FY 2013-14	(\$52,930)	\$0	(\$47,505)	(\$5,425)
FY 2014-15	\$1,456	\$0	\$2,150	(\$694)
<b>Subtotal</b>	<b>(\$52,806)</b>	<b>\$0</b>	<b>(\$46,045)</b>	<b>(\$6,761)</b>

(Dollars in Thousands)

<b>Audit Settlements</b>	<b>TF</b>	<b>GF</b>	<b>Title XIX</b>	<b>Title XXI</b>
FY 2008-09	\$2,485	\$418	\$2,046	\$21
FY 2010-11	\$1,248	\$685	\$581	(\$18)
FY 2011-12	(\$12,797)	\$0	(\$12,129)	(\$668)
<b>Subtotal</b>	<b>(\$9,064)</b>	<b>\$1,103</b>	<b>(\$9,502)</b>	<b>(\$665)</b>
<b>Total FY 2020-21</b>	<b>(\$61,870)</b>	<b>\$1,103</b>	<b>(\$55,547)</b>	<b>(\$7,426)</b>

#### 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:** 78  
**IMPLEMENTATION DATE:** 12/2015  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1951

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,209,581,000	\$2,387,038,000
<b>- STATE FUNDS</b>	\$890,060,000	\$1,193,519,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,209,581,000	\$2,387,038,000
<b>STATE FUNDS</b>	\$890,060,000	\$1,193,519,000
<b>FEDERAL FUNDS</b>	\$1,319,521,000	\$1,193,519,000

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

ACA DSH Reduction  
 COVID-19 Increased FMAP Extension – DHCS

**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 provides 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 steers 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, receive their allocation of the federal DSH payments through the Global Payment Program.

## GLOBAL PAYMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 78

On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a six-month GPP extension through December 31, 2020. An additional GPP one-year extension is under development which would extend the program from January 1, 2021 through December 31, 2021. If approved, a GPP renewal will be developed under the successor to the Medi-Cal 2020 demonstration, and is expected to exclude the SNCP funding component.

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 postponed the reduction until October 1, 2019. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019, and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the ACA DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. See the ACA DSH Reduction policy change for more information.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to the inclusion of one year of SNCP funding for program year (PY) 2020-21, and applying the FFCRA increased FMAP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the increased DSH allotment estimate for FY 2021-22, and the inclusion of six months of SNCP funding for PY 2021-22.

#### **Methodology:**

1. The PY for the Global Payment Program is from July 1 to June 30, to align with the state fiscal year.
2. On July 14, 2016, CMS approved \$236 million in SNCP funding for PY 2016-17 through PY 2019-20. The SNCP funding is assumed to continue through December 31, 2021.

## GLOBAL PAYMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 78

3. The total federal funding for the GPP for PY 2015-16 through PY 2021-22 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	\$931,427	\$236,000	\$1,167,427
PY 2018-19	\$967,116	\$236,000	\$1,203,116
PY 2019-20	\$981,730	\$257,948	\$1,239,678
PY 2020-21	\$999,535	\$257,948	\$1,257,483
PY 2021-22	\$1,022,181	\$118,000	\$1,140,181

4. Payments are made on a quarterly basis where three quarters are paid in the current fiscal year and the fourth quarter is paid the following fiscal year.
5. The PY 2017-18 round 6 final close out recoupment of \$6.406 million TF will occur in FY 2020-21.
6. The PY 2018-19 final reconciliation net payment of \$98.416 million TF will occur in FY 2020-21.
7. Assume PY 2020-21 includes the CMS approved six-month extension period from July 1, 2020 through December 31, 2020 and six months of the one-year extension under development from January 1, 2021 through June 30, 2021. PY 2020-21 assumes the inclusion SNCP funding.
8. Assume PY 2021-22 includes six months of the one-year extension from July 1, 2021 through December 31, 2021, which is under development and assumes the inclusion of SNCP funding. Assume January 1, 2022 through June 30, 2022 is pending the GPP renewal development and submission to CMS, which will exclude SNCP funding.
9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**GLOBAL PAYMENT PROGRAM**  
REGULAR POLICY CHANGE NUMBER: 78

10. The estimated GPP payments on a cash basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>	<b>FFCRA</b>
PY 2017-18	(\$6,406)	(\$3,203)	(\$3,203)	\$0
PY 2018-19	\$98,416	\$49,208	\$49,208	\$0
PY 2019-20	\$429,671	\$104,755	\$276,053	\$48,863
PY 2020-21	\$1,687,900	\$739,300	\$843,950	\$104,650
<b>Total</b>	<b>\$2,209,581</b>	<b>\$890,060</b>	<b>\$1,166,008</b>	<b>\$153,513</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>
PY 2020-21	\$617,768	\$308,884	\$308,884
PY 2021-22	\$1,769,270	\$884,635	\$884,635
<b>Total</b>	<b>\$2,387,038</b>	<b>\$1,193,519</b>	<b>\$1,193,519</b>

**Funding:**

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

100% Global Payment Program Special Fund (4260-601-8108)

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)

## PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL

**REGULAR POLICY CHANGE NUMBER:** 79  
**IMPLEMENTATION DATE:** 8/2016  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1950

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,039,219,000	\$0
<b>- STATE FUNDS</b>	\$440,129,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,039,219,000	\$0
<b>STATE FUNDS</b>	\$440,129,000	\$0
<b>FEDERAL FUNDS</b>	\$599,090,000	\$0

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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: 79**

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- Inclusion of DY 2017-18 adjustment payments,
- Inclusion of remaining DY 2018-19 supplemental and high performance pool fund payments,
- DY 2019-20 semi-annual payments shifted from FY 2019-20 to FY 2020-21,
- Updated DY 2019-20 payment data, and
- Inclusion of the FFCRA increased FMAP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due the completion of the program payments in FY 2020-21.

#### **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. 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. Remaining adjustment payments to DMPHs will be paid in FY 2020-21.
4. 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. DY 2018-19 high performance pool payments, will be paid in FY 2020-21.
5. In DY 2019-20, the annual allocation to DMPHs and DPHs was phased down by an additional 15%. In FY 2019-20, the first semi-annual payment for DY 2019-20 was estimated based on the additional 15% phased down allocation. In FY 2020-21, the annual payment for DY 2019-20 is estimated based on the additional 15% phased down allocation.
6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased

**PUBLIC HOSPITAL REDESIGN & INCENTIVES IN MEDI-CAL**  
**REGULAR POLICY CHANGE NUMBER: 79**

FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>	<b>FFCRA</b>
DY 2017-18				
DPH	\$0	\$0	\$0	\$0
DMPH	\$777,000	\$388,000	\$389,000	\$0
Total	\$777,000	\$388,000	\$389,000	\$0
DY 2018-19				
DPH	\$89,576,000	\$44,788,000	\$44,788,000	\$0
DMPH	\$46,737,000	\$23,503,000	\$23,234,000	\$0
Total	\$136,313,000	\$68,291,000	\$68,022,000	\$0
DY 2019-20				
DPH	\$795,385,000	\$348,378,000	\$397,693,000	\$49,314,000
DMPH	\$106,744,000	\$46,754,000	\$53,372,000	\$6,618,000
Total	\$902,129,000	\$395,132,000	\$451,065,000	\$55,932,000
<b>Total FY 2020-21</b>	<b>\$1,039,219,000</b>	<b>\$463,811,000</b>	<b>\$519,476,000</b>	<b>\$55,932,000</b>

**Funding:**

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

100% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

6.2% FFCRA Increased FFP (4260-101-0890)

## MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

**REGULAR POLICY CHANGE NUMBER:** 80  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1953

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,038,646,000	\$600,000,000
<b>- STATE FUNDS</b>	\$414,481,000	\$300,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,038,646,000	\$600,000,000
<b>STATE FUNDS</b>	\$414,481,000	\$300,000,000
<b>FEDERAL FUNDS</b>	\$624,165,000	\$300,000,000

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 Department requested a one-year extension for the 2020 Medi-Cal Waiver, to extend the provisions of the waiver, including WPC, to December 31, 2021. The extension is pending based on CMS' approval. We anticipate receiving a decision from CMS before the end of the calendar year 2020.

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



## MEDI-CAL 2020 WHOLE PERSON CARE PILOTS

### REGULAR POLICY CHANGE NUMBER: 80

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 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 WPC 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 2020-21 is due to an increase in unexpended funding from PY4 (CY 2019) having rolled into PY5 (CY 2020) as well as delayed invoice processing. The Department allowed Lead Entities (LEs) to submit their invoices a month later than usual due to the impact of COVID-19.

The change from FY 2020-21 to FY 2021-22 is a decrease, due to updated cost estimates for the requested program year extension. WPC is a five-year pilot program set to end in December 2020; however an extension has been requested for an additional program year. The Department anticipates to receive a decision from CMS before the end of calendar year 2020.

#### **Methodology:**

1. First Round LEs 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 LEs 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.

## **MEDI-CAL 2020 WHOLE PERSON CARE PILOTS**

### **REGULAR POLICY CHANGE NUMBER: 80**

3. Payments are made through an Intergovernmental Transfer process.
4. For First Round LEs, PYs correspond to calendar years. PY 1 began January 1, 2016.
5. For Second Round LEs, PY 1 was 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 LEs and correspond to calendar years. PY 3 began January 2018.
6. PY 3 payments were made in October 2018, and May 2019.
7. PY 4 payments were made in October 2019, June 2020, and July 2020.
8. PY 5 payments will be made in November 2020, and June 2021.
9. LEs may roll over unused funds from the prior PY. The rollover process affects actual expenditures in the current year and projected expenditures in the budget year. The PY4 budget rollover process was finalized after July 2019; therefore, the total funding for FY 2020-21 was changed.
10. A county withdrew from WPC in June 2018. When the county withdrew from WPC, the county's budget was deducted from the overall program budget; therefore, the total funding for FY 2020-21 was changed.
11. The payment process for FY 2019-20 was delayed by a month, causing many payments to be processed in FY 2020-21. The Department allowed additional time for LEs to submit their invoices due to the COVID-19 pandemic. Some invoices were processed on time in June 2020; however, the majority of invoices were processed in July 2020.
12. The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.
13. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
14. DHCS requested a one-year extension for the 2020 Medi-Cal Waiver, to extend the provisions of the waiver, including WPC, to December 31, 2021. The extension and the estimated budget of \$600M is pending based on CMS' approval. We anticipate receiving a decision from CMS before the end of the calendar year 2020. The enhanced FMAP is not applied to this estimated budget; therefore, would reflect 50% federal funds and 50% local match dollars.

**MEDI-CAL 2020 WHOLE PERSON CARE PILOTS**  
REGULAR POLICY CHANGE NUMBER: 80

15. Below is the expected payment for FY 2020-21 and FY 2021-22:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>IGT*</b>	<b>FF</b>
Fed Share Only Title XIX	\$571,744	\$0	\$571,744
WPC Pilot Special Fund	\$414,481	\$414,481	\$0
FFCRA 6.2% FFP	\$52,421	\$0	\$52,421
<b>Total</b>	<b>\$1,038,646</b>	<b>\$414,481</b>	<b>\$624,165</b>

Totals may differ due to rounding.

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>IGT*</b>	<b>FF</b>
Fed Share Only Title XIX	\$300,000	\$0	\$300,000
WPC Pilot Special Fund	\$300,000	\$300,000	\$0
<b>Total</b>	<b>\$600,000</b>	<b>\$300,000</b>	<b>\$300,000</b>

Totals may differ due to rounding.

**Funding:**

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

\*Whole Person Care Pilot Special Fund (4260-601-8107)

FFCRA 6.2% Increased FFP (4260-113-0890)

FFCRA 6.2% GF (4260-101-0001)

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

**REGULAR POLICY CHANGE NUMBER:** 81  
**IMPLEMENTATION DATE:** 1/2017  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1954

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$242,033,000	\$205,358,000
<b>- STATE FUNDS</b>	\$106,009,500	\$102,679,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	29.93 %	26.65 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$169,592,500	\$150,630,100
<b>STATE FUNDS</b>	\$74,280,860	\$75,315,050
<b>FEDERAL FUNDS</b>	\$95,311,670	\$75,315,050

**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) Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

## **MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE**

### **REGULAR POLICY CHANGE NUMBER: 81**

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. 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. Of the eleven pilot counties selected, the Department has only seen payment activity in five counties. As of January 1, 2019, this domain has expanded to eighteen additional counties. The attributes considered when selecting these counties for expansion were ratio of restorative to preventative services (greater than 45%), provider populations, and robust eligible beneficiary count.

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. As of January 1, 2019, this domain has expanded to include 19 counties and a rate increase of \$60. The Department hopes to increase utilization and participation with the expansion efforts.

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.

The Medi-Cal 2020 Waiver was scheduled to sunset at the end of calendar year 2020, but the Department is working with Centers for Medicare & Medicaid Services (CMS) on an extension.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net increase due to an increase in Domain 3 payments made in July 2020, an increase in Domain 2 estimate due to updated check write data, and the extension of the Medi-Cal Waiver 2020 for an additional year of Domains 1-3. However, there is a slight decrease in Domain 1 payments in FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to the phase out of Domains 1-3 and costs for Domain 4 concluding in FY 2020-21.

## MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

### REGULAR POLICY CHANGE NUMBER: 81

#### 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 2020-21 includes incentive payments for CY 2020 and the remainder of CY 2019 and FY 2021-22 includes incentive payments for CY 2021 and the remainder of CY 2020.
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 has re-baselined providers who have participated for two program years and has trended the expenditures to account for providers who will not make their future benchmarks.

Total Domain 1 costs are estimated to be:

Fiscal Year	TF	GF	FF
FY 2020-21	\$56,524,000	\$24,757,000	\$31,767,000
FY 2021-22	\$57,276,000	\$28,638,000	\$28,638,000

##### Domain 2: Caries Risk Assessment and Disease Management

5. This four year incentive program was 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 2020-21 includes incentive payments for the second six months of CY 2020 and first six months of CY 2021 while FY 2021-22 will include incentive payments for the second six months of CY 2021 and the first six months of CY 2022.

Total Domain 2 costs are estimated to be:

## MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

### REGULAR POLICY CHANGE NUMBER: 81

Fiscal Year	TF	GF	FF
<b>FY 2020-21</b>	<b>\$81,393,000</b>	<b>\$35,650,000</b>	<b>\$45,743,000</b>
<b>FY 2021-22</b>	<b>\$61,498,000</b>	<b>\$30,749,000</b>	<b>\$30,749,000</b>

#### 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 2020-21 will include incentive payments for CY 2019 and runout for CY 2018, while FY 2021-22 includes incentive payments for FY 2020 and runout for FY 2019.
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.

Total Domain 3 costs are estimated to be:

Fiscal Year	TF	GF	FF
<b>FY 2020-21</b>	<b>\$83,913,000</b>	<b>\$36,754,000</b>	<b>\$47,159,000</b>
<b>FY 2021-22</b>	<b>\$86,584,000</b>	<b>\$43,292,000</b>	<b>\$43,292,000</b>

#### 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).

## MEDI-CAL 2020 DENTAL TRANSFORMATION INITIATIVE

### REGULAR POLICY CHANGE NUMBER: 81

Total Domain 4 costs are estimated to be:

Fiscal Year	TF	GF	FF
<b>FY 2020-21</b>	<b>\$20,204,000</b>	<b>\$8,849,000</b>	<b>\$11,355,000</b>
<b>FY 2021-22</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

17. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

18. On a cash basis, the FY 2020-21 and FY 2021-22 total demonstration costs are:

FY 2020-21	TF	GF	FF
Domain 1	\$56,524,000	\$24,757,000	\$31,767,000
Domain 2	\$81,393,000	\$35,650,000	\$45,743,000
Domain 3	\$83,913,000	\$36,754,000	\$47,159,000
Domain 4	\$20,204,000	\$8,849,000	\$11,355,000
<b>Total</b>	<b>\$242,034,000</b>	<b>\$106,010,000</b>	<b>\$136,024,000</b>

FY 2021-22	TF	GF	FF
Domain 1	\$57,276,000	\$28,638,000	\$28,638,000
Domain 2	\$61,498,000	\$30,749,000	\$30,749,000
Domain 3	\$86,584,000	\$43,292,000	\$43,292,000
Domain 4	\$0	\$0	\$0
<b>Total</b>	<b>\$205,358,000</b>	<b>\$102,679,000</b>	<b>\$102,679,000</b>

\*Totals may not add due to rounding

#### Funding:

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

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 6.2% GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 82  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Joy Oda  
 FISCAL REFERENCE NUMBER: 1769

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
FULL YEAR COST - TOTAL FUNDS	\$324,000	\$316,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$324,000	\$316,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$324,000	\$316,000

### 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: 82

#### 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 in 2009 include:

- Acupuncture<sup>3</sup>
- Audiology<sup>5</sup>
- Chiropractic
- Dental<sup>1,4</sup>
- Incontinence creams and washes<sup>5</sup>
- Optician/optical lab<sup>5</sup>
- Podiatry<sup>5</sup>
- Psychology<sup>2</sup>
- Speech therapy<sup>5</sup>

<sup>1</sup>AB 82 (Chapter 23, Statutes of 2013) restored certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration did not affect calendar year 2013. For calendar year (CY) 2014, eliminated dental services were claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and are no longer claimable under this program.

<sup>2</sup>SBX1 1 (Chapter 4, Statutes of 2013) restored psychology services, effective January 1, 2014.

<sup>3</sup>SB 833 (Chapter 30, Statutes of 2016) restored acupuncture services, effective July 1, 2016.

<sup>4</sup>SB 97 (Chapter 52, Statutes of 2017) restored full adult dental benefits, effective January 1, 2018.

## UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

### REGULAR POLICY CHANGE NUMBER: 82

<sup>5</sup>SB 78 (Chapter 38, Statutes of 2019) restored coverage for audiology, optician and optical lab, incontinence creams and washes, podiatry, and speech therapy in the Medi-Cal program, effective January 1, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to updated encounter data and the actual IHS global encounter rate for CY 2020.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to remaining CY 2019 payments which included more encounters, and decreased estimated encounter data beginning in CY 2020 due to the restoration of additional benefits effective January 1, 2020.

#### Methodology:

1. The Department is pursuing a one-year extension for the Medi-Cal 2020 waiver. Assume IHS payments will continue through December 31, 2021.
2. Assume 51 outstanding encounters for CY 2019 will be paid in FY 2020-21.
3. Assume 628 encounters for CY 2020 will be paid over four quarters in FY 2020-21, and 32 outstanding encounters will be paid in FY 2021-22.
4. Assume 628 encounters for the CY 2021 will be paid over four quarters in FY 2021-22, and 32 outstanding encounters will be paid in a future year.
5. Assume no encounter data impact with the expected suspension of adult optional benefits outlined in SB 78 (Chapter 38, Statutes of 2019) on December 31, 2021.
6. The IHS global encounter rate is updated on the Federal Register for each CY. For CY 2020, the rate is \$479. Assume the rate is \$479 for CY 2021.
7. IHS claims are paid for each encounter. Assume 660 encounters for CY 2020 and CY 2021.

Calendar Year 2020	660 encounters x	\$479 =	\$316,140 FF
Calendar Year 2021	660 encounters x	\$479 =	\$316,140 FF

8. Assume IHS payments will be made as follows on a cash basis:

FY 2020-21	TF	FF
Calendar Year 2019	\$23,000	\$23,000
Calendar Year 2020	\$301,000	\$301,000
<b>Total</b>	<b>\$324,000</b>	<b>\$324,000</b>

FY 2021-22	TF	FF
Calendar Year 2020	\$15,000	\$15,000
Calendar Year 2021	\$301,000	\$301,000
<b>Total</b>	<b>\$316,000</b>	<b>\$316,000</b>

**UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG**  
REGULAR POLICY CHANGE NUMBER: 82

**Funding:**

100% Health Care Support Fund (4260-601-7503)

## MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 83  
**IMPLEMENTATION DATE:** 11/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1952

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$94,542,000	-\$158,900,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$94,542,000	-\$158,900,000
<b>FEDERAL FUNDS</b>	\$94,542,000	\$158,900,000

**Purpose:**

This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using state only programs 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

## MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM

### REGULAR POLICY CHANGE NUMBER: 83

**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:

<b>State Only Medical Programs</b>
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)
<b>Workforce Development Programs</b>
Office of Statewide Health Planning & Development (OSHPD)
<ul style="list-style-type: none"> <li>• Song-Brown Health Care Workforce Training</li> <li>• Steven M. Thompson Physician Corp Loan Repayment Program (STLRP)</li> <li>• Mental Health Loan Assumption Program (MHLAP)</li> </ul>

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 2020-21, from the prior estimate, is due to a slight increase in claiming data based on updated actual DTI expenditures.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to higher expected claiming amounts for FY 2021-22.

**Methodology:**

1. Program allocations are updated based on actual claims for FY 2020-21. Assume \$158.9 million FFP will be claimed in FY 2021-22.
2. Assume a one-year Medi-Cal 2020 waiver extension to continue Medi-Cal 2020 DSHP claiming.
3. On a cash basis, the total DSHP payments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	\$0	(\$94,542)	\$94,542
FY 2021-22	\$0	(\$158,900)	\$158,900

**MEDI-CAL 2020 DESIGNATED STATE HEALTH PROGRAM**  
**REGULAR POLICY CHANGE NUMBER: 83**

**Funding:**

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

**BTR - LIHP - MCE**

**REGULAR POLICY CHANGE NUMBER:** 84  
**IMPLEMENTATION DATE:** 7/2011  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1578

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$7,214,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$7,214,000	\$0
<b>FEDERAL FUNDS</b>	-\$7,214,000	\$0

**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: 84**

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 2020-21, from the prior estimate, is due to the delay of the remaining DY 2011-12 recoupments which shifted from FY 2019-20 to FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of the outstanding recoupments in FY 2020-21.

**Methodology:**

1. The remaining DY 2011-12 final reconciliation recoupments will occur in FY 2020-21.

The outstanding MCE recoupments on a cash basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>
2011-12	\$0	\$7,214	(\$7,214)
<b>Total FY 2020-21</b>	<b>\$0</b>	<b>\$7,214</b>	<b>(\$7,214)</b>

**Funding:**

Title XIX (4260-101-0890)

LIHP IGT Fund (4260-607-8502)

**MH/UCD—SAFETY NET CARE POOL**

**REGULAR POLICY CHANGE NUMBER:** 85  
**IMPLEMENTATION DATE:** 9/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1072

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$26,021,000	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$26,021,000	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$26,021,000	\$0

**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 health care 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.

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

## MH/UCD—SAFETY NET CARE POOL

### REGULAR POLICY CHANGE NUMBER: 85

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 2020-21, from the prior estimate, is due to the delay in DY 2007-08, DY 2008-09, and DY 2009-10 recoupments which shifted from FY 2019-20 to FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of the remaining recoupments in FY 2020-21.

#### Methodology:

1. The final reconciliation payments for DY 2007-08, DY 2008-09, and DY 2009-10 were completed FY 2019-20.

The outstanding recoupments on a cash basis are:

(Dollars in Thousands)

FY 2020-21	FF
DY 2007-08	(\$5,287)
DY 2008-09	(\$16,374)
DY 2009-10	(\$4,360)
<b>Total</b>	<b>(\$26,021)</b>

#### Funding:

100% Health Care Support Fund (4260-601-7503)

## 2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP.

**REGULAR POLICY CHANGE NUMBER:** 89  
**IMPLEMENTATION DATE:** 9/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2178

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,176,921,000	\$2,528,944,000
<b>- STATE FUNDS</b>	\$1,142,755,720	\$927,812,450
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,176,921,000	\$2,528,944,000
<b>STATE FUNDS</b>	\$1,142,755,720	\$927,812,450
<b>FEDERAL FUNDS</b>	\$2,034,165,280	\$1,601,131,550

**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:**

AB 115 (Chapter 348, Statutes of 2019)

**Interdependent Policy Changes:**

2020 MCO Enrollment Tax Mgd. Care Plans  
 2020 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. 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 for the three year period of January 1, 2020, through December 31, 2022.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a slight decrease due to updated funding splits and rounding of the actuarially certified per member per month rates attributable to the January 2020 through December 2020 rating period. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the FY 2020-21 amounts including retroactive payments attributable to the January 2020 through June 2020 rating period.

## 2020 MCO ENROLLMENT TAX MGD. CARE PLANS-INCR. CAP. REGULAR POLICY CHANGE NUMBER: 89

### 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 and “all-other” enrollees as defined in AB 115.
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. Assume the January 2020 to June 2020 (FY 2019-20) estimated payments will occur in FY 2020-21.
6. Starting FY 2020-21, assume a one month payment lag for all plans subject to MCO tax.
7. FFCRA increased FMAP is assumed for expenditures through June 30, 2021, and is budgeted for in the COVID-19 Increased FMAP – DHCS policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change. The estimated federal funds increase is \$133,217,000 for FY 2020-21 and \$8,466,000 for FY 2021-22.
8. The costs of capitation rate increases related to the imposition of the MCO Enrollment Tax are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	GF (MCO Tax)	FF
FY 2020-21	\$3,176,921	\$1,142,755	\$2,034,165
FY 2021-22	\$2,528,944	\$927,812	\$1,601,132

### Funding:

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CCI-MANAGED CARE PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 90  
**IMPLEMENTATION DATE:** 4/2014  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1766

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,489,560,000	\$8,798,756,000
<b>- STATE FUNDS</b>	\$4,244,780,000	\$4,399,378,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	65.89 %	66.17 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,895,788,900	\$2,976,619,200
<b>STATE FUNDS</b>	\$1,447,894,460	\$1,488,309,580
<b>FEDERAL FUNDS</b>	\$1,447,894,460	\$1,488,309,580

**Purpose:**

This policy change estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioned 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:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

In coordination with Federal and State Government, the Coordinated Care Initiative (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.

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 as of January 1, 2018.

## CCI-MANAGED CARE PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 90

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a slight decrease due to updated rate payment timing and updated draft budget rates for CY 2020 and CY 2021. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to CY 2022 rates being assumed equal to CY 2021 draft budget 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 and individuals receiving partial Medicare coverage had their LTC and community-based services included in Medi-Cal managed care no later than July 1, 2014, except for Orange County. Orange County began July 1, 2015.
3. Paid rates vary throughout the fiscal year depending on the most recently available approved rates. CY 2019, Bridge Period (July 2019 – December 2020), CY 2020, and CY 2021 rates will be paid in FY 2020-21, while CY 2021 and CY 2022 rates will be paid in FY 2021-22.
4. Estimated below is the overall impact of the CCI demonstration in FY 2020-21 and FY 2021-22.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimb</b>	<b>HTF</b>
CCI-Managed Care Payments:					
Base managed care payments	\$8,491,294	\$4,244,780	\$4,245,647	\$0	\$867
Prop 56 - ICF/DD Supplemental Payments	(\$1,734)		(\$867)		(\$867)
<b>Total Managed Care Payments</b>	<b>\$8,489,560</b>	<b>\$4,244,780</b>	<b>\$4,244,780</b>	<b>\$0</b>	<b>\$0</b>
CCI-Savings and Deferral :					
Total Savings (In the Base)	(\$8,524,321)	(\$4,262,160)	(\$4,262,160)	\$0	
CCI-Admin Costs, HCO Costs	\$12,223	\$6,112	\$6,112	\$0	
Retro MC Rate Adjustments	\$144,922	\$71,898	\$73,025	\$0	\$0
CCI-Quality Withhold Repayments	\$16,822	\$8,411	\$8,411	\$0	
Health Insurer Fee	\$924	\$462	\$462	\$0	
Total of CCI PCs including pass through	\$140,130	\$69,502	\$70,629	\$0	

\*Totals may differ due to rounding.

**CCI-MANAGED CARE PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 90

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimb</b>	<b>HTF</b>
CCI-Managed Care Payments:					
Base managed care payments	\$8,800,450	\$4,399,378	\$4,400,225	\$0	\$847
Prop 56 - ICF/DD Supplemental Payments	(\$1,694)		(\$847)		(\$847)
<b>Total Managed Care Payments</b>	<b>\$8,798,756</b>	<b>\$4,399,378</b>	<b>\$4,399,378</b>	<b>\$0</b>	<b>\$0</b>
CCI-Savings and Deferral :					
Total Savings (In the Base)	(\$8,838,656)	(\$4,419,328)	(\$4,419,328)	\$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	\$0	\$0	\$0	\$0	
Total of CCI PCs including pass through	(\$10,855)	(\$5,427)	(\$5,427)	\$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)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## MANAGED CARE PUBLIC HOSPITAL EPP

**REGULAR POLICY CHANGE NUMBER:** 91  
**IMPLEMENTATION DATE:** 9/2019  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2060

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,517,179,000	\$1,208,317,000
<b>- STATE FUNDS</b>	\$697,155,340	\$403,446,780
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,517,179,000	\$1,208,317,000
<b>STATE FUNDS</b>	\$697,155,340	\$403,446,780
<b>FEDERAL FUNDS</b>	\$1,820,023,660	\$804,870,220

**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)  
 Title 42, Code of Federal Regulations (CFR), Section 438.6(c)

**Interdependent Policy Changes:**

Managed Care Reimbursements to the General Fund  
 COVID-19 Increased FMAP – DHCS

**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 states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plan (MCP) contracts based on allowable directed payments.

Effective July 1, 2017, with the FY 2017-18 rating period, the Department directed MCPs to make enhanced network contracted payments to California's 21 DPHs. 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: 91**

Prior to implementation of a directed payment program, CMS requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form. This “pre-print” is typically submitted on an annual basis.

On December 17, 2018, the Department received CMS pre-print approval to continue the EPP Directed Payment program for the FY 2018-19 rating period. On June 30, 2019, the Department submitted a pre-print requesting program continuation and approval for the July 1, 2019 through December 31, 2020 rating period.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the earlier timing of payments associated with the July 1, 2019, through June 30, 2020, portion of the Bridge Period Capitated sub-pool, resulting in costs shifting from FY 2021-22 to FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to fewer program periods anticipated to pay, on a cash basis, in FY 2021-22 compared to FY 2020-21. Additionally, for both FY 2020-21 and FY 2021-22, the funding splits have been revised based on updated enrollment data for FY 2018-19 and the Bridge Period (July 1, 2019 through December 31, 2020).

#### **Methodology:**

1. The value of the entire public hospital EPP pool is \$1,541,109,000 TF for rating period FY 2018-19 on an accrual basis.
2. The value of the entire public hospital EPP pool is \$2,544,528,000 TF for the July 1, 2019, through December 31, 2020, (Bridge Period) rating period on an accrual basis.
3. The FY 2018-19 Capitated sub-pool payments were made in September 2020.
4. The FY 2018-19 FFS sub-pool payments are split into two separate payment periods. The July 1, 2018, through December 31, 2018, period was paid in September 2020. The January 1, 2019, through June 30, 2019, period will pay in March 2021.
5. The payments associated with the July 1, 2019, through December 31, 2019, portion of the Bridge Period Capitated sub-pool are anticipated to be made in March 2021. The payments associated with the January 1, 2020, through June 30, 2020, portion of the Bridge Period Capitated sub-pool are anticipated to be made in May 2021.
6. The payments associated with the July 1, 2019, through December 31, 2019, portion of the Bridge Period FFS sub-pool are anticipated to be made in September 2021. The payments associated with the January 1, 2020, through June 30, 2020, portion of the Bridge Period FFS sub-pool and the payments associated with the July 1, 2020, through December 31, 2020, portion of the Bridge Period Capitated sub-pool are anticipated to be made in March 2022.

**MANAGED CARE PUBLIC HOSPITAL EPP**  
REGULAR POLICY CHANGE NUMBER: 91

7. On a cash basis, the estimated payments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>ACA</b>
Title XIX	\$1,196,934	\$598,467	\$598,467	\$0
Title XXI 88/12	\$47,584	\$5,710	\$41,874	\$0
Title XXI 76.5/23.5	\$18,887	\$4,438	\$14,448	\$0
ACA 2018 94/6	\$450,781	\$27,047	\$0	\$423,734
ACA 2019 93/7	\$626,887	\$43,882	\$0	\$583,005
ACA 2020 90/10	\$176,106	\$17,611	\$0	\$158,496
<b>Total FY 2020-21</b>	<b>\$2,517,179</b>	<b>\$697,155</b>	<b>\$654,789</b>	<b>\$1,165,235</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>ACA</b>
Title XIX	\$706,104	\$353,052	\$353,052	\$0
Title XXI 88/12	\$5,057	\$607	\$4,450	\$0
Title XXI 76.5/23.5	\$21,466	\$5,044	\$16,421	\$0
Title XXI 65/35	\$6,295	\$2,203	\$4,092	\$0
ACA 2019 93/7	\$146,644	\$10,265	\$0	\$136,379
ACA 2020 90/10	\$322,751	\$32,275	\$0	\$290,476
<b>Total FY 2021-22</b>	<b>\$1,208,317</b>	<b>\$403,447</b>	<b>\$378,015</b>	<b>\$426,855</b>

\*Total may differ due to rounding.

**Funding:**

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

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)

90% Title XIX ACA 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)

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

## MANAGED CARE HEALTH CARE FINANCING PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 92  
**IMPLEMENTATION DATE:** 5/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2061

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,928,567,000	\$1,061,465,000
<b>- STATE FUNDS</b>	\$656,872,360	\$369,493,650
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,928,567,000	\$1,061,465,000
<b>STATE FUNDS</b>	\$656,872,360	\$369,493,650
<b>FEDERAL FUNDS</b>	\$1,271,694,640	\$691,971,350

**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:**

COVID-19 Increased FMAP – DHCS

**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 2020-21, is an increase due to updated program participation levels. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to FY 2020-21 total payments consisting of the first twelve months of the 18-month Bridge Period (July 2019 through December 2020) and FY 2021-22 total payments consisting of the final six months of the 18-month Bridge Period.

**Methodology:**

1. The Managed Care Health Care Financing Program began with the FY 2018-19 rating period.
2. Based on final participation levels for the first twelve months of the 18-month Bridge Period, it is estimated total payments of \$1,928,567,000 TF are occurring in FY 2020-21.
3. Based on preliminary participation levels for the final six months of the 18-month Bridge Period, it is estimated total payments will be \$1,061,465,000 TF, and are anticipated to occur in FY 2021-22.

**MANAGED CARE HEALTH CARE FINANCING PROGRAM**  
REGULAR POLICY CHANGE NUMBER: 92

## 4. Anticipated costs on a cash basis are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Bridge Period Title XIX	\$1,149,984	\$574,992	\$574,992
Bridge Period Title XXI 88/12	\$31,828	\$3,819	\$28,009
Bridge Period Title XXI 76.5/23.5	\$96,576	\$22,695	\$73,881
Bridge Period ACA 93/7	\$321,742	\$22,522	\$299,220
Bridge Period ACA 90/10	\$328,437	\$32,844	\$295,593
<b>Total for FY 2020-21</b>	<b>\$1,928,567</b>	<b>\$656,872</b>	<b>\$1,271,695</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Bridge Period Title XIX	\$626,001	\$313,000	\$313,000
Bridge Period Title XXI 76.5/23.5	\$33,629	\$7,903	\$25,727
Bridge Period Title XXI 65/35	\$33,629	\$11,770	\$21,859
Bridge Period ACA 90/10	\$368,206	\$36,821	\$331,385
<b>Total for FY 2021-22</b>	<b>\$1,061,465</b>	<b>\$369,494</b>	<b>\$691,971</b>

\*Totals may differ due to rounding.

**Funding:**

50% Title XIX / 50% 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)

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

## MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

**REGULAR POLICY CHANGE NUMBER:** 93  
**IMPLEMENTATION DATE:** 9/2019  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2062

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,324,714,000	\$962,754,000
<b>- STATE FUNDS</b>	\$315,840,480	\$246,967,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,324,714,000	\$962,754,000
<b>STATE FUNDS</b>	\$315,840,480	\$246,967,500
<b>FEDERAL FUNDS</b>	\$1,008,873,520	\$715,786,500

**Purpose:**

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:**

Managed Care Reimbursements to the General Fund  
 COVID-19 Increased FMAP – DHCS

**Background:**

The Centers for Medicare & Medicaid Services (CMS) instituted the final rule which modernized Medicaid managed care regulations. Title 42, Code of Federal Regulations, section 438.6 (c) provides states flexibility to implement delivery system and provider payment initiatives under MCP contracts based on allowable directed payments.

Effective July 1, 2017, for the FY 2017-18 rating period, the Department has directed MCPs to make QIP payments to DPHs tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. 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).

Prior to implementation of a directed payment program, CMS requires states seek pre-approval of any requested directed payment program through the standard CMS “pre-print” form.

On December 17, 2018, the Department received CMS pre-print approval to continue the QIP Directed Payment program through June 30, 2021.

## MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL

### REGULAR POLICY CHANGE NUMBER: 93

The Department requested CMS pre-print approval to implement two new QIP program for DPHs and District Municipal Public Hospitals (DMPHs) for the period of July 1, 2020, through December 31, 2020. The new programs will be separate and distinct from the existing Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program. The goal of the new programs is to enable hospitals to continue quality improvement efforts that have been underway subsequent to the June 30, 2020, expiration of the PRIME program. Due to the timing of quality data reporting for this period, payments are expected to be issued in FY 2021-22.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase due to payment for the first 12 months of the 18-month Bridge Period (July 1, 2019 through December 31, 2020) shifting from FY 2021-22 to FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to FY 2020-21 total payments consisting of the first twelve months of the 18-month Bridge Period and FY 2021-22 total payments consisting of the final six months of the 18-month Bridge Period.

#### Methodology:

1. The maximum value of the FY 2018-19 QIP is \$667.8 million total fund. During the FY 2018-19 period, a portion of the quality metrics were met by the participating public hospitals, which resulted in 93.3% (\$623.2 million) of the total pool amount being paid out in FY 2020-21.
2. The maximum value of the Bridge Period QIP is \$1.664 billion total fund. Assume 12 months of the Bridge Period pool (July 1, 2019 through June 30, 2020) will pay in FY 2020-21. Assume 6 months of the Bridge Period pool (July 1, 2020 through December 31, 2020) will pay in FY 2021-22.
3. On a cash basis, the estimated FY 2018-19 and Bridge Period QIP payments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>ACA</b>
FY 2018-19 Title XIX	\$235,345	\$117,672	\$117,672	\$0
FY 2018-19 ACA 2018 94/6	\$185,080	\$11,105	\$0	\$173,975
FY 2018-19 ACA 2019 93/7	\$185,080	\$12,956	\$0	\$172,125
FY 2018-19 Title XXI	\$17,701	\$2,124	\$15,577	\$0
BP Jul'19-Jun'20 Title XIX	\$264,914	\$132,457	\$132,457	\$0
BP Jul'19-Jun'20 ACA 2019 93/7	\$208,334	\$14,583	\$0	\$193,751
BP Jul'19-Jun'20 ACA 2020 90/10	\$208,334	\$20,833	\$0	\$187,501
BP Jul'19-Jun'20 Title XXI 88/12	\$4,981	\$884	\$4,097	\$0
BP Jul'19-Jun'20 Title XXI 76.5/23.5	\$14,944	\$3,225	\$11,719	\$0
<b>Total FY 2020-21</b>	<b>\$1,324,714</b>	<b>\$315,840</b>	<b>\$281,522</b>	<b>\$727,351</b>

\*Difference due to rounding.

**MGD. CARE PUBLIC HOSPITAL QUALITY INCENTIVE POOL**  
**REGULAR POLICY CHANGE NUMBER: 93**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>ACA</b>
BP Jul'20-Dec'20 Title XIX	\$132,457	\$66,229	\$66,229	\$0
BP Jul'20-Dec'20 ACA 2020 90/10	\$208,334	\$20,833	\$0	\$187,501
BP Jul'20-Dec'20 Title XXI 65/35	\$4,981	\$1,743	\$3,238	\$0
BP Jul'20-Dec'20 Title XXI 76.5/23.5	\$4,981	\$1,171	\$3,811	\$0
PRIME Accruals FY 20/21 Service Period:				
BP Jul'20-Dec'20 Title XIX	\$231,113	\$115,556	\$115,556	\$0
BP Jul'20-Dec'20 ACA 2020 90/10	\$363,504	\$36,350	\$0	\$327,154
BP Jul'20-Dec'20 Title XXI 65/35	\$8,692	\$3,042	\$5,649	\$0
BP Jul'20-Dec'20 Title XXI 76.5/23.5	\$8,692	\$2,043	\$6,649	\$0
<b>Total FY 2021-22</b>	<b>\$962,754</b>	<b>\$246,967</b>	<b>\$201,132</b>	<b>\$514,654</b>

\*Difference due to rounding.

**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)

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change



## RETRO MC RATE ADJUSTMENTS

**REGULAR POLICY CHANGE NUMBER:** 96  
**IMPLEMENTATION DATE:** 1/2016  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1788

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$403,089,000	\$174,899,000
<b>- STATE FUNDS</b>	\$224,118,380	\$82,301,950
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$403,089,000	\$174,899,000
<b>STATE FUNDS</b>	\$224,118,380	\$82,301,950
<b>FEDERAL FUNDS</b>	\$178,970,620	\$92,597,050

**Purpose:**

This policy change estimates retroactive managed care capitation rate adjustments.

**Authority:**

Welfare & Institutions Code, section 14087.3

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS

**Background:**

This policy change accounts for retroactive:

- Martin Luther King, Jr. (MLK) Pass Through rate adjustments,
- Managed Care Pass Through payments,
- Coordinated Care Initiative (CCI) full dual payments,
- American Indian Health Services (AIHS) payments

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to:

- Projected final rates and higher anticipated enrollment for CCI full duals January-June 2020 rating period, and
- Updated MLK member months and adjusted Retro pass-through payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to no retroactive payments associated to CCI occurring in FY 2021-22.

**Methodology:**

1. The Department estimates the following retroactive managed care capitation rate adjustments in FY 2020-21 and FY 2021-22:

## RETRO MC RATE ADJUSTMENTS

### REGULAR POLICY CHANGE NUMBER: 96

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
MLK Pass Through Payments (Bridge Period)	\$41,752	\$13,533	\$28,219
AIHS Reconciliation	\$0	(\$17,655)	\$17,655
Retro Pass Through Payments	\$216,414	\$156,343	\$60,072
CCI Full Duals (CY 2020, 6 mons.)			
CMC	\$5,472	\$2,736	\$2,736
MLTSS	\$138,231	\$69,115	\$69,116
CCI Full Duals (CY 2017 Retro)			
CMC	\$7,328	\$3,664	\$3,664
CMC Reimb.	(\$411)	(\$411)	\$0
MLTSS	(\$7,281)	(\$3,640)	(\$3,641)
MLTSS Reimb.	(\$716)	(\$716)	\$0
CCI Full Duals (CY 2018 Retro)			
CMC	\$9,529	\$4,764	\$4,765
MLTSS	(\$7,230)	(\$3,615)	(\$3,615)
<b>Total FY 2020-21*</b>	<b>\$403,089</b>	<b>\$224,118</b>	<b>\$178,971</b>

\*Difference due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
MLK Pass Through Payments (Bridge Period)	\$23,409	\$7,417	\$15,992
Retro Pass Through Payments	\$151,490	\$74,885	\$76,605
<b>Total FY 2021-22</b>	<b>\$174,899</b>	<b>\$82,302</b>	<b>\$92,597</b>

**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 / 23.5% GF (4260-113-0001/0890)

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

ACA 93/7 (2019) (4260-101-0890)

ACA 90/10 (2019) (4260-101-0890)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

**EXTENDED FILE CORRECTION**

**REGULAR POLICY CHANGE NUMBER:** 97  
**IMPLEMENTATION DATE:** 11/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2242

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$300,000,000	\$0
<b>- STATE FUNDS</b>	\$335,205,360	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$300,000,000	\$0
<b>STATE FUNDS</b>	\$335,205,360	\$0
<b>FEDERAL FUNDS</b>	-\$35,205,360	\$0

**Purpose:**

This policy change estimates the recoupment and/or payout of funds associated with managed care beneficiaries placed in an incorrect aid code or an incorrect category of aid.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

In 2018, the Department created and ran an extended file in the CAPMAN system to provide enrollment and disenrollment information beyond the standard 13 months of information that CAPMAN receives to run the monthly capitation process. Creating the extended file allowed for the correction of the Medicare logic as well as the rates and funding issues associated with beneficiaries placed in an incorrect aid code or an incorrect category of aid for service months back to January 2014. However, there was a technical issue with the file build and some beneficiaries were not accurately accounted for in the file.

The Department is currently working on a new extended file to correct this issue. Once completed and verified, the file will be processed through the CAPMAN system. This will create a corrected file reflecting the proper enrollments and disenrollments from January 2014 up to the current calendar year, thus resulting in either a recoupment or pay out of the appropriate plan funds for the identified beneficiaries.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. An estimated net pay-out of **\$300,000,000 TF** will occur in **FY 2020-21**.

**EXTENDED FILE CORRECTION**  
**REGULAR POLICY CHANGE NUMBER: 97**

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50%GF (4260-101-0001/0890)	\$29,357	\$14,679	\$14,679
100% State GF (4260-101-0001)	\$325,963	\$325,963	\$0
100% Title XIX ACA FF (4260-101-0001/0890)	(\$10,637)	\$0	(\$10,637)
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	(\$6,156)	(\$308)	(\$5,848)
94% Title XIX ACA FF / 6% GF (4260-101-0001/0890)	(\$8)	(\$0)	(\$8)
65% Title XXI FF / 35% GF (4260-113-0001/0890)	(\$36)	(\$13)	(\$23)
88% Title XXI FF / 12% GF (4260-113-0001/0890)	(\$34,134)	(\$4,096)	(\$30,038)
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	(\$4,328)	(\$1,017)	(\$3,311)
90% Title XIX / 10% GF (4260-101-0890/0001)	(\$21)	(\$2)	(\$19)
<b>Total</b>	<b>\$300,000</b>	<b>\$335,205</b>	<b>(\$35,205)</b>

## HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

**REGULAR POLICY CHANGE NUMBER:** 98  
**IMPLEMENTATION DATE:** 10/2018  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1907

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$138,589,000	\$98,780,000
<b>- STATE FUNDS</b>	\$15,886,500	\$26,671,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$138,589,000	\$98,780,000
<b>STATE FUNDS</b>	\$15,886,500	\$26,671,300
<b>FEDERAL FUNDS</b>	\$122,702,500	\$72,108,700

**Purpose:**

This policy change estimates the local assistance cost of the Health Home Program (HHP).

**Authority:**

AB 361 (Chapter 642, Statutes of 2013)  
 SB 75 (Chapter 18, Statutes of 2015)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 authorized the Department to create a HHP for beneficiaries with chronic conditions. The HHP serves eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. The HHP 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 is used to pay for the non-federal share of HHP costs. It is anticipated that the HHP fund will be exhausted in FY 2021-22. As such, the General Fund (GF) will be used to pay for the non-federal share of the HHP costs through the remainder of the program.

ACA Section 2703 allows geographic phasing of HHP services. The Department is implementing the HHP in four phases, by counties and conditions:

## HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

### REGULAR POLICY CHANGE NUMBER: 98

	July 2018	January 2019	July 2019	January 2020	July 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 4				Eligible Chronic Physical Conditions	Eligible SMIs

- Group 1 represents San Francisco County. Medi-Cal managed care health plans (MCPs) in this group for members with eligible chronic physical conditions implemented in July 2018. MCPs in this group for members with SMIs implemented in January 2019.
- Group 2 represents the following two counties: Riverside and San Bernardino. MCPs in this group for members with eligible chronic physical conditions implemented in January 2019. MCPs in this group for members with SMIs implemented in July 2019.
- Group 3 represents eight counties: Alameda, Imperial, Kern, Los Angeles, Sacramento, San Diego, Santa Clara, and Tulare. MCPs in this group for members with eligible chronic physical conditions implemented in July 2019. MCPs in this group for members with SMIs implemented in January 2020.
- Group 4 represents Orange County. The MCP in this group for members with eligible chronic physical conditions implemented January 2020, while members with SMI implement July 2020.

The HHP will discontinue as of December 31, 2021, and the successful elements of the HHP will be transitioned to a statewide Enhanced Care Management (ECM) Program beginning January 1, 2022, as part of the CalAIM initiative.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to updated enrollment projections. The change in the current estimate, from FY 2020-21 to FY 2021-22, is a decrease due to the HHP ending effective December 31, 2021. There is however an inclusion of GF in FY 2021-22 due to the exhaustion of the HHP fund in FY 2021-22.

## HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

### REGULAR POLICY CHANGE NUMBER: 98

#### Methodology:

1. The program began July 2018. Enrollment will phase-in based on county and condition.
2. The average weighted rate across all plans and rating regions for FY 2020-21 is \$385.92. The average weighted rate across all plans and rating regions for FY 2021-22 (July 2021 through December 2021) is \$385.92.
3. Assume 383,941 member months for FY 2020-21 and 191,971 member months for FY 2021-22 (July 2021-December 2021).
4. Assume the following payment lags for each HHP Group:
  - HHP Group 1 supplemental payments began February 2019.
  - HHP Group 2 supplemental payments began March 2019.
  - HHP Group 3 supplemental payments began September 2019.
  - HHP Group 4 supplemental payments began March 2020.
5. Assume the May and June 2020 capitation payments from FY 2019-20 will be deferred to FY 2021-22. The May and June 2021 capitation payment from FY 2020-21 will be deferred to FY 2021-22.
6. Funding for HHP begins at 90% Federal Fund (FF) and 10% non-FF; this funding adjusts to 50% FF and 50% non-FF two years after each implementation date. The non-Federal share will be funded through the HHP Fund until available HHP Funds are exhausted.
7. Assume the HHP Fund is exhausted, on a cash basis, as of October 2021. The non-Federal share will be paid by the GF through the remainder of the program.
8. On an accrual basis, the costs for FY 2020-21 and FY 2021-22 are expected to be:
  - FY 2020-21: 383,941 x \$385.92 = \$148,170,000 TF
  - FY 2021-22: 191,971 x \$385.92 = \$74,085,000 TF
9. On a cash basis, the costs for FY 2020-21 and FY 2021-22 are expected to be:

(Dollars in Thousands)

Fiscal Year	TF	HHP Fund	FF
FY 2020-21 (90/10)	\$133,520	\$13,352	\$120,168
FY 2020-21 (50/50)	\$5,069	\$2,535	\$2,535
<b>Total FY 2020-21*</b>	<b>\$138,589</b>	<b>\$15,887</b>	<b>\$122,703</b>

(Dollars in Thousands)

Fiscal Year	TF	GF	HHP Fund	FF
FY 2021-22 (90/10)	\$56,797	\$2,972	\$2,707	\$51,117
FY 2021-22 (50/50)	\$41,983	\$10,985	\$10,006	\$20,992
<b>Total FY 2021-22</b>	<b>\$98,780</b>	<b>*\$13,958</b>	<b>\$12,713</b>	<b>\$72,109</b>

\*Difference due to rounding.

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## HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS

REGULAR POLICY CHANGE NUMBER: 98

**Funding:**

90% Title XIX FF / 10% HHP Fund (4260-101-0890 / 4260-601-0942)

50% Title XIX FF / 50% HHP Fund (4260-101-0890 / 4260-601-0942)

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change



## SAN MATEO HEALTH PLAN REIMBURSEMENT

**REGULAR POLICY CHANGE NUMBER:** 101  
**IMPLEMENTATION DATE:** 11/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2193

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$30,000,000	\$0
<b>- STATE FUNDS</b>	\$30,000,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$30,000,000	\$0
<b>STATE FUNDS</b>	\$30,000,000	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates a one-time reimbursement to San Mateo Health Plan for additional costs related to a rate adjustment for Burlingame Long Term Care a Distinct Part Skilled Nursing Facility (DP-NF).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The San Mateo County Health System currently operates two DP-NFs, Burlingame Skilled Nursing and an in hospital Skilled Nursing Facility (SNF) unit, which together provide more than 300 beds. In 2003, the Department leadership requested that San Mateo County assume responsibility for operations of the Burlingame Long Term Care nursing facility (now called Burlingame Skilled Nursing) when it would have otherwise closed following the bankruptcy of a private operator. The Department had placed the previous operator in receivership due to quality of care concerns subsequent to the unexpected deaths of two residents. As a result, San Mateo County Health's San Mateo Medical Center assumed the facility's 281 Distinct Part SNF beds on its state license, leasing the building from its owner, and began operating the unit as a department of the hospital. San Mateo Health Plan contracts with Burlingame Skilled Nursing to provide long term care services to beneficiaries.

The Department is entering into a settlement to update the DP-NF rate for rate years 2014-2018 which will substantially increase the rate for these time periods. Due to this rate adjustment and to maintain access and avoid closure of the facility, San Mateo will have significant additional costs retroactively to pay at these higher rates. As the rate change was due to the inappropriate application of a cost adjustment, the Department believes it is necessary to provide additional funding via a one-time reimbursement.

## **SAN MATEO HEALTH PLAN REIMBURSEMENT**

**REGULAR POLICY CHANGE NUMBER: 101**

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to this being a one-time reimbursement occurring in FY 2020-21.

**Methodology:**

1. A one-time reimbursement of **\$30,000,000 TF (\$30,000,000 GF)** occurring in **FY 2020-21**.

**Funding:**

100% State GF (4260-101-0001)

## CCI-QUALITY WITHHOLD REPAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 102  
**IMPLEMENTATION DATE:** 5/2017  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2031

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$18,830,000	\$16,822,000
<b>- STATE FUNDS</b>	\$9,415,000	\$8,411,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$18,830,000	\$16,822,000
<b>STATE FUNDS</b>	\$9,415,000	\$8,411,000
<b>FEDERAL FUNDS</b>	\$9,415,000	\$8,411,000

**Purpose:**

This policy change estimates the repayment of the quality withholds for the Coordinated Care Initiative (CCI).

**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 the 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 the 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, increasing to 3% in CY 2017 through CY 2019, and increasing to 4% in CY 2020 through CY 2022. Repayments of withholds will be based on performance measures.

## CCI-QUALITY WITHHOLD REPAYMENTS

### REGULAR POLICY CHANGE NUMBER: 102

Based on lessons learned from the CCI demonstration project, the 2017 Budget extended the CMC program and the mandatory enrollment of dual eligibles and integration of long-term services and support, except 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 2020-21, is an increase due to updated actuals. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to FY 2021-22 being based on estimated amounts from prior years.

#### 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. The Centers for Medicare and Medicaid Services 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 2017 will be repaid in FY 2020-21.
4. Assume quality withholds for CY 2018 will be repaid in FY 2021-22.

FY 2020-21	TF	GF	FF
Quality Withhold Repayment (CY 2017)	\$18,830,000	\$9,415,000	\$9,415,000

FY 2021-22	TF	GF	FF
Quality Withhold Repayment (CY 2018)	\$16,822,000	\$8,411,000	\$8,411,000

#### Funding:

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

## CAPITATED RATE ADJUSTMENT FOR FY 2021-22

**REGULAR POLICY CHANGE NUMBER:** 105  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1338

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$1,185,484,000
<b>- STATE FUNDS</b>	\$0	\$407,117,700
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$1,185,484,000
<b>STATE FUNDS</b>	\$0	\$407,117,700
<b>FEDERAL FUNDS</b>	\$0	\$778,366,300

**Purpose:**

The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2021-22.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Managed care capitation rates will be rebased in Calendar Year (CY) 2022 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 2020-21 to FY 2021-22.

**Reason for Change:**

The change in capitation rates from FY 2020-21 to FY 2021-22 is a 3.45% average rate increase on a cash basis, including Optional Expansion rates.

**Methodology:**

<b>Managed Care Models</b>	<b>CY 2021 Estimated Cost</b>	<b>Rate Adjustment</b>	<b>Rate Increase</b>
COHS	\$9,084,277,000	3.45%	\$313,775,000
GMC	\$3,746,390,000	3.45%	\$129,402,000
Regional	\$1,310,435,000	3.45%	\$45,263,000
Two Plan	\$20,180,514,000	3.45%	\$697,044,000
<b>Total</b>	<b>\$34,321,616,000</b>		<b>\$1,185,484,000</b>

**CAPITATED RATE ADJUSTMENT FOR FY 2021-22**  
**REGULAR POLICY CHANGE NUMBER: 105**

**Funding:**

<b>FY 2021-22</b>	<b>Two Plan</b>	<b>COHS</b>	<b>GMC</b>	<b>Regional</b>	<b>Total</b>
Title XIX 50/50 FFP (4260-101-0001/0890)	\$400,867,000	\$189,280,000	\$75,275,000	\$26,231,000	\$691,653,000
State GF (4260-101-0001)	\$869,000	\$179,000	\$167,000	\$54,000	\$1,269,000
Family Planning 90/10 GF (4260-101-0001-0890)	\$3,077,000	\$1,395,000	\$571,000	\$211,000	\$5,254,000
Title XXI 65/35 (4260-101-0001/0890)	\$24,810,000	\$12,410,000	\$4,393,000	\$1,451,000	\$43,064,000
ACA 90% FFP / 10% GF (2020)	\$267,421,000	\$110,511,000	\$48,996,000	\$17,316,000	\$444,244,000
<b>TF</b>	\$697,044,000	\$313,775,000	\$129,402,000	\$45,263,000	<b>\$1,185,484,000</b>
<b>GF</b>	\$237,036,000	\$110,353,000	\$44,298,750	\$15,430,000	<b>\$407,117,750</b>
<b>FF</b>	\$460,008,000	\$203,422,000	\$85,103,250	\$29,833,000	<b>\$778,366,250</b>

## 2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

**REGULAR POLICY CHANGE NUMBER:** 106  
**IMPLEMENTATION DATE:** 10/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2176

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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 January 1, 2020.

**Authority:**

AB 115 (Chapter 348, Statutes of 2019)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates  
2020 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. 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 for the three year period of January 1, 2020, through December 31, 2022. This policy change estimates GF savings resulting from the imposition of the MCO Enrollment Tax.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## 2020 MCO ENROLLMENT TAX MANAGED CARE PLANS

### REGULAR POLICY CHANGE NUMBER: 106

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to updated funding splits, enrollment projections, and the associated member mix. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the FY 2020-21 amounts including retroactive payments attributable to the January 2020 through June 2020 rating period.

**Methodology:**

1. The MCO Enrollment Tax is based on the cumulative enrollment of health plans during the 12-month period between January 1, 2018, and December 31, 2018.
2. Different rates are assessed to Medi-Cal and non-Medi-Cal health plans.
3. The following taxing tier structures are used to determine the MCO Enrollment Tax per state fiscal year:

FY 2020-21 Medi-Cal	
Enrollees	Rate
0-675,000	\$0.00
675,001-4,000,000	\$45.00
Over 4,000,000	\$0.00

FY 2020-21 Non-Medi-Cal	
Enrollees	Rate
0-675,000	\$0.00
675,001-4,000,000	\$1.50
Over 4,000,000	\$0.00

FY 2021-22 Medi-Cal	
Enrollees	Rate
0-675,000	\$0.00
675,001-4,000,000	\$50.00
Over 4,000,000	\$0.00

FY 2021-22 Non-Medi-Cal	
Enrollees	Rate
0-675,000	\$0.00
675,001-4,000,000	\$1.50
Over 4,000,000	\$0.00

The total Medi-Cal and Non-Medi-Cal MCO Enrollment Tax on an accrual basis is:

FY 2020-21: \$2,317,734,000

FY 2021-21: \$2,584,032,000

4. The impact of the increase in capitation payments related to the tax is included in the 2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates policy change.
5. FFCRA increased FMAP is assumed for expenditures through June 30, 2021. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.



**2020 MCO ENROLLMENT TAX MANAGED CARE PLANS**  
REGULAR POLICY CHANGE NUMBER: 106

6. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>MCO Tax</b>
<b>FY 2020-21</b>	<b>\$0</b>	<b>(\$1,760,119)</b>	<b>\$1,760,119</b>
<b>FY 2021-22</b>	<b>\$0</b>	<b>(\$1,598,111)</b>	<b>\$1,598,111</b>

**Funding:**  
3334 MCO Tax

## 2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

**REGULAR POLICY CHANGE NUMBER:** 107  
**IMPLEMENTATION DATE:** 10/2020  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2177

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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:**

AB 115 (Chapter 348, Statutes of 2019)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

2020 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap. Rates  
2020 MCO Enrollment Tax Managed Care Plans  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

Effective January 1, 2020, the department implemented an MCO provider tax that provides for a statewide tax on managed care plans based on reported enrollment into these plans during the 12-month period between January 1, 2018, and December 31, 2018. 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 for the three year period of January 1, 2020, through December 31, 2022. This policy change estimates the offset of GF costs for the capitated rate increases.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## 2020 MCO ENROLLMENT TAX MGD CARE PLANS-FUNDING ADJ

REGULAR POLICY CHANGE NUMBER: 107

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to updated funding splits, enrollment projections, and the associated member mix. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the FY 2020-21 amounts including retroactive payments attributable to the January 2020 through June 2020 rating period.

**Methodology:**

1. Total revenues for Medi-Cal managed care plans are based on the number of Medi-Cal enrollees and “all-other” enrollees as defined in AB 115.
2. Only tax relating to Medi-Cal enrollees are budgeted in this PC.
3. FFCRA increased FMAP is assumed for expenditures through June 30, 2021. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
4. The MCO Enrollment Tax fund transfers to the GF are expected to be:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>MCO Tax</b>
<b>FY 2020-21</b>	<b>\$0</b>	(\$1,009,538)	\$1,009,538
<b>FY 2021-22</b>	<b>\$0</b>	(\$919,347)	\$919,347

**Funding:**

3334 MCO Tax

## MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND

**REGULAR POLICY CHANGE NUMBER:** 108  
**IMPLEMENTATION DATE:** 2/2019  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2063

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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:**

COVID-19 Increased FMAP – DHCS

**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 2020-21, is an increase due to the GF reimbursement collection in this PC being updated to align with the most recent corresponding GF expenditure payments and expected GF reimbursement levels. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to updated GF expenditures and reimbursements.

**Methodology:**

1. Data from FY 2018-19 and the Bridge Period (July 2019 through December 2020) are used to estimate the annual commitment from allowable public entities.

**MANAGED CARE REIMBURSEMENTS TO THE GENERAL FUND**  
**REGULAR POLICY CHANGE NUMBER: 108**

2. On a cash basis, the estimated reimbursements to the General Fund are:

(Dollars in Thousands)

Reimbursement	GF
FY 2018-19	\$506,542
July 1, 2019-Dec 31, 2020 (Bridge Period)	\$1,346,397
Total	\$1,852,940
July 1, 2019-Dec 31, 2020 Support Cost to GF	(\$251)
GF	(\$1,852,689)
<b>FY 2020-21 Net Impact</b>	<b>\$0</b>

(Dollars in Thousands)

Reimbursement	GF
July 1, 2019-Dec 31, 2020 (Bridge Period)	\$1,104,590
CY 2021	\$9,596
Total	\$1,114,186
July 1, 2019-Dec 31, 2020 Support Cost to GF	(\$251)
GF	(\$1,113,935)
<b>FY 2021-22 Net Impact</b>	<b>\$0</b>

**Funding:**

Reimbursement (4260-601-0995)

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

## COORDINATED CARE INITIATIVE RISK MITIGATION

**REGULAR POLICY CHANGE NUMBER:** 110  
**IMPLEMENTATION DATE:** 6/2022  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2135

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	-\$111,260,000
<b>- STATE FUNDS</b>	\$0	-\$55,630,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	-\$111,260,000
<b>STATE FUNDS</b>	\$0	-\$55,630,000
<b>FEDERAL FUNDS</b>	\$0	-\$55,630,000

**Purpose:**

This policy change estimates additional payments to and recoveries from managed care plans (MCPs) participating in the Coordinated Care Initiative (CCI) related to the risk mitigation strategies applicable to Cal MediConnect (CMC) and non-CMC full benefit dual-eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries.

**Authority:**

Welfare and Institutions (W&I) Code section 14182.18  
 CMC Three-Way Contract

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Risk mitigation strategies are in place for CMC and non-CMC full-benefit dual eligible beneficiaries. Risk mitigation strategies are also in place for partial-benefit dual eligible beneficiaries and non-dual-eligible beneficiaries enrolled in managed care in the CCI counties.

There is a limited up-side risk corridor and a limited down-side risk corridor for CMC full-benefit dual eligible beneficiaries, as specified in the CMC Three-Way Contract, for all demonstration years (DYs) through December 31, 2017. For non-CMC full-benefit dual eligible beneficiaries, partial-benefit dual eligible beneficiaries, and non-dual-eligible beneficiaries, there are separate 24-month symmetrical down-side and up-side risk corridors, as specified in W&I Code, section 14182.18 and existing Medi-Cal MCP contracts.

Capitation payments for CMC and non-CMC full-benefit dual eligible beneficiaries are subject to an additional ongoing risk mitigation requirement. This ongoing requirement is applicable to periods for which capitation payments are based on a projected mix of members of varying acuity levels. If there is a difference between the projected member mix and the actual member mix that would result in a greater than 2.5 percent impact to the capitation rates, the Department and MCPs will equally share any increases or decreases beyond the 2.5 percent threshold (independent of the MCPs' actual gains or losses).

## COORDINATED CARE INITIATIVE RISK MITIGATION

### REGULAR POLICY CHANGE NUMBER: 110

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease in recoupments due to a delay in the system implementation of the required CCI data logic fix and the need to recollect data from MCPs. As a result, the previously budgeted FY 2020-21 recoupments are now shifting to FY 2021-22. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in recoupments due to a shift in recoupments previously budgeted in FY 2020-21 that are now anticipated to occur in FY 2021-22.

#### Methodology:

1. Assume all payments and recoupments attributable to the full dual eligibles for the 2.5 percent member mix threshold for 2014 through 2018 will occur in FY 2021-22.
2. Assume all CMC payments and recoupments for DY one (1) through three (3) will occur in FY 2021-22.
3. Assume all payments and recoupments for the first 24-month period, for the non-CMC full-benefit dual eligible, partial-benefit dual eligible, and non-dual-eligible will occur in FY 2021-22.
4. Total recoupments are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2021-22	(\$111,260)	(\$55,630)	(\$55,630)

\*Totals may differ due to rounding.

#### Funding:

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

## RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 111  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2160

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$1,166,000	\$0
<b>- STATE FUNDS</b>	-\$457,650	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$1,166,000	\$0
<b>STATE FUNDS</b>	-\$457,650	\$0
<b>FEDERAL FUNDS</b>	-\$708,350	\$0

**Purpose:**

This policy change estimates the recoupment of capitation payments from Managed Care Plans (MCPs) for beneficiaries that were not initially shown as deceased.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

An audit conducted by the Office of the Inspector General determined that the Department paid MCPs capitation payments for deceased beneficiaries and recommended that the Centers for Medicare and Medicaid be paid back for these capitation payments. The Department recouped capitation payments from MCP's dating back to July 2011, for any inappropriate payments made for beneficiaries who were not identified as deceased, and returned the associated federal funds.

The Department recouped all dollars tied to active MCP contracts in FY 2019-20. Dollars that have not been recouped were tied to expired MCP contracts and In-Home Supportive Services (IHSS) invoices that were produced.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the recoupment of dollars that were not previously recouped for expired MCP contracts and IHSS invoices. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the remaining recoupment occurring in FY 2020-21. There is no recoupment in FY 2021-22.

**Methodology:**

1. A one-time recoupment of the remaining **\$1,166,000 TF (\$458,000 GF)** will occur in **FY 2020-21**.



**RECOUPMENT OF UNALLOWED CAPITATION PAYMENTS**  
**REGULAR POLICY CHANGE NUMBER: 111**

**Funding:**

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

100% State GF (4260-101-0001)

100% Title XIX ACA FF (4260-101-0001/0890)

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

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

## MANAGED CARE EFFICIENCIES

**REGULAR POLICY CHANGE NUMBER:** 112  
**IMPLEMENTATION DATE:** 2/2021  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 2224

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$199,574,000	-\$481,443,000
<b>- STATE FUNDS</b>	-\$64,469,950	-\$155,548,750
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$199,574,000	-\$481,443,000
<b>STATE FUNDS</b>	-\$64,469,950	-\$155,548,750
<b>FEDERAL FUNDS</b>	-\$135,104,050	-\$325,894,250

**Purpose:**

This policy changes estimates the savings associated with implementing Managed Care rate adjustments and efficiencies as deemed actuarially appropriate.

**Authority:**

42 CFR §438  
WIC § 14301.1

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**Background:**

The Department will implement the following Managed Care rate adjustments and efficiencies as deemed actuarially appropriate beginning in calendar year (CY) 2021 in an effort to continue to drive Managed Care rate and contracting efficiencies with the goal of preserving the prudent use of federal and State resources:

- Implement new Managed Care efficiency adjustments including but not limited to:
  - Low Acuity Non-Emergent (LANE) Services Efficiency Adjustment - The LANE efficiency adjustment focuses on identifying instances in which an emergency room visit could have been avoided had effective outreach, care coordination, and access to preventive care been available.
  - Healthcare Common Procedure Coding System (HCPCS) Efficiency Adjustment - The HCPCS efficiency adjustment identifies opportunities for Managed Care plan savings, by identifying historical contracting levels that can be reduced in future prospective periods. This efficiency adjustment promotes improved contracting with providers for clinician-administered drugs billed via HCPCS codes.
- Implement a reduced Managed Care Underwriting Gain (UG) within the final certified capitation rates. The UG would be reduced from 2 percent to 1.5 percent, resulting in a 0.5 percent reduction.
- General rate adjustments as determined actuarially appropriate.

## MANAGED CARE EFFICIENCIES

### REGULAR POLICY CHANGE NUMBER: 112

The applicability of these adjustments will be evaluated on an annual basis thereafter, to determine the actuarial appropriateness of continuing for future rating periods.

#### Reason for Change:

The increased savings from the prior estimate, for FY 2020-21, is due to updated enrollment projections, refined estimates for LANE and HCPCS adjustments on a statewide basis, and updated estimates of UW gain reduction savings based on updated draft CY 2021 rates.

The increased savings from FY 2020-21 to FY 2021-22, in the current estimate, is due to five months of savings budgeted in FY 2020-21 and 12 months of savings budgeted in FY 2021-22. CY 2022 rates account for a slight increase of expected growth.

#### Methodology:

- Beginning January 1, 2021, service period, on a cash basis, associated Managed Care rate adjustments and efficiencies savings expected to be realized in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

Fiscal Year	TF	GF	FF
FY 2020-21	(\$199,574)	(\$64,470)	(\$135,104)
FY 2021-22	(\$481,443)	(\$155,549)	(\$325,894)

#### Funding:

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020

**REGULAR POLICY CHANGE NUMBER:** 113  
**IMPLEMENTATION DATE:** 9/2020  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 2221

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$603,348,000	\$0
<b>- STATE FUNDS</b>	-\$186,307,300	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$603,348,000	\$0
<b>STATE FUNDS</b>	-\$186,307,300	\$0
<b>FEDERAL FUNDS</b>	-\$417,040,700	\$0

**Purpose:**

This policy changes estimates the savings associated with reducing the managed care capitation rates gross medical expense (GME) for the period of July 1, 2019 through December 31, 2020 (Bridge Period).

**Authority:**

42 Code of Federal Regulations 438.7(c)(3)  
Welfare & Institutions Code 14301.11

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS

**Background:**

The managed care rates for the Bridge Period were developed prior to the COVID-19 pandemic. Therefore, the anticipated utilization decreases resulting for the pandemic were not considered in the Bridge Period rate development. As a result, the Department will implement a 1.5 percent GME rate reduction for the Adult, Child, Optional Expansion, and Seniors and Persons with Disabilities (SPD) rating categories per the federal authority granted in 42 CFR §438.7(c)(3).

The uncertainty of actual managed care plan (MCP) costs and utilization during this timeframe will require efforts to mitigate upside and downside risks to the MCPs, the State, and federal government. The Department will be implementing a complementing risk corridor for this time period. The risk corridor calculations, and associated payments or recoupments, are anticipated to occur in FY 2022-23.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is an increase in savings due to updated enrollment projections.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease in savings due to no rate reduction being applied to the calendar year 2021 or 2022 rating periods. The Department will reassess whether it will be necessary to implement a rate reduction to the CY 2021 rating period in the future.

## ADJUST MC CAP PAYMENTS FOR JULY 2019-DEC 2020

REGULAR POLICY CHANGE NUMBER: 113

**Methodology:**

1. Calculated the 1.5% rate reduction for Adult, Child, Optional Expansion, and SPD rating categories utilizing the GME component of the Bridge Period rates.
2. The reduction will apply to the entire Bridge Period of July 1, 2019, through December 31, 2020.
3. On a cash basis, associated rate reduction savings are expected to be realized in FY 2020-21.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Bridge Period Savings	(\$603,348)	(\$186,307)	(\$417,041)
<b>Total</b>	<b>(\$603,348)</b>	<b>(\$186,307)</b>	<b>(\$417,041)</b>

**Funding:**

50% Title XIX FF / 50% SF (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)

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

## MANAGED CARE DRUG REBATES

**REGULAR POLICY CHANGE NUMBER:** 114  
**IMPLEMENTATION DATE:** 4/2013  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 1585

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$1,504,915,000	-\$1,415,902,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$1,504,915,000	-\$1,415,902,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$1,504,915,000	-\$1,415,902,000

**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)  
 SB 78 (Chapter 38, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Medi-Cal Drug Rebate Fund  
 COVID-10 Increased FMAP Extension – DHCS

**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.

SB 78 established 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 Rebate Fund policy change for the estimated total transfers from Fund 3331 to the General Fund (GF).

Beginning with the April 2020 through June 2020 quarterly drug rebates, COHS rebates are now reported with managed care rebates. COHS rebates were previously reported with Fee-for-Service (FFS) rebates. Rebates for COHS will continue to be reported with managed care rebates until the COHS and managed care pharmacy claims are transitioned to Medi-Cal Rx on January 1, 2021. Furthermore, after the Medi-Cal Rx transition on January 1, 2021, a majority of the rebates currently reported as managed care rebates will be reported as FFS federal rebates.

## MANAGED CARE DRUG REBATES

### REGULAR POLICY CHANGE NUMBER: 114

Until more data is available for these transitions, this policy change does not include changes to the rebate reporting categories related to the COHS rebates to managed care transition or Medi-Cal Rx transition.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease in rebate savings due to:

- Including two additional quarters of actual rebate collection data through the quarter ending June 2020,
- Updated managed care eligible data used to project the estimated managed care rebate collections,
- Estimating a decrease in rebate collections per managed care beneficiary based on the historical trend, and
- Including FFCRA increased Federal Financial Participation (FFP) in FY 2020-21, resulting in rebate savings shifting from the GF to the federal government.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is decrease in rebate savings due to:

- Estimating a decrease in managed care beneficiaries, and
- FFCRA increased FFP is not assumed for FY 2021-22.

#### Methodology:

1. Rebates are invoiced quarterly and payments occur six months after the conclusion of each quarter.
2. Assume family planning drugs account for 0.21% of the regular federal drug rebates and are funded with 90% federal funds (FF) and 10% GF.
3. The 6.2% Title XIX FFCRA increased FMAP and 4.34% Title XXI FFCRA increased FMAP is assumed for drug rebates through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
4. CHIP drug rebates are funded at 88% FF / 12% GF through September 30, 2019, and 76.5% FF / 23.5% GF beginning October 1, 2019, and 65% FF / 35% GF beginning October 1, 2020. Assume CHIP drug rebate collections are estimated to be \$75,175,000 FF and \$69,503,000 FF in FY 2020-21 and FY 2021-22, respectively.
5. Collections for the optional expansion ACA population are estimated to be \$742,940,000 TF for FY 2020-21, of which \$713,646,000 FF is budgeted in this policy change. The amount of \$79,294,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund. For

## MANAGED CARE DRUG REBATES

### REGULAR POLICY CHANGE NUMBER: 114

FY 2021-22, a total of \$782,930,000 TF is estimated for the optional expansion population, of which \$704,637,000 FF is budgeted in this policy change. The amount of \$78,293,000 SF is the estimated non-federal share in the Medi-Cal Drug Rebate Fund.

6. The ongoing additional FF claimed by CMS (ACA Offset) is fully reflected in this policy change. The additional FF is \$77,115,000 TF for FY 2020-21 and \$77,316,000 TF for FY 2021-22.
7. The Department estimates \$603,557,000 and \$678,271,000 managed care drug rebates to be collected and transferred to the Medi-Cal Drug Rebate Fund in FY 2020-21 and FY 2021-22, respectively.

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$564,417,000)	(\$564,417,000)	(\$598,825,000)
FFCRA 6.2% Increased FFP	(\$69,724,000)	(\$69,724,000)	\$69,724,000
100% Title XIX ACA FF	(\$713,646,000)	(\$713,646,000)	(\$79,294,000)
100% Title XXI FF	(\$75,175,000)	(\$75,175,000)	\$0
FFCRA 4.34% Increased FFP	(\$4,838,000)	(\$4,838,000)	\$4,838,000
ACA Offset	(\$77,115,000)	(\$77,115,000)	\$0
<b>Total</b>	<b>(\$1,504,915,000)</b>	<b>(\$1,504,915,000)</b>	<b>(\$603,557,000)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>Fund 3331 Transfer*</b>
100% Title XIX FF	(\$564,446,000)	(\$564,446,000)	(\$599,978,000)
100% Title XIX ACA FF	(\$704,637,000)	(\$704,637,000)	(\$78,293,000)
100% Title XXI FF	(\$69,503,000)	(\$69,503,000)	\$0
ACA Offset	(\$77,316,000)	(\$77,316,000)	\$0
<b>Total</b>	<b>(\$1,415,902,000)</b>	<b>(\$1,415,902,000)</b>	<b>(\$678,271,000)</b>

\*The Fund 3331 Transfer column is for informational purposes only. See Methodology #7.

#### Funding:

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 4.34% Increased FFP (4260-113-0890)



## DPH INTERIM RATE GROWTH

**REGULAR POLICY CHANGE NUMBER:** 115  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1162

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$257,252,000	\$257,252,000
<b>- STATE FUNDS</b>	\$128,626,000	\$128,626,000
<b>PAYMENT LAG</b>	0.7486	1.0000
<b>% REFLECTED IN BASE</b>	0.62 %	0.56 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$191,384,900	\$255,811,400
<b>STATE FUNDS</b>	\$95,692,430	\$127,905,690
<b>FEDERAL FUNDS</b>	\$95,692,430	\$127,905,700

**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 2020-21, from the prior estimate, is due to an increase based on updated DPH actual data through July 2020 and increased costs related to the national public health emergency.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no rate increases expected in FY 2021-22.

**Methodology:**

- The DPHs received new FY 2020-21 interim rates implemented and effective July 1, 2020. These rates were based on FY 2019-20 costs trended to FY 2020-21. Assume the FY 2021-22 interim rates will be implemented in July 2021.

## DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 115

2. For FY 2020-21:
  - Assume an 11.08% interim rate increase for county DPHs.
  - Assume a 35.76% interim rate increase for community-based DPHs.
  - An additional cost of \$257,252,000 TF is estimated for the FY 2020-21 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$191,385,000 TF.
3. For FY 2021-22:
  - Assume no interim rate increase for county and community-based DPHs.
  - An additional cost of \$257,252,000 TF is estimated for the FY 2021-22 interim rates. The lagged cost on a cash basis, not in the base, is estimated to be approximately \$255,811,000 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

## GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

**REGULAR POLICY CHANGE NUMBER:** 116  
**IMPLEMENTATION DATE:** 4/2019  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 2081

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$226,313,000	\$223,616,000
<b>- STATE FUNDS</b>	\$67,675,000	\$72,768,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	13.29 %	13.45 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$196,236,000	\$193,539,600
<b>STATE FUNDS</b>	\$58,680,990	\$62,980,700
<b>FEDERAL FUNDS</b>	\$137,555,010	\$130,558,940

**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)  
 SPA 18-004  
 SPA 19-0020  
 Families First Coronavirus Response Act (FFCRA)  
 AB 1705 (Chapter 544, Statutes of 2019)  
 SPA 20-0009

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 collects gross transport and revenue data from GEMT providers in order to calculate an annual QAF amount. The QAF is assessed on each GEMT transport for base ground emergency medical services, effective July 1, 2018. The revenue generated by the QAF collections is deposited directly into the Medi-Cal Emergency Medical Transportation Fund (MEMTF).

For fiscal year 2018-19, the Department was required to provide an add-on to the Medi-Cal FFS reimbursements 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.

## **GROUND EMERGENCY MEDICAL TRANSPORTATION QAF**

### **REGULAR POLICY CHANGE NUMBER: 116**

The add-on increase was calculated to be \$220.80 for FY 2018-19, to the extent that FFP was available. SPA 18-004 was approved on February 7, 2019, for the FY 2018-19 add-on. The add-on will also be provided for codes A0225 Neonatal Emergency Transport and A0434 Specialty Care Transport, for FY 2019-20, effective July 1, 2019. SPA 19-0020 was approved on September 6, 2019, for the FY 2019-20 add-on. SPA 20-0009 was approved on October 15, 2020, for the FY 2020-21 add-on.

AB 1705 requires the Department to implement a public provider GEMT Inter-Governmental Transfer (IGT) program no sooner than July 1, 2021. The public providers currently in the GEMT QAF program will transition into the new AB 1705 IGT Program. These providers would no longer participate in the GEMT QAF program and funds associated with AB 1705 (public providers) are expected to shift into a new policy change when the final implementation date is known.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is a net increase due to:

- Increased managed care enrollment assumptions, resulting in an increase in the managed care annual estimates.
- Revised GF offset estimate, and
- Including the FFCRA increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to:

- Less of the GF offset occurring in FY 2021-22, and
- Decreased FFS estimate for FY 2021-22.

#### **Methodology:**

1. The effective date for the GEMT QAF is July 1, 2018.
2. Assume the GEMT QAF revenue will be \$88,931,000 in FY 2020-21 and \$80,938,000 in FY 2021-22.
3. For FY 2018-19, \$1,003,000 will be transferred from the MEMTF to the GF for administration costs. Beginning FY 2019-20 and every year after, \$374,000 will be transferred.
4. The transfer from the MEMTF to the GF for the 10 percent set aside for health care coverage is estimated to be \$8,233,000 for FY 2020-21 and \$7,493,000 for FY 2021-22. The FY 2020-21 offset is expected to occur in FY 2020-21 and the FY 2021-22 offset is expected to occur in FY 2021-22. The FY 2018-19 and FY 2019-20 offsets are estimated to be delayed to FY 2021-22 or later.

## GROUND EMERGENCY MEDICAL TRANSPORTATION QAF

### REGULAR POLICY CHANGE NUMBER: 116

5. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2020-21 are estimated to be \$226,992,000 TF, of which \$30,066,000 TF is for FFS and \$196,926,000 TF is for Managed Care GEMT transport services.
6. From the remaining GEMT QAF revenue available, total annual GEMT add-on payments for FY 2021-22 are estimated to be \$224,200,000 TF, of which \$27,365,000 TF is for FFS and \$196,835,000 TF is for Managed Care GEMT transport services.
7. FFS Payments: The FY 2020-21 FFS add-on payments will continue to be paid in FY 2020-21. Assume the FY 2021-22 FFS add-on payments will continue to be paid in FY 2021-22, upon federal approval. A decrease in FY 2021-22 payments is anticipated due to the impact of AB 1705.
8. Managed Care Payments:
  - a. The Department implemented a onetime 18-month rating period for the period of July 1, 2019, through December 31, 2020 (Bridge Period). On a cash basis, FY 2020-21 is expected to include 7 months of the Bridge Period rates and 5 months of the CY 2021 rates.
  - b. FY 2021-22 is expected to include 7 months of the CY 2021 rates and 5 months of the CY 2022 rates.
  - c. Expenditures associated with AB 1705 are expected to shift into the new IGT program once the final implementation date is known.
9. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
10. The cash basis estimate is summarized as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>MEMTF</b>	<b>FF</b>	<b>FFCRA</b>
GF Offset 20-21	\$0	(\$8,233,000)	\$8,233,000	\$0	\$0
FFS Pmts (ongoing)	\$30,066,000	\$0	\$8,539,000	\$20,650,000	\$877,000
Mgd Care Pmts	\$196,247,000	\$0	\$59,136,000	\$131,787,000	\$5,324,000
<b>Total</b>	<b>\$226,313,000</b>	<b>(\$8,233,000)</b>	<b>\$75,908,000</b>	<b>\$152,437,000</b>	<b>\$6,201,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>MEMTF</b>	<b>FF</b>
GF Offset 21-22	\$0	(\$7,493,000)	\$7,493,000	\$0
FFS Pmts (ongoing)	\$27,364,000	\$0	\$8,580,000	\$18,784,000
Mgd Care Pmts	\$196,252,000	\$0	\$64,188,000	\$132,064,000
<b>Total</b>	<b>\$223,616,000</b>	<b>(\$7,493,000)</b>	<b>\$80,261,000</b>	<b>\$150,848,000</b>

**GROUND EMERGENCY MEDICAL TRANSPORTATION QAF**  
REGULAR POLICY CHANGE NUMBER: 116

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>	<b>FFCRA</b>
100% GF (4260-101-0001)	(\$8,233,000)	(\$8,233,000)	\$0	\$0	\$0
MEMTF (4260-601-3323)	\$75,908,000	\$0	\$75,908,000	\$0	\$0
ACA Title XIX FF (4260-101-0890)	\$85,493,000	\$0	\$0	\$85,493,000	\$0
Title XIX FF (4260-101-0890)	\$62,069,000	\$0	\$0	\$62,069,000	\$0
Title XXI FF (4260-113-0890)	\$4,875,000	\$0	\$0	\$4,875,000	\$0
FFCRA 4.34% FF	\$312,000	\$0	\$0	\$0	\$312,000
FFCRA 6.2% FF	\$5,889,000	\$0	\$0	\$0	\$5,889,000
<b>Total</b>	<b>\$226,313,000</b>	<b>(\$8,233,000)</b>	<b>\$75,908,000</b>	<b>\$152,437,000</b>	<b>\$6,201,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
100% GF (4260-101-0001)	(\$7,493,000)	(\$7,493,000)	\$0	\$0
MEMTF (4260-601-3323)	\$80,261,000	\$0	\$80,261,000	\$0
ACA Title XIX FF (4260-101-0890)	\$64,950,000	\$0	\$0	\$64,950,000
Title XIX FF (4260-101-0890)	\$81,273,000	\$0	\$0	\$81,273,000
Title XXI FF (4260-113-0890)	\$4,625,000	\$0	\$0	\$4,625,000
<b>Total</b>	<b>\$223,616,000</b>	<b>(\$7,493,000)</b>	<b>\$80,261,000</b>	<b>\$150,848,000</b>

## RATE INCREASE FOR FQHCS/RHCS/CBRCs

**REGULAR POLICY CHANGE NUMBER:** 117  
**IMPLEMENTATION DATE:** 10/2005  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 88

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$169,196,000	\$182,471,000
<b>- STATE FUNDS</b>	\$65,024,800	\$70,126,700
<b>PAYMENT LAG</b>	0.9287	0.9350
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$157,132,300	\$170,610,400
<b>STATE FUNDS</b>	\$60,388,530	\$65,568,460
<b>FEDERAL FUNDS</b>	\$96,743,790	\$105,041,920

**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:**

COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**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) the clinic's 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the Medicare Economic Index 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 1<sup>st</sup> of each year.

**Reason for Change:**

The change from the prior estimate, in FY 2020-21, is a decrease due to additional audited actual visits which decreased projected visits year over year for FQHCs and RHCs. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the projected increase in rates.

## RATE INCREASE FOR FQHCS/RHCS/CBRCS

### REGULAR POLICY CHANGE NUMBER: 117

**Methodology:**

- The projected visits are based on the average percent increase of the last three years actual visit counts.
- The rate increase will be used as a trend factor to calculate the estimated cost per visit rate. The rate increase percent was 2.73% for calendar year (CY) 2019, CY 2020, and CY 2021.

Rate Year	Projected Visits	Current Rate	Rate with Increase
2019	19,262,490	\$167.52	$\$167.52 \times (1+2.73\%) = \$172.09$
2020	18,736,045	\$172.09	$\$172.09 \times (1+2.73\%) = \$176.78$
2021	18,223,988	\$176.78	$\$176.78 \times (1+2.73\%) = \$181.60$

- 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
2019	\$3,226,852	\$3,314,881	\$88,030
2020	\$3,224,286	\$3,312,158	\$87,872
2021	\$3,221,637	\$3,309,476	\$87,840

- The FY 2020-21 CBRC rate increase of \$15,262,000 is based on the FY 2016-17 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2018-19. 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 2018-19. The audited PPS rate for FY 2016-17 audits were effective July 1, 2019.
- The FY 2021-22 CBRC rate increase of \$13,457,000 is based on the FY 2017-18 audited PPS and the reported PPS rate for three hospitals in which the FY 2017-18 audit was not completed. FY 2017-18 audited PPS rates utilized payment data from the Paid Claims Summary Reports for FY 2019-20. 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 2019-20. The audited PPS rate for FY 2017-18 audits were effective July 1, 2020.



**RATE INCREASE FOR FQHCS/RHCS/CBRCS**  
REGULAR POLICY CHANGE NUMBER: 117

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CY 2020 Increase	\$84,598	\$32,512	\$52,086
CY 2021 Increase	\$84,598	\$32,512	\$52,086
<b>FY 2020-21 Total</b>	<b>\$169,196</b>	<b>\$65,024</b>	<b>\$104,172</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CY 2021 Increase	\$91,236	\$35,063	\$56,173
CY 2022 Increase	\$91,235	\$35,063	\$56,172
<b>FY 2021-22 Total</b>	<b>\$182,471</b>	<b>\$70,126</b>	<b>\$112,345</b>

\*Totals may differ due to rounding.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$120,263,000	\$60,132,000	\$60,131,000
90% Title XIX ACA / 10% GF	\$48,933,000	\$4,893,000	\$44,040,000
<b>FY 2020-21 Total</b>	<b>\$169,196,000</b>	<b>\$65,025,000</b>	<b>\$104,171,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$129,699,000	\$64,850,000	\$64,849,000
90% Title XIX ACA / 10% GF	\$52,772,000	\$5,277,000	\$47,495,000
<b>FY 2021-22 Total</b>	<b>\$182,471,000</b>	<b>\$70,127,000</b>	<b>\$112,344,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## DPH INTERIM & FINAL RECONS

**REGULAR POLICY CHANGE NUMBER:** 118  
**IMPLEMENTATION DATE:** 10/2007  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1152

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$136,116,000	-\$123,313,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$136,116,000	-\$123,313,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$136,116,000	-\$123,313,000

**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: 118

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to decreased Demonstration Year (DY) 2011-12 and DY 2012-13 payments and increased DY 2014-15 recoupments based on updated final reconciliation data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the varying reconciliation estimates from the different reconciliation years. The final reconciliations estimated to occur in FY 2021-22 are recoupments compared to the net additional payments estimated in FY 2020-21.

**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)

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>
2011-12 Final Reconciliation	\$72,803	\$72,803	\$0
2012-13 Final Reconciliation	\$67,460	\$67,460	\$0
2013-14 Final Reconciliation	(\$4,147)	(\$11,812)	\$7,665
<b>Total</b>	<b>\$136,116</b>	<b>\$128,451</b>	<b>\$7,665</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>
2014-15 Final Reconciliation	(\$52,908)	(\$44,384)	(\$8,524)
2015-16 Final Reconciliation	(\$63,344)	(\$51,684)	(\$11,660)
2016-17 Final Reconciliation	(\$7,061)	\$16,831	(\$23,892)
<b>Total</b>	<b>(\$123,313)</b>	<b>(\$79,237)</b>	<b>(\$44,076)</b>

**Funding:**

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

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

**DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST**

**REGULAR POLICY CHANGE NUMBER:** 119  
**IMPLEMENTATION DATE:** 5/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2238

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$134,994,000	\$11,249,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$134,994,000	\$11,249,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$134,994,000	\$11,249,000

**Purpose:**

This policy change estimates the additional interim payments to the Designated Public Hospitals (DPHs) as a result of the 6.2% Title XIX increased Federal Medical Assistance Percentage (FMAP) related to the coronavirus 2019 (COVID-19).

**Authority:**

Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. Interim payments based on these rates are 100% federal funds (FF) based on the hospitals' certified public expenditures (CPEs), resulting in 50% FF and 50% CPE.

The FFCRA provides increased federal funding by increasing the FMAP by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency (PHE) on October 23, 2020.

Adjustment payments will be issued to the DPHs for service periods from January 1, 2020 through the end of the quarter in which the PHE ends. The PHE period is currently extended through October 31, 2020, which extends the increased FMAP effective through December 31, 2020. This policy change assumes the COVID increased FMAP will be effective through June 30, 2021. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

## DPH INTERIM RATE COVID-19 INCREASED FMAP ADJUST

### REGULAR POLICY CHANGE NUMBER: 119

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures from January 1, 2020 through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
2. Adjustment payments for January 2020 through May 2020 were paid in FY 2019-20.
3. The June 2020 adjustment payments totaling \$5.791 million FF were paid in July 2020.
4. The July 2020 adjustment payments totaling \$10.077 million FF were paid in August 2020.
5. The August 2020 adjustment payments totaling \$17.879 million FF will be paid in September 2020.
6. Assume a one-month payment lag in making the monthly adjustment for the prior service month, on a cash basis.
7. Assume the September 2020 through May 2021 adjustment payments will occur in FY 2020-21.
8. Assume the June 2021 adjustment payments will occur in FY 2021-22.
9. The estimated adjustment payments on a cash basis are:

(Dollars in Thousands)

Fiscal Year	TF	FFCRA
FY 2020-21	\$134,994	\$134,994
FY 2021-22	\$11,249	\$11,249

**Funding:**

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)

## AB 1629 ANNUAL RATE ADJUSTMENTS

**REGULAR POLICY CHANGE NUMBER:** 120  
**IMPLEMENTATION DATE:** 8/2014  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 1508

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$322,242,000	\$399,140,000
<b>- STATE FUNDS</b>	\$161,121,000	\$199,570,000
<b>PAYMENT LAG</b>	0.9287	0.9776
<b>% REFLECTED IN BASE</b>	69.62 %	53.40 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$90,917,100	\$181,832,900
<b>STATE FUNDS</b>	\$45,458,530	\$90,916,430
<b>FEDERAL FUNDS</b>	\$45,458,530	\$90,916,430

**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).

In the prior estimate, the impact of the AB 1629 Quality Assurance Fee (QAF) rate adjustments for the period beginning August 2020, and forward were budgeted separately in the Nursing Facility Financing Reform policy change. In the November 2020 Estimate, due to extension of the existing AB 1629 QAF program, financing reforms were not implemented and the Nursing Facility Financing Reform policy change is no longer budgeted in the Estimate. The ongoing AB 1629 rate adjustments will continue to be budgeted for the rate years beginning August 2020 in this policy change.

**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  
 SPA 18-0050  
 AB 81 (Chapter 13, Statutes of 2020)

**Interdependent Policy Changes:**

Funding Adjust.—ACA Opt. Expansion  
 Funding Adjust.—OTLIP  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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

## **AB 1629 ANNUAL RATE ADJUSTMENTS**

### **REGULAR POLICY CHANGE NUMBER: 120**

(FS/PSA) facilities. The QAF is used to offset a portion of the General Fund (GF) costs associated with paying FS/NF-B, FSSA/NF-B, and FS/PSA reimbursement rates. Pursuant to AB 81, FS/PSA are exempt from the QA fee as of the rating period ending July 31, 2020.

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. For the August through December 2020 rate period and calendar year 2021 rate year, the Department will use three-year old data as the base revenue and trending adjustments to project estimated revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is currently 6%. 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. For the August through December 2020 rate period and calendar year 2021 rate year, the Department will continue to provide the 2019-20 add-ons, plus any new add-ons applicable to these periods.

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 (RYs).

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payment (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 RY 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 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 RY 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.

## **AB 1629 ANNUAL RATE ADJUSTMENTS**

### **REGULAR POLICY CHANGE NUMBER: 120**

The Department received approval from CMS on December 4, 2018, to implement SPA 18-0050, to revise the building construction and estimated building value used to calculate the Capital Cost category of the reimbursement rate methodology for FS/NF-B and FSSA/NF-B facilities. Overall, the change is cost neutral, but will provide a more appropriate level of reimbursement for new facility construction.

AB 81 extended the AB 1629 program through December 2022. The extension includes a bridge period that extends the current methodology for five months, from August through December 2020, and provides an additional rate increase in January 2021, and each January thereafter, thereby transitioning the AB 1629 RY from an August start date to a January start date to align with the managed care RY. Additionally, the QASP program was extended for an additional two years.

Additionally, AB 81 updates the AB 1629 rate methodology as follows:

- The number of peer groups used to establish facility specific rates increased from 7 to 11,
- Direct Labor and Indirect Labor cost category per diem reimbursements are capped at the 95th percentile of the facility's peer group for those cost categories, previously capped at the 90th percentile, and
- AB 81 requires that no facility will see a rate decrease from the adjustments to the rate development methodology from the RY 2019-20 rate methodology.

During the COVID Public Health Emergency (PHE), long-term care facilities received a 10% rate increase. See the COVID-19 FFS Reimbursement Rates policy change for the impact of this rate increase.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net increase due to:

- Adding the costs for rates and add-ons beginning August 2020, which were previously budgeted in the Nursing Facility Financing Reform policy change in the May 2020 Estimate.
- The Rate Year 2018-19 and 2019-20 rates and add-ons are fully captured in the FFS Base trends, but are included in the total funds in FY 2020-21 and FY 2021-22. In addition, the RY 2019-20 impact estimate in the FFS Base for FSSA/NF-Bs, has been updated and was higher than the previous estimate.
- Revised FFS days based on updated actual utilization data,
- Revised estimates for the August 2020 to December 2020, and Calendar Year (CY) 2021 rate adjustments, and
- Add-ons that would have ended for the August 2020 to December 2020 period were extended, therefore increasing the add-ons impact for that period.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net increase due to including:

- A full year of the August 2020 to December 2020, and CY 2021 rate adjustments,
- Six months of the CY 2022 rate adjustments, and
- Less retroactive payments in FY 2021-22.



## AB 1629 ANNUAL RATE ADJUSTMENTS

### REGULAR POLICY CHANGE NUMBER: 120

#### Methodology:

1. The effective date for the August through December 2020 rate increase and add-ons is August 1, 2020. The effective date for the CY 2021 rate year is January 1, 2021. The effective date for the CY 2022 rate year is January 1, 2022.
2. The rate increase for August through December 2020 rate period is 3.62%. The rate is estimated to occur by November 2020. The retroactive payment is estimated to occur in December 2020.
3. The rate increase for CY 2021 is 3.5%. This rate is estimated to occur in February 2021. The retroactive payment is estimated to occur in June 2021. The rate increase for CY 2022 is 2.4%. This rate is estimated to occur in February 2022. The retroactive payment is estimated to occur in June 2022.
4. The temporary 10% COVID-19 emergency increased amount will continue and be provided in addition to the August through December 2020 rates, and continue through the public health emergency period. Refer to COVID-19 FFS Reimbursement Rates policy change for the impact of the increased funding.
5. The estimated managed care rate adjustment impact for RY 2020-21 and RY 2021-22 is included in the FY 2020-21 and FY 2021-22 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. \$11.00 per hour, effective January 2018
    - ii. \$12.00 per hour, effective January 2019
    - iii. \$13.00 per hour, effective January 2020
    - iv. \$14.00 per hour, effective January 2021
    - iv. \$15.00 per hour, effective January 2022
  - 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. These add-ons are scheduled to end with the calendar year 2022 RY.
    - i. Phase I – Antimicrobial Stewardship
    - ii. Phase II – Infection Control, Food and Nutrition Services
    - 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. These add-ons are scheduled to end with the calendar year 2022 RY.
  - Lesbian, Gay, Bisexual, and Transgender (LGBT) training: Effective August 1, 2018, SB 219 requires SNFs to implement an LGBT training program. These add-ons are scheduled to end with the calendar year 2022 RY.

**AB 1629 ANNUAL RATE ADJUSTMENTS**  
REGULAR POLICY CHANGE NUMBER: 120

7. The estimated payments on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
FFS (Rate Increase)			
RY 2018-19 rate	\$81,992,000	\$40,996,000	\$40,996,000
RY 2019-20 rate	\$100,436,000	\$50,218,000	\$50,218,000
Aug-Dec 2020 rate	\$11,458,000	\$5,729,000	\$5,729,000
CY 2021 rate	\$79,998,000	\$39,999,000	\$39,999,000
Add-Ons			
RY 2018-19 add-ons	\$27,670,000	\$13,835,000	\$13,835,000
RY 2019-20 add-ons	(\$1,742,000)	(\$871,000)	(\$871,000)
Aug-Dec 2020 add-ons	\$1,832,000	\$916,000	\$916,000
CY 2021 add-ons	(\$6,136,000)	(\$3,068,000)	(\$3,068,000)
Retro			
Aug-Dec 2020 rate (RETRO)	\$17,188,000	\$8,594,000	\$8,594,000
Aug-Dec 2020 add-ons (RETRO)	\$2,748,000	\$1,374,000	\$1,374,000
CY 2021 rate (RETRO)	\$9,124,000	\$4,562,000	\$4,562,000
CY 2021 add-ons (RETRO)	(\$2,326,000)	(\$1,163,000)	(\$1,163,000)
Managed Care	\$0	\$0	\$0
<b>Total</b>	<b>\$322,242,000</b>	<b>\$161,121,000</b>	<b>\$161,121,000</b>

**AB 1629 ANNUAL RATE ADJUSTMENTS**  
REGULAR POLICY CHANGE NUMBER: 120

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
<b>FFS Rate Increase</b>			
RY 2018-19 rate	\$81,992,000	\$40,996,000	\$40,996,000
RY 2019-20 rate	\$100,436,000	\$50,218,000	\$50,218,000
Aug-Dec 2020 rate	\$34,376,000	\$17,188,000	\$17,188,000
CY 2021 rate	\$54,746,000	\$27,373,000	\$27,373,000
CY 2022 rate	\$111,740,000	\$55,870,000	\$55,870,000
<b>Add-Ons</b>			
RY 2018-19 add-ons	\$27,670,000	\$13,835,000	\$13,835,000
RY 2019-20 add-ons	(\$1,742,000)	(\$871,000)	(\$871,000)
Aug-Dec 2020 add-ons	\$5,494,000	\$2,747,000	\$2,747,000
CY 2021 add-ons	(\$13,958,000)	(\$6,979,000)	(\$6,979,000)
CY 2022 add-ons	(\$6,474,000)	(\$3,237,000)	(\$3,237,000)
<b>Retro</b>			
CY 2022 rate (RETRO)	\$4,442,000	\$2,221,000	\$2,221,000
<b>Managed Care</b>	\$418,000	\$209,000	\$209,000
<b>Total</b>	<b>\$399,140,000</b>	<b>\$199,570,000</b>	<b>\$199,570,000</b>

**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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## PROP 56 - HOME HEALTH RATE INCREASE

**REGULAR POLICY CHANGE NUMBER:** 121  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2077

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$167,320,000	\$92,754,000
<b>- STATE FUNDS</b>	\$77,151,580	\$43,338,200
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	55.43 %	100.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$74,574,500	\$0
<b>STATE FUNDS</b>	\$34,386,460	\$0
<b>FEDERAL FUNDS</b>	\$40,188,060	\$0

**Purpose:**

This policy change estimates the costs of a rate increase for Fee-for-Service (FFS) home health and private duty nursing (PDN) services, effective July 1, 2018.

**Authority:**

SB 856 (Chapter 30, Statutes of 2018)  
 SPA 18-0037  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 developed 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP).

## PROP 56 - HOME HEALTH RATE INCREASE

### REGULAR POLICY CHANGE NUMBER: 121

The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments, effective July 1, 2021, the Department assumes the continuation of the Proposition 56 Home Health payments.

#### Reason for Change:

The change for FY 2020-21, from the prior estimate, is due to:

- A delay in the additional Erroneous Payment Correction (EPC). This was previously estimated to occur in June 2020, instead, the EPC occurred in August 2020. In addition, the EPC estimate has increased from the prior estimate.
- Updating FFS funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- The completion of the additional EPC in FY 2020-21.
- Less FFCRA funding estimated in FY 2021-22.

#### Methodology:

1. The Department increased 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 were implemented on December 28, 2018. The EPC for the retroactive period from July 2018 to December 2018 occurred in April 2019. An additional EPC, for claims not captured in the original EPC, occurred in August 2020.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.

FY 2020-21	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$92,754,000	\$40,445,000	\$2,691,000	\$43,424,000	\$637,000	\$5,557,000
EPC	\$74,566,000	\$36,707,000	\$2,438,000	\$34,909,000	\$512,000	\$0
<b>Total</b>	<b>\$167,320,000</b>	<b>\$77,152,000</b>	<b>\$5,129,000</b>	<b>\$78,333,000</b>	<b>\$1,149,000</b>	<b>\$5,557,000</b>

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$92,754,000	\$43,338,000	\$2,577,000	\$43,424,000	\$637,000	\$2,778,000
<b>Total</b>	<b>\$92,754,000</b>	<b>\$43,338,000</b>	<b>\$2,577,000</b>	<b>\$43,424,000</b>	<b>\$637,000</b>	<b>\$2,778,000</b>

**PROP 56 - HOME HEALTH RATE INCREASE**  
REGULAR POLICY CHANGE NUMBER: 121

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$156,667,000	\$78,334,000	\$78,333,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$1,277,000	\$128,000	\$1,149,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$4,178,000	\$982,000	\$3,196,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$2,973,000	\$1,040,000	\$1,933,000	\$0
100% GF (4260-101-0001)	\$2,225,000	\$2,225,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$172,000)	(\$172,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$172,000	\$0	\$0	\$172,000
FFCRA 6.2% GF (4260-101-0001)	(\$5,385,000)	(\$5,385,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$5,385,000	\$0	\$0	\$5,385,000
<b>Total</b>	<b>\$167,320,000</b>	<b>\$77,152,000</b>	<b>\$84,611,000</b>	<b>\$5,557,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$86,848,000	\$43,424,000	\$43,424,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$708,000	\$71,000	\$637,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$3,964,000	\$1,387,000	\$2,577,000	\$0
100% GF (4260-101-0001)	\$1,234,000	\$1,234,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$86,000)	(\$86,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$86,000	\$0	\$0	\$86,000
FFCRA 6.2% GF (4260-101-0001)	(\$2,692,000)	(\$2,692,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$2,692,000	\$0	\$0	\$2,692,000
<b>Total</b>	<b>\$92,754,000</b>	<b>\$43,338,000</b>	<b>\$46,638,000</b>	<b>\$2,778,000</b>

## FQHC/RHC/CBRC RECONCILIATION PROCESS

**REGULAR POLICY CHANGE NUMBER:** 122  
**IMPLEMENTATION DATE:** 7/2008  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1329

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$44,610,000	\$44,908,000
<b>- STATE FUNDS</b>	\$17,144,200	\$17,258,800
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$44,610,000	\$44,908,000
<b>STATE FUNDS</b>	\$17,144,200	\$17,258,800
<b>FEDERAL FUNDS</b>	\$27,465,800	\$27,649,200

**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 2016-17 audited levels were used to update the CBRC rates as of July 1, 2019. The Department partially completed the CBRC reconciliation audit for FY 2017-18 in FY 2019-20, and is scheduled to complete the remaining FY 2017-18 audits and FY 2018-19 audit levels in FY 2020-21. Interim rates will be adjusted to the completed FY 2017-18 audit levels beginning in FY 2020-21. The remaining interim rates, to the FY 2017-18 audit levels, will be adjusted beginning in FY 2021-22.

Currently, there are 1,317 active FQHCs, 266 active RHCs, 25 active CBRCs, and 94 active IHS/MOA.

## FQHC/RHC/CBRC RECONCILIATION PROCESS

### REGULAR POLICY CHANGE NUMBER: 122

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to a decrease in the total amounts paid for each Erroneous Payment Corrections (EPC) and a decrease in the settlement recoveries from issued reconciliations for the period of July 2017 through June 2020.

Additionally, scheduled FY 2017-18 CBRC audits were not fully completed, resulting in adjustments from the interim rates to the final rates for the remaining FY 2017-18 CBRC audits scheduled to be completed in FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the combined net effect from the total amounts paid for each EPC and the FY 2021-22 settlement recoveries being based on a three-year average of actual and estimated projected settlements from July 2018 through June 2021.

#### Methodology:

1. FY 2020-21 FQHC and RHC reconciliations are based on actual settlements from July 2017 through June 2020. FY 2021-22 reconciliations are based on a three-year average of actual and estimated projected settlements from July 2018 through June 2021. FY 2017-18, FY 2018-19, and FY 2019-20 FQHC reconciliations include settlements for IHS.
2. The estimated FQHC retroactive rate adjustment of \$29,490,000 for FY 2020-21 is based on a three-year average of FY 2017-18, FY 2018-19, and FY 2019-20 EPC actuals. For FY 2021-22, the amount of \$28,358,000 is based on a three-year average of FY 2018-19 and FY 2019-20 EPC actuals and estimated EPCs for FY 2020-21. The change from the prior year estimate is attributed to a higher estimated EPC paid than the actual current EPC implemented and paid. Currently, the fiscal intermediary processes EPCs quarterly.
3. The LA CBRC reconciliation for FY 2020-21 reconciliation is based on settlement of 95% of the FY 2017-18 audited settlements. The FY 2021-22 reconciliation is based on 95% of the projected FY 2018-19 settlements calculated utilizing an average percentage between the CBRC interim payments over revenues for FY 2015-16, FY 2016-17, and FY 2017-18. The change from the prior year estimate is due to FY 2017-18 hospital audits scheduled to be completed in FY 2020-21.

Reconciliations and Adjustments	FY 2020-21	FY 2021-22
FQHCs Reconciliation	(\$36,232,000)	(\$43,998,000)
RHCs Reconciliation	(\$259,000)	(\$152,000)
FQHC Retroactive Rate Adjustment	\$29,490,000	\$28,358,000
LA CBRCs Reconciliation	\$51,611,000	\$60,700,000
<b>Total</b>	<b>\$44,610,000</b>	<b>\$44,908,000</b>

FY 2020-21	TF	GF	FF
90% Title XIX ACA / 10% GF	\$12,902,000	\$1,290,000	\$11,612,000
50% Title XIX / 50% GF	\$31,708,000	\$15,854,000	\$15,854,000
<b>FY 2020-21 Total</b>	<b>\$44,610,000</b>	<b>\$17,144,000</b>	<b>\$27,466,000</b>

FY 2021-22	TF	GF	FF
90% Title XIX ACA / 10% GF	\$12,988,000	\$1,299,000	\$11,689,000
50% Title XIX / 50% GF	\$31,920,000	\$15,960,000	\$15,960,000
<b>FY 2021-22 Total</b>	<b>\$44,908,000</b>	<b>\$17,259,000</b>	<b>\$27,649,000</b>



**FQHC/RHC/CBRC RECONCILIATION PROCESS**  
REGULAR POLICY CHANGE NUMBER: 122

**Funding:**

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

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

## LTC RATE ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 123  
**IMPLEMENTATION DATE:** 8/2007  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 1046

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$58,825,000	\$88,348,000
<b>- STATE FUNDS</b>	\$29,412,500	\$44,174,000
<b>PAYMENT LAG</b>	0.9662	0.9687
<b>% REFLECTED IN BASE</b>	46.98 %	42.59 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$30,134,800	\$49,133,000
<b>STATE FUNDS</b>	\$15,067,410	\$24,566,520
<b>FEDERAL FUNDS</b>	\$15,067,410	\$24,566,520

### 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)  
 AB 81 (Chapter 13, Statutes of 2020)

### Interdependent Policy Changes:

Funding Adjust. – ACA Opt. Expansion  
 Funding Adjust. – OTLICP  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

### Background:

Prior to rate year 2009-10, Medi-Cal rates for LTC facilities were adjusted after completion of an annual rate study for specified provider types. ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP/PSA.

## LTC RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 123

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.

Effective September 1, 2013, SPA 13-034 exempted Rural Swing Beds in DP/NF-B facilities located in designated rural and frontier areas from the AB 97 rate freeze and rate reduction. All other bed types in DP/NF-B facilities were exempted October 1, 2013.

The Department also received CMS approval to exempt DP Adult Subacute and DP/PSA from the rate freeze based on access and utilization analyses.

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.

AB 119 extends the FS Pediatric Subacute Facilities QAF sunset from July 31, 2015 to July 31, 2020. Pursuant to AB 81, FS/PSA are exempt from the QA fee as of the rating period ending July 31, 2020.

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. ABX2 1 also required the Department to restore the AB 97 payment reduction and reimburse ICF/DD facilities at the 2008-09 levels, increased by 3.7%.

Restore AB 97	Increase 3.7%	Total
\$5,791,000	\$19,330,000	\$25,121,000

The reimbursement rates for DP Adult Subacute and DP Pediatric Subacute types are described in the State Plan and are currently not subject to any rate reductions.

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.

During the COVID Public Health Emergency (PHE), long-term care facilities received a 10% rate increase. See the COVID-19 FFS Reimbursement Rates policy change for the impact of this rate increase.

## LTC RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 123

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a net increase due to:

- Updated RY 2019-20 and 2020-21 estimates;
- Revised FFS utilization based on updated actual utilization data;
- Updated RY 2020-21 add-ons; and
- Revised estimate of retroactive payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net increase due to:

- A full year of the RY 2020-21 rate adjustments in FY 2021-22;
- Including the RY 2021-22 rate adjustments in FY 2021-22; and
- Less retroactive payments in FY 2021-22.

#### Methodology:

1. The effective date for the rate adjustments is August 1<sup>st</sup> of each rate year. The expected RY 2020-21 and RY 2021-22 implementation dates are as follows:

Facility	FY 2020-21	FY 2021-22
DP/NF-B	12/31/2020	11/1/2021
Rural Swing Beds (non-exempt)	12/31/2020	11/1/2021
Rural Swing Beds (exempt)	12/31/2020	11/1/2021
DP Adult Subacute	12/31/2020	11/1/2021
NF-A	12/31/2020	11/1/2021
ICF/DDs	8/17/2020	11/1/2021
DP Pediatric Subacute	10/26/2020	10/15/2021
FS Pediatric Subacute	10/26/2020	10/15/2021

2. The estimated managed care rate adjustment impacts for rate year 2020-21 and 2021-22 are included in the managed care capitation rates.
3. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze. The add-on descriptions are listed below:
  - SB 3 (Chapter 4, Statutes of 2016) 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.
    - v. \$14.00 per hour, effective January 2021.
    - vi. \$15.00 per hour, effective January 2022.
  - 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.

## LTC RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 123

- 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 (Chapter 483, Statutes of 2017) requires SNFs to implement an LGBT training program.
  - Fire Safety Add-on: Effective July 5, 2016, CMS formally adopted requirements from the 2012 Life Safety Code, which requires ICF/DD-H and N facilities to comply with amended fire safety requirements for attics by July 5, 2019.
4. The temporary 10% COVID-19 emergency increased amount will continue and be provided in addition to the August through December 2020 rates, and continue through the public health emergency period. Refer to the COVID-19 FFS Reimbursement Rates policy change for the impact of the increased funding.
5. Payments for FY 2020-21 include retroactive payments for 2020-21. Payments for FY 2021-22 include retroactive payments for 2021-22. The costs below reflect the incremental rate adjustments and add-ons for each facility type:

<b>Fee-for-Service</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
Rate Adjustment (19-20)		
DP/NF-B	\$10,727,000	\$10,727,000
Rural Swing Beds (non-exempt)	\$1,000	\$1,000
Rural Swing Beds (exempt)	\$52,000	\$52,000
DP Adult Subacute	\$9,536,000	\$9,536,000
NF-A	\$110,000	\$110,000
ICF/DDs	\$15,349,000	\$15,349,000
DP Pediatric Subacute	\$658,000	\$658,000
FS Pediatric Subacute	\$15,000	\$15,000
Rate Adjustment (20-21)		
DP/NF-B	\$3,827,000	\$7,653,000
Rural Swing Beds (non-exempt)	\$0	\$1,000
Rural Swing Beds (exempt)	\$35,000	\$70,000
DP Adult Subacute	\$3,146,000	\$6,292,000
NF-A	\$14,000	\$28,000
ICF/DDs	\$7,952,000	\$9,542,000
DP Pediatric Subacute	\$682,000	\$1,023,000
FS Pediatric Subacute	(\$233,000)	(\$350,000)
Rate Adjustment (21-22)		
DP/NF-B		\$7,092,000
Rural Swing Beds (non-exempt)		\$1,000
Rural Swing Beds (exempt)		\$36,000
DP Adult Subacute		\$4,879,000
NF-A		\$26,000

**LTC RATE ADJUSTMENT**  
REGULAR POLICY CHANGE NUMBER: 123

ICF/DDs		\$7,688,000
DP Pediatric Subacute		\$362,000
FS Pediatric Subacute		\$17,000
Retro Rate Adjustments		
DP/NF-B	\$3,189,000	\$2,660,000
Rural Swing Beds (non-exempt)	\$1,000	\$1,000
Rural Swing Beds (exempt)	\$55,000	\$13,000
DP Adult Subacute	\$2,621,000	\$1,830,000
NF-A	\$12,000	\$10,000
ICF/DDs	\$795,000	\$2,883,000
DP Pediatric Subacute	\$366,000	\$136,000
FS Pediatric Subacute	(\$85,000)	\$7,000
<b>Total FFS</b>	<b>\$58,825,000</b>	<b>\$88,348,000</b>
Managed care	\$0	\$0
<b>Total Cost</b>	<b>\$58,825,000</b>	<b>\$88,348,000</b>

**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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## EMERGENCY MEDICAL AIR TRANSPORTATION ACT

**REGULAR POLICY CHANGE NUMBER:** 124  
**IMPLEMENTATION DATE:** 11/2012  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1612

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$13,972,000	\$8,539,000
<b>- STATE FUNDS</b>	\$4,794,000	\$3,038,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$13,972,000	\$8,539,000
<b>STATE FUNDS</b>	\$4,794,000	\$3,038,000
<b>FEDERAL FUNDS</b>	\$9,178,000	\$5,501,000

**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)  
 AB 651 (Chapter 537, Statutes of 2019)  
 AB 2450 (Chapter 52, Statutes of 2020)  
 SPA 18-0030  
 SPA 19-0012  
 Families First Coronavirus Response Act (FFCRA)  
 SPA 20-0011

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 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. The change in remittance procedures increased the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the appropriated funds is used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the appropriated amount is matched with federal

## **EMERGENCY MEDICAL AIR TRANSPORTATION ACT**

### **REGULAR POLICY CHANGE NUMBER: 124**

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. On August 23, 2019, SPA 19-0012 was approved for the FY 2019-20 augmentation payments. On November 24, 2020, SPA 20-0011 was approved for the FY 2020-21 augmentation payments.

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.

AB 651 extends the assessment of the \$4 penalty for vehicle code violations until July 1, 2020, extends supplemental payments until December 31, 2021, and extends the EMATA sunset date to July 1, 2022.

AB 2450 extends the assessment of the \$4 penalty for vehicle code violations until July 1, 2021, extends supplemental payments until December 31, 2022, and extends the EMATA sunset date to July 1, 2024.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is an increase due to:

- An increase in the GF transfer amounts in FY 2020-21,
- An increase in estimated payments due to adding FY 2018-19 reconciliation payments and increased estimates for the FY 2019-20 and FY 2020-21 payments made in FY 2020-21.
- Including FFCRA increased FFP for the applicable periods FY 2019-20 and FY 2020-21 augmentation payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to:

- The impact of the one-year program extension is included in FY 2021-22, with the first half FY 2021-22 augmentation payments estimated in FY 2021-22.
- Decreased augmentation estimated due to no prior year reconciliation payments are estimated in FY 2021-22.
- Decreased GF transfer estimate for FY 2021-22.
- Decreased FFCRA increased FFP due to the assumed applicable period in FY 2021-22.

#### **Methodology:**

1. Implementation date began November 2012.



## EMERGENCY MEDICAL AIR TRANSPORTATION ACT

### REGULAR POLICY CHANGE NUMBER: 124

2. Assume revenue collections for the penalty assessments that end July 1, 2021, will continue to be collected through June 2022.
3. The FY 2020-21 estimated payments include the:
  - FFS augmentation payments for the second half of FY 2019-20, and the first half of FY 2020-21,
  - FFS reconciliation payments from FY 2018-19.
  - GF transfer from the second half of FY 2019-20 collections, which is expected to be \$885,000, and
  - GF transfer from all FY 2020-21 collections, which is expected to be \$1,325,000.
4. The FY 2021-22 estimated payments include the:
  - FFS augmentation payments for the second half of FY 2020-21, and the first half of FY 2021-22, and
  - GF transfer from the FY 2021-22 collections, which is expected to be \$408,000.
5. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
6. Based on estimated fee collections, the estimated payments on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>EMATCC</b>	<b>FFP</b>	<b>FFCRA</b>
GF Offset	\$0	(\$2,210,000)	\$2,210,000	\$0	\$0
Augment Payment	\$13,972,000	\$0	\$4,794,000	\$8,665,000	\$513,000
<b>Total</b>	<b>\$13,972,000</b>	<b>(\$2,210,000)</b>	<b>\$7,004,000</b>	<b>\$8,665,000</b>	<b>\$513,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>EMATCC</b>	<b>FFP</b>	<b>FFCRA</b>
GF Offset	\$0	(\$408,000)	\$408,000	\$0	\$0
Augment Payment	\$8,539,000	\$0	\$3,038,000	\$5,207,000	\$294,000
<b>Total</b>	<b>\$8,539,000</b>	<b>(\$408,000)</b>	<b>\$3,446,000</b>	<b>\$5,207,000</b>	<b>\$294,000</b>

**Funding:**

100% GF (4260-101-0001)  
 Title XIX FFP (4260-101-0890)  
 EMATA / EMATCC Fund (4260-101-3168)  
 FFCRA Increased FFP (4260-101-0890)

## HOSPICE RATE INCREASES

**REGULAR POLICY CHANGE NUMBER:** 125  
**IMPLEMENTATION DATE:** 10/2006  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 96

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$11,260,000	\$16,321,000
<b>- STATE FUNDS</b>	\$5,630,000	\$8,160,500
<b>PAYMENT LAG</b>	0.8224	0.9520
<b>% REFLECTED IN BASE</b>	2.54 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$9,025,000	\$15,537,600
<b>STATE FUNDS</b>	\$4,512,510	\$7,768,800
<b>FEDERAL FUNDS</b>	\$4,512,510	\$7,768,800

**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  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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.

Effective January 1, 2016, the CMS final hospice rule changed 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. Additionally, the CMS final hospice rule established a Service Intensity Add-On (SIA) payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary's life for a maximum of four hours a day.

**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

## HOSPICE RATE INCREASES

### REGULAR POLICY CHANGE NUMBER: 125

Developmentally Disabled – Habilitative (ICF/DD-H). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

Pursuant to 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 for 2020-21, from the prior estimate, is a decrease due to revised projected expenditures based on actual RY 2019 Hospice rates.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to:

- A full year of RY 2019-20 hospice services rates occurring in FY 2020-21,
- Including the RY 2020-21 hospice services rates in FY 2020-21, and
- More retroactive hospice services payments occurring in FY 2020-21 than in FY 2019-20.

#### Methodology:

1. Hospice Services:
  - a. The estimated weighted change for hospice service rates, excluding RHC and SIA, is -16.77% for RY 2020-21 and 5.97% for RY 2021-22.
  - b. RY 2018-19 hospice services rates were implemented on December 24, 2018. The EPC for the retroactive period of October 1, 2018, through December 23, 2018, occurred in June 2019.
  - c. The RY 2019-20 hospice rates were implemented on February 25, 2020. The retroactive payment for the period of October 2019 through February 24, 2020, is expected to be implemented in August 2020.
  - d. The RY 2020-21 hospice rates are expected to be implemented in January 2021. The retroactive payment for the period of October 2020 through December 2020 is expected to be implemented in June 2021.
  - e. The RY 2021-22 hospice rates are expected to be implemented in January 2022. The retroactive payment for the period of October 2021 through December 2021 is expected to be implemented in June 2022.
2. 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 is 11.27% for RY 2020-21 and 3.92% RY 2021-22.

## HOSPICE RATE INCREASES

### REGULAR POLICY CHANGE NUMBER: 125

3. The estimated managed care rate adjustment impact for RY 2019-20 and RY 2020-21 is included in the FY 2019-20 and FY 2020-21 managed care capitation rates, respectively.
4. The estimated payments on a cash basis are:

<b>Cash Basis</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
Hospice Services (19-20)	\$81,000	\$81,000
RHC & SIA Payments (19-20)	\$461,000	\$461,000
Hospice Services (19-20) retro	\$34,000	
RHC & SIA Payments (19-20) retro	\$192,000	
Hospice Services (20-21)	(\$120,000)	(\$241,000)
RHC & SIA Payments (20-21)	\$813,000	\$1,627,000
Room & Board (20-21)	\$9,452,000	\$10,311,000
Hospice Services Retro (20-21) retro	(\$60,000)	
RHC & SIA Payments (20-21) retro	\$407,000	
Hospice Services (21-22)		\$36,000
RHC & SIA Payments (21-22)		\$246,000
Room & Board (21-22)		\$3,659,000
Hospice Services Retro (21-22) retro		\$18,000
RHC & SIA Payments (21-22) retro		\$123,000
<b>TOTAL</b>	<b>\$11,260,000</b>	<b>\$16,321,000</b>

**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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

**REGULAR POLICY CHANGE NUMBER:** 126  
**IMPLEMENTATION DATE:** 1/2019  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2098

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$17,353,000	\$14,246,000
<b>- STATE FUNDS</b>	\$7,741,120	\$6,655,550
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	82.09 %	100.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,107,900	\$0
<b>STATE FUNDS</b>	\$1,386,440	\$0
<b>FEDERAL FUNDS</b>	\$1,721,490	\$0

**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  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**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.

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 developed the structure and parameters for a rate increase in 2018-19 for PDHC facilities. The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0037 on September 17, 2018, to increase PDHC rates, effective July 1, 2018.

## PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE

### REGULAR POLICY CHANGE NUMBER: 126

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments, effective July 1, 2021, the Department assumes the continuation of the Proposition 56 PDHC payments.

#### Reason for Change:

The change for FY 2020-21, from the prior estimate, is due to:

- A delay in the additional Erroneous Payment Correction (EPC). This was previously estimated to occur in June 2020, instead, the EPC occurred in August 2020. In addition, the EPC estimate has increased from the prior estimate.
- Updating FFS funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- The completion of the additional EPC in FY 2020-21.
- Less FFCRA funding estimated in FY 2021-22.

#### Methodology:

1. The Medi-Cal FFS reimbursement rate for PDHC services was \$29.41 per hour.
2. The reimbursement rate for EPSDT PDHC support service rates was increased by 50 percent.
3. The PDHC rate increase implemented on December 28, 2018. An EPC for the retroactive period of July 2018 through December 2018 occurred in April 2019. An additional EPC, for claims not captured in the original EPC, occurred in August 2020.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.

FY 2020-21	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Ongoing	\$14,246,000	\$6,212,000	\$413,000	\$6,669,000	\$98,000	\$854,000
EPC	\$3,107,000	\$1,529,000	\$102,000	\$1,455,000	\$21,000	\$0
<b>Total</b>	<b>\$17,353,000</b>	<b>\$7,741,000</b>	<b>\$515,000</b>	<b>\$8,124,000</b>	<b>\$119,000</b>	<b>\$854,000</b>

**PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE**  
REGULAR POLICY CHANGE NUMBER: 126

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Title XXI FF</b>	<b>Title XIX FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FFS Ongoing	\$14,246,000	\$6,656,000	\$396,000	\$6,669,000	\$98,000	\$427,000
<b>Total</b>	<b>\$14,246,000</b>	<b>\$6,656,000</b>	<b>\$396,000</b>	<b>\$6,669,000</b>	<b>\$98,000</b>	<b>\$427,000</b>

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$16,248,000	\$8,124,000	\$8,124,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$132,000	\$13,000	\$119,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$285,000	\$67,000	\$218,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$457,000	\$160,000	\$297,000	\$0
100% GF (4260-101-0001)	\$231,000	\$231,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$26,000)	(\$26,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$26,000	\$0	\$0	\$26,000
FFCRA 6.2% GF (4260-101-0001)	(\$828,000)	(\$828,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$828,000	\$0	\$0	\$828,000
<b>Total</b>	<b>\$17,353,000</b>	<b>\$7,741,000</b>	<b>\$8,758,000</b>	<b>\$854,000</b>

**PROP 56 - PEDIATRIC DAY HEALTH CARE RATE INCREASE**  
REGULAR POLICY CHANGE NUMBER: 126

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$13,339,000	\$6,670,000	\$6,669,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$109,000	\$11,000	\$98,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$609,000	\$213,000	\$396,000	\$0
100% GF (4260-101-0001)	\$189,000	\$189,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$13,000)	(\$13,000)	\$0	\$0
FFCRA 4.34% GF (4260-113-0890)	\$13,000	\$0	\$0	\$13,000
FFCRA 6.2% GF (4260-101-0001)	(\$414,000)	(\$414,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$414,000	\$0	\$0	\$414,000
<b>Total</b>	<b>\$14,246,000</b>	<b>\$6,656,000</b>	<b>\$7,163,000</b>	<b>\$427,000</b>



## GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

**REGULAR POLICY CHANGE NUMBER:** 127  
**IMPLEMENTATION DATE:** 12/2020  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 2184

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,776,000	\$2,776,000
<b>- STATE FUNDS</b>	\$1,388,000	\$1,388,000
<b>PAYMENT LAG</b>	0.8290	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,301,300	\$2,776,000
<b>STATE FUNDS</b>	\$1,150,650	\$1,388,000
<b>FEDERAL FUNDS</b>	\$1,150,650	\$1,388,000

**Purpose:**

This policy change estimates the costs associated with a fee increase 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:**

COVID-19 Increased FMAP - DHCS  
COVID-19 Increased FMAP Extension – DHCS

**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 newborn screening 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).

The RUSP adopted the Spinal Muscular Atrophy (SMA) condition 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. A fee increase of \$35.00 per specimen was effective July 1, 2020 for costs associated with adding SMA to the Newborn Screening panel, increased contracted screening rates, and increased referrals for case management, coordination, and diagnostic services.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a decrease due to a reduction in the caseload estimate.

- In the prior estimate, the total estimated Medi-Cal fee-for-service (FFS) and managed births was included in the policy change. In this estimate, managed care costs are

## GDSP NEWBORN SCREENING PROGRAM FEE INCREASE

### REGULAR POLICY CHANGE NUMBER: 127

included in the base capitation rates, therefore, managed care costs are removed from this policy change.

- There is a slight decrease in the total estimated GDSP caseload in California.

There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

#### Methodology:

1. The Department of Public Health implemented a \$35.00 fee increase for the GDSP NBS program, effective July 1, 2020. The Department implements a corresponding Medi-Cal FFS GDSP NBS rate increase based on this fee increase.
2. The Medi-Cal FFS rate increase, that covers the increased fee, is expected to be implemented in December 2020. The retroactive correction for the July 1, 2020 to November 30, 2020 period, is expected to be implemented in April 2021.
3. The estimated GDSP caseload in California is 444,234 for FY 2020-21 and FY 2021-22. GDSP assumes approximately 99% of newborns will be screened by the NBS Program each year.
4. Assume approximately 55% of newborns screened are from the Medi-Cal population. Of the percentage Medi-Cal newborn population, assume approximately 33% are in Medi-Cal FFS.
5. The Medi-Cal managed care impact is assumed in the managed care base capitation rates; therefore, there are no managed care costs included in this policy change.
6. Assume 99% of Medi-Cal FFS claims submitted are paid. The annual Medi-Cal FFS costs are estimated to be \$2,776,000 TF.
7. The estimated Medi-Cal FFS costs for FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS Prospective Rate Increase	\$1,618,000	\$809,000	\$809,000
FFS Retroactive Payments	\$1,158,000	\$579,000	\$579,000
<b>Total</b>	<b>\$2,776,000</b>	<b>\$1,388,000</b>	<b>\$1,388,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS Prospective Rate Increase	\$2,776,000	\$1,388,000	\$1,388,000
<b>Total</b>	<b>\$2,776,000</b>	<b>\$1,388,000</b>	<b>\$1,388,000</b>

#### Funding:

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

**DPH INTERIM RATE**

**REGULAR POLICY CHANGE NUMBER:** 128  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1161

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$436,092,100	-\$461,715,700
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$436,092,100	-\$461,715,700
<b>FEDERAL FUNDS</b>	\$436,092,100	\$461,715,700

**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: 128

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to updated DPH actual data through July 2020, and higher expected costs incurred from the national public health emergency.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to a slight increase in estimated users in FY 2021-22 based on actual data through July 2020.

**Methodology:**

- The funding adjustment is estimated at:

(Dollars in Thousands)

	<b>Expenditures</b>	<b>GF to FF Shift</b>
<b>FY 2020-21</b>	<b>\$1,411,893</b>	<b>\$436,092</b>
<b>FY 2021-22</b>	<b>\$1,486,881</b>	<b>\$461,716</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$737,258)	(\$368,629)	(\$368,629)
100% Title XIX FF (4260-101-0890)	\$1,411,893	\$0	\$1,411,893
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$674,635)	(\$67,463)	(\$607,172)
<b>Total Funds</b>	<b>\$0</b>	<b>(\$436,092)</b>	<b>\$436,092</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890 / 0001)	(\$782,570)	(\$391,285)	(\$391,285)
100% Title XIX FF (4260-101-0890)	\$1,486,881	\$0	\$1,486,881
90% Title XIX ACA / 10% GF (4260-101-0890 / 0001)	(\$704,311)	(\$70,431)	(\$633,880)
<b>Total Funds</b>	<b>\$0</b>	<b>(\$461,716)</b>	<b>\$461,716</b>

\*Totals may differ due to rounding.

## LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

**REGULAR POLICY CHANGE NUMBER:** 129  
**IMPLEMENTATION DATE:** 8/2013  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1784

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to the State General Fund (GF) to partially offset GF costs associated with providing Long Term Care Services.

**Authority:**

AB 1467 (Chapter 23, Statutes of 2012)  
 AB 119 (Chapter 17, Statutes of 2015)  
 SB 833 (Chapter 30, Statutes of 2016)  
 AB 81 (Chapter 13, Statutes of 2020)

**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 to partially offset LTC rate reimbursement. 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-PSAs)  
(Pursuant to AB 81, FS-PSAs are exempt from the QA fee as of the rating period ending July 31, 2020.)

AB 1467 established the LTCQAF. Effective August 1, 2013, the QA fees collected by LTC and ICF-DD facilities 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. 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 developed to collect past due AB 1629 QAF assessed on specified Skilled Nursing Facilities. The withheld portion is transferred to the LTCQAF, and subsequently to the GF. The withheld QAF payments are budgeted in the QAF Withhold Transfer policy change.

AB 81 (Chapter 13, Statutes of 2020) extends the QAF and AB 1629 methodology through December 31, 2022, and exempts Freestanding Pediatric Subacute facilities from the QAF, effective August 1, 2020.

#### Reason for Change:

The change for FY 2020-21, from the prior estimate, is an estimated net increase in GF transfers due to:

- Actual total QAF collections from May 2020 to August 2020 were higher than the prior projections.
- Based on updated collections data through August 2020, the projected monthly average collections increased.
- A decrease in FY 2019-20 GF transfers because the April 2020 collections were transferred earlier to the GF in FY 2019-20. The prior estimate estimated the transfer to occur in FY 2020-21.
- Actual withhold transfers totals were lower than previously projected.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an estimated decrease in GF transfers due to:

- Actual QAF collections transferred in FY 2020-21 are higher than the projected monthly average transfers estimated to occur in FY 2021-22.
- There are fewer prior year QAF withhold transfers expected to occur in FY 2021-22.

#### Methodology:

1. Based on collections and transfer data through August 2020; assume \$628.56 million will be transferred to the GF in FY 2020-21 and \$532.75 million in FY 2021-22.
2. The estimated withhold transfers for the AB 1629 QAF and QAF assessed on ICF-DDs are expected to occur is \$133.73 million in FY 2020-21 and \$70.45 million in FY 2021-22.

## LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 129

3. The estimated fund adjustment from the LTCQAF to the GF is:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>LTCQAF</b>
FY 2019-20	\$0	(\$89,845)	\$89,845
FY 2020-21	\$0	(\$404,983)	\$404,983
Subtotal	\$0	(\$494,828)	\$494,828
Withhold Transfers	\$0	(\$133,728)	\$133,728
<b>Total</b>	<b>\$0</b>	<b>(\$628,556)</b>	<b>\$628,556</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>LTCQAF</b>
FY 2020-21	\$0	(\$77,050)	\$77,050
FY 2021-22	\$0	(\$385,252)	\$385,252
Subtotal	\$0	(\$462,302)	\$462,302
Withhold Transfers	\$0	(\$70,450)	\$70,450
<b>Total</b>	<b>\$0</b>	<b>(\$532,752)</b>	<b>\$532,752</b>

**Funding:**

Long Term Care Quality Assurance Fund (4260-601-3213)  
100% GF (4260-101-0001)

## DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

**REGULAR POLICY CHANGE NUMBER:** 130  
**IMPLEMENTATION DATE:** 4/2020  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 2161

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$2,464,000	-\$3,296,000
<b>- STATE FUNDS</b>	-\$1,114,380	-\$1,527,380
<b>PAYMENT LAG</b>	1.0000	0.8928
<b>% REFLECTED IN BASE</b>	18.67 %	17.53 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$2,004,000	-\$2,426,800
<b>STATE FUNDS</b>	-\$906,320	-\$1,124,600
<b>FEDERAL FUNDS</b>	-\$1,097,650	-\$1,302,220

**Purpose:**

This policy change estimates the costs to adjust Medi-Cal Fee-for-Service (FFS) Durable Medical Equipment (DME) reimbursement rates.

**Authority:**

Welfare and Institutions Code 14105.48  
 SPA 19-0005  
 SPA 20-0005  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

Pursuant to W&I Code 14105.48, the Department is required to set Medi-Cal FFS DME reimbursement rates at no more than 80% of the corresponding Medicare rural rate, except for wheelchairs, wheelchair accessories, and speech-generating devices and related accessories, which shall be reimbursed at no more than 100% of Medicare's rural rate.

On February 25, 2020, the Centers for Medicare and Medicaid Services (CMS) approved SPA 19-0005 to adjust Medi-Cal FFS DME reimbursement rates based on Medicare rural rates, effective January 1, 2019. The Department will submit a SPA to adjust Medi-Cal FFS DME reimbursement rates based on Medicare rural rates, effective January 1, 2021.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.



## DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 130

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a net decrease in savings due to:

- No longer assuming a January 2020 rate adjustment.
- A shift in implementation for the January 2019 recoupment from September 2020 to December 2020, resulting in less months of savings in FY 2020-21.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to:

- Including the January 2021 rate adjustment in FY 2021-22.
- More months of retroactive recoupments occurring in FY 2020-21.

#### Methodology:

1. This policy is effective January 1, 2019, through December 31, 2021.
2. The January 2019 updated rates were implemented on March 24, 2020. The FFS annual savings is estimated to be \$1.425 million TF. The retroactive recoupment for the period of January 2019 through March 23, 2020 is expected to occur over 12 months beginning in December 2020.
3. System implementation for the January 2021 updated rates is expected in August 2021. The FFS annual savings is estimated to be \$713,000 TF. A retroactive recoupment for the period of January 2021 through July 2020 is expected to occur over 12 months beginning in December 2021.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
5. The FFS savings are estimated to be:

Fiscal Year	TF	GF	FFP	FFCRA
FY 2020-21	(\$2,464,000)	(\$1,114,000)	(\$1,340,000)	(\$10,000)
FY 2021-22	(\$3,296,000)	(\$1,527,000)	(\$1,765,000)	(\$4,000)

## DURABLE MEDICAL EQUIPMENT RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 130

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>FFCRA</b>
50% Title XIX/ 50% GF	(\$2,120,000)	(\$1,060,000)	(\$1,060,000)	\$0
93% Title XIX / 7% GF	(\$48,000)	(\$3,000)	(\$45,000)	\$0
90% Title XIX / 10% GF	(\$65,000)	(\$6,000)	(\$59,000)	\$0
88% Title XXI / 12% GF	(\$98,000)	(\$12,000)	(\$86,000)	\$0
76.5 Title XXI / 23.5% GF	(\$33,000)	(\$8,000)	(\$25,000)	\$0
65% Title XXI / 35% GF	(\$100,000)	(\$35,000)	(\$65,000)	\$0
FFCRA 4.34% GF	\$6,000	\$6,000	\$0	\$0
FFCRA 4.34% FF	(\$6,000)	\$0	\$0	(\$6,000)
FFCRA 6.2% GF	\$4,000	\$4,000	\$0	\$0
FFCRA 6.2% FFP	(\$4,000)	\$0	\$0	(\$4,000)
<b>Total</b>	<b>(\$2,464,000)</b>	<b>(\$1,114,000)</b>	<b>(\$1,340,000)</b>	<b>(\$10,000)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>FFCRA</b>
50% Title XIX/ 50% GF	(\$2,836,000)	(\$1,418,000)	(\$1,418,000)	\$0
93% Title XIX / 7% GF	(\$7,000)	(\$1,000)	(\$6,000)	\$0
90% Title XIX / 10% GF	(\$144,000)	(\$14,000)	(\$130,000)	\$0
88% Title XXI / 12% GF	(\$14,000)	(\$2,000)	(\$12,000)	\$0
76.5 Title XXI / 23.5% GF	(\$56,000)	(\$13,000)	(\$43,000)	\$0
65% Title XXI / 35% GF	(\$239,000)	(\$83,000)	(\$156,000)	\$0
FFCRA 4.34% GF	\$2,000	\$2,000	\$0	\$0
FFCRA 4.34% FF	(\$2,000)	\$0	\$0	(\$2,000)
FFCRA 6.2% GF	\$2,000	\$2,000	\$0	\$0
FFCRA 6.2% FFP	(\$2,000)	\$0	\$0	(\$2,000)
<b>Total</b>	<b>(\$3,296,000)</b>	<b>(\$1,527,000)</b>	<b>(\$1,765,000)</b>	<b>(\$4,000)</b>

## REDUCTION TO RADIOLOGY RATES

**REGULAR POLICY CHANGE NUMBER:** 131  
**IMPLEMENTATION DATE:** 8/2015  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1505

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$4,028,000	-\$12,420,000
<b>- STATE FUNDS</b>	-\$2,014,000	-\$6,210,000
<b>PAYMENT LAG</b>	0.9999	0.9992
<b>% REFLECTED IN BASE</b>	20.00 %	8.96 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$3,222,100	-\$11,298,100
<b>STATE FUNDS</b>	-\$1,611,040	-\$5,649,060
<b>FEDERAL FUNDS</b>	-\$1,611,040	-\$5,649,060

**Purpose:**

This policy change estimates savings resulting from adjustments made to certain radiology reimbursement rates.

**Authority:**

SB 853 (Chapter 717, Statutes of 2010)  
 SPA 17-014  
 SPA 19-0003  
 SPA 20-0004

**Interdependent Policy Changes:**

Funding Adjust.—ACA Opt. Expansion  
 Funding Adjust.—OTLICP  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

SB 853 mandates that Medi-Cal rates for radiology services not exceed 80% of Medicare rates for dates of service on or after October 1, 2010. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% payment reduction, and that a lengthy retroactive recoupment would likely create access to care issues for radiology services, 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. CMS approved SPA 17-014 to adjust radiology rates exceeding 80% of Medicare rates, effective April 1, 2017. SPA 19-0003 was approved on June 4, 2019, to adjust radiology rates exceeding 80% of Medicare's rates, effective January 1, 2019, in order to remain compliant with state statutory requirements. SPA 20-0004 was approved on April 20, 2020, for rate adjustments effective January 1, 2020.

## REDUCTION TO RADIOLOGY RATES

### REGULAR POLICY CHANGE NUMBER: 131

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a decrease in savings due to:

- Less prospective savings due to delayed implementation of the January 2019 and January 2020 rates.
- Less retroactive savings due to a shift in the implementation of the January 2019 and January 2020 recoupments from FY 2020-21 to FY 2021-22.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to:

- Including a full year of prospective rate adjustments in FY 2020-21.
- More retroactive savings expected in FY 2021-22.

#### Methodology:

1. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of Medicare rates.
2. Any managed care impact would be captured through the current rate setting process and included in the applicable base policy changes in future years.
3. The rate adjustments effective April 1, 2017, reflect an annual FFS savings of \$805,000 TF. These rates were implemented on July 22, 2019.

The total recoupment of retroactive savings from April 1, 2017, through July 21, 2019, is estimated to be \$1,877,000 TF. The recoupment began in March 2020 and is expected to be completed over 17 months.

4. The rate adjustments effective January 1, 2019, reflect an annual FFS savings of \$3,218,000 TF. These rates are expected to be implemented in January 2021.

The total recoupment of retroactive savings from January 1, 2019, through December 31, 2020, is estimated to be \$6,435,000 TF and is expected to be implemented in June 2021 over 12 months.

5. The rate adjustments effective January 1, 2020, reflect an annual FFS savings of \$577,000 TF. These rates are expected to be implemented in January 2021.

The total recoupment of retroactive savings from January 1, 2020, through December 31, 2020, is estimated to be \$577,000 TF and is expected to be implemented in June 2021 over 12 months.

6. The rate adjustments effective January 1, 2021, reflect an annual FFS savings of \$577,000 TF. These rates are expected to be implemented in August 2021.

The total recoupment of retroactive savings from January 1, 2021, through July 31, 2021, is estimated to be \$337,000 TF and is expected to be implemented in January 2022 over 12 months.

**REDUCTION TO RADIOLOGY RATES**  
REGULAR POLICY CHANGE NUMBER: 131

7. The estimated savings for the reduction to radiology reimbursement rates are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Prospective Savings	(\$2,702,000)	(\$1,351,000)	(\$1,351,000)
Recoupment of Retro Savings	(\$1,326,000)	(\$663,000)	(\$663,000)
<b>Total</b>	<b>(\$4,028,000)</b>	<b>(\$2,014,000)</b>	<b>(\$2,014,000)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Prospective Savings	(\$5,128,000)	(\$2,564,000)	(\$2,564,000)
Recoupment of Retro Savings	(\$7,292,000)	(\$3,646,000)	(\$3,646,000)
<b>Total</b>	<b>(\$12,420,000)</b>	<b>(\$6,210,000)</b>	<b>(\$6,210,000)</b>

**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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## 10% PROVIDER PAYMENT REDUCTION

**REGULAR POLICY CHANGE NUMBER:** 132  
**IMPLEMENTATION DATE:** 12/2011  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 1580

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$171,841,000	-\$171,841,000
<b>- STATE FUNDS</b>	-\$85,920,500	-\$85,920,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	91.89 %	91.89 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$13,936,300	-\$13,936,300
<b>STATE FUNDS</b>	-\$6,968,150	-\$6,968,150
<b>FEDERAL FUNDS</b>	-\$6,968,150	-\$6,968,150

**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: 132

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:

There is no change for FY 2020-21, from the prior estimate. There is no change from FY 2020-21 to FY 2021-22, in the current estimate.

#### 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

## 10% PROVIDER PAYMENT REDUCTION

### REGULAR POLICY CHANGE NUMBER: 132

age of 21 are exempt from the 10% payment reduction effective August 31, 2013.

- For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 are exempt from the 10% payment reduction effective December 1, 2013.
  - Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions are exempt from the 10% payment reduction effective March 31, 2012.
  - The 10% payment reduction for dental providers was implemented September 2013. Effective July 1, 2015, SB 75 (Chapter 18, Statutes of 2015) exempts dental providers from the 10% payment reductions.
  - 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%.
- **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
<b>Phase I</b>	6/1/2011	12/20/2011	7	6/29/2012	24
<b>Phase II</b>					
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	64
<b>Phase III (CHDP)</b>	10/1/2014	10/1/2014	N/A	N/A	N/A

4. The estimated savings (TF) from AB 97 payment reduction are:



**10% PROVIDER PAYMENT REDUCTION**  
REGULAR POLICY CHANGE NUMBER: 132

(Dollars in Thousands)

Provider Type		FY 2020-21	FY 2021-22	Annual
<b>Phase I</b>	FFS	(\$46,823)	(\$46,823)	(\$46,823)
	FFS Retro	\$0	\$0	\$0
	Phase I Total	(\$46,823)	(\$46,823)	(\$46,823)
<b>Phase II</b>				
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	(\$8,551)	(\$8,551)	(\$8,551)
	FFS Retro	(\$6,430)	(\$6,430)	(\$6,430)
	FFS	(\$108,664)	(\$108,664)	(\$108,664)
	FFS Retro	(\$13,940)	(\$13,940)	(\$13,940)
	Phase II Total	(\$122,604)	(\$122,604)	(\$122,604)
<b>Phase III (CHDP)</b>	FFS	(\$2,414)	(\$2,414)	(\$2,414)
	FFS Retro	\$0	\$0	\$0
	Phase III Total	(\$2,414)	(\$2,414)	(\$2,414)
	FFS	(\$157,901)	(\$157,901)	(\$157,901)
	FFS Retro	(\$13,940)	(\$13,940)	(\$13,940)
	Managed Care	\$0	\$0	\$0
<b>Grand Total</b>	<b>Grand Total</b>	<b>(\$171,841)</b>	<b>(\$171,841)</b>	<b>(\$171,841)</b>

**10% PROVIDER PAYMENT REDUCTION**  
REGULAR POLICY CHANGE NUMBER: 132

**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:** 133  
**IMPLEMENTATION DATE:** 2/2016  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 1703

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$31,152,000	-\$41,574,000
<b>- STATE FUNDS</b>	-\$15,576,000	-\$20,787,000
<b>PAYMENT LAG</b>	0.9515	0.9426
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$29,641,100	-\$39,187,700
<b>STATE FUNDS</b>	-\$14,820,560	-\$19,593,830
<b>FEDERAL FUNDS</b>	-\$14,820,560	-\$19,593,830

### Purpose:

This policy change estimates savings from clinical laboratories or laboratory services expenditures resulting from a 10% payment reduction for a retroactive period, savings from a weighted reimbursement methodology conducted every three years, and savings from an annual rate adjustment to reduce Fee-for-Service Medi-Cal rates to no more than 80% of corresponding Medicare rates.

### 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)  
 Welfare and Institutions (W&I) Code 14105.22  
 SPA 15-015  
 SPA 19-0011  
 SPA 20-0003

### Interdependent Policy Changes:

Funding Adjust.—ACA Opt. Expansion  
 Funding Adjust.—OTLICP  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

### Background:

AB 1494 required the Department to develop a new rate methodology for clinical laboratories or laboratory services, as part of the overall reimbursement methodology. 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

## **LABORATORY RATE METHODOLOGY CHANGE**

### **REGULAR POLICY CHANGE NUMBER: 133**

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.

#### **Annual Rate Adjustment to 80% Medicare**

The Centers for Medicare & Medicaid Services (CMS) approved SPA 19-0011 to adjust the reimbursement rates in accordance with W&I Code 14105.22, effective April 1, 2019, which provides that reimbursement for clinical laboratory or laboratory services may not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

SPA 20-0003 was approved on November 9, 2020, which adjusts clinical laboratory or laboratory services reimbursement rates exceeding 80% of the corresponding Medicare rates, effective January 1, 2020.

#### **Triennial Rate Adjustment**

Every three years, rates for certain services will be adjusted using a weighted reimbursement methodology that is based on an average of the lowest prices other third-party payers are paying for similar services.

The Department submitted SPA 20-0010 to seek federal approval to adjust clinical laboratory or laboratory services reimbursement rates based on the triennial reimbursement methodology, effective July 1, 2020. AB 1494 requires that the Department requests input from beneficiaries, providers, and other interested stakeholders concerning the proposed SPA 20-0010.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is a net increase in savings due to:

- A revised estimate of the 2020 triennial rate adjustment and delayed rate implementation, resulting in increased annual savings and the total retro recoupment amount;
- A revised estimate of the 2020 annual rate adjustment and delayed rate implementation, resulting in increased annual savings and the total retro recoupment amount;
- Less months of the 2020 triennial rate adjustment, 2019 annual rate adjustment, and 2020 annual rate adjustment based on shifts in rate implementation;
- Less months of retro recoupment for the 2019 annual rate adjustment and 2020 annual rate adjustment due to delays in implementation;
- Including the 2021 annual rate adjustment in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to a full year of prospective savings and more months of recoupments occurring in FY 2020-21.

#### **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 retroactive AB 1494 10% savings from July 1, 2012 to June 30, 2015, was implemented in May 2018 and is expected to continue throughout FY 2020-21 and FY 2021-22.

## LABORATORY RATE METHODOLOGY CHANGE

### REGULAR POLICY CHANGE NUMBER: 133

4. **Annual rate adjustment:** The annual Medi-Cal rate adjustments will apply to clinical laboratory or laboratory services reimbursement rates exceeding 80% of corresponding Medicare rates.
- a. The 2019 annual rate adjustment is effective April 1, 2019. The savings for this rate adjustment is estimated to be \$1,343,000 TF and is expected to be implemented in November 2020. The retroactive recoupment from April 2019 through October 2020 is expected to be implemented in December 2020.
  - b. The 2020 annual rate adjustment is effective January 1, 2020. The savings for this rate adjustment is estimated to be \$14,900,000 TF and is expected to be implemented in December 2020. The retroactive recoupment from January 2020 through November 2020 is expected to be implemented in April 2021.
  - c. The 2021 annual rate adjustment is effective January 1, 2021. The savings for this rate adjustment is estimated to be \$1,343,000 TF and is expected to be implemented in June 2021. The retroactive recoupment from January 2021 through May 2021 is expected to be implemented in December 2021.
5. **Triennial rate adjustment:** The Centers for Medicare and Medicaid Services (CMS) approved the new laboratory rate methodology in July 2015.
- a. The 2015-16 rate year change was implemented in February 2016. The recoupment of retroactive savings from July 2015 through January 2016 is expected to be completed in FY 2020-21.
  - b. The savings resulting from the July 2020 rate adjustment is estimated to be \$11,300,000 TF and is expected to be implemented November 2020. The retroactive recoupment from July 2020 through October 2020 is expected to be implemented in March 2021.
6. The expected savings in FY 2019-20 and FY 2020-21 are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Prospective Savings			
2020 New Rate Methodology	(\$6,606,000)	(\$3,303,000)	(\$3,303,000)
2019 Annual Rate Adjustment	(\$1,120,000)	(\$560,000)	(\$560,000)
2020 Annual Rate Adjustment	(\$8,692,000)	(\$4,346,000)	(\$4,346,000)
2021 Annual Rate Adjustment	(\$112,000)	(\$56,000)	(\$56,000)
Retroactive Recoupments			
AB 1494 (retro)	(\$974,000)	(\$487,000)	(\$487,000)
2015 New Rate Methodology (retro)	(\$4,276,000)	(\$2,138,000)	(\$2,138,000)
2020 New Rate Methodology (retro)	(\$4,718,000)	(\$2,359,000)	(\$2,359,000)
2019 Annual Rate Adjustment (retro)	(\$1,240,000)	(\$620,000)	(\$620,000)
2020 Annual Rate Adjustment (retro)	(\$3,414,000)	(\$1,707,000)	(\$1,707,000)
<b>Total savings</b>	<b>(\$31,152,000)</b>	<b>(\$15,576,000)</b>	<b>(\$15,576,000)</b>

**LABORATORY RATE METHODOLOGY CHANGE**  
**REGULAR POLICY CHANGE NUMBER: 133**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Prospective Savings			
2020 New Rate Methodology	(\$11,322,000)	(\$5,661,000)	(\$5,661,000)
2019 Annual Rate Adjustment	(\$1,344,000)	(\$672,000)	(\$672,000)
2020 Annual Rate Adjustment	(\$14,900,000)	(\$7,450,000)	(\$7,450,000)
2021 Annual Rate Adjustment	(\$1,344,000)	(\$672,000)	(\$672,000)
Retroactive Recoupments			
AB 1494 (retro)	(\$974,000)	(\$487,000)	(\$487,000)
2019 Annual Rate Adjustment (retro)	(\$886,000)	(\$443,000)	(\$443,000)
2020 Annual Rate Adjustment (retro)	(\$10,244,000)	(\$5,122,000)	(\$5,122,000)
2021 Annual Rate Adjustment (retro)	(\$560,000)	(\$280,000)	(\$280,000)
<b>Total savings</b>	<b>(\$41,574,000)</b>	<b>(\$20,787,000)</b>	<b>(\$20,787,000)</b>

**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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## HOSPITAL QAF - FFS PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 134  
**IMPLEMENTATION DATE:** 7/2017  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1475

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$5,179,786,000	\$3,302,291,000
<b>- STATE FUNDS</b>	\$2,620,056,000	\$1,467,659,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$5,179,786,000	\$3,302,291,000
<b>STATE FUNDS</b>	\$2,620,056,000	\$1,467,659,000
<b>FEDERAL FUNDS</b>	\$2,559,730,000	\$1,834,632,000

**Purpose:**

This policy change estimates the fee-for-service (FFS) payments that hospitals will receive from the hospital quality assurance fee (QAF) program.

For more information about the Hospital QAF, see the Hospital QAF - Managed Care Payments, Managed Care Private Hospital Directed Payments, and Hospital QAF – Children’s Health Care policy changes.

**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)  
 Proposition 52 (2016)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 provided instructions for implementation of future program periods and 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).

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency (PHE) on October 23, 2020.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is a net increase due to:

- Including the FFCRA Increased FMAP for applicable payments FY 2019-20 and FY 2020-21 payments.
- The FY 2019-20 ACA FF adjustment was revised based on updated data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to:

- Fewer quarters of HQAF payments are expected to be paid in FY 2021-22.
- Fewer quarters applicable for FFCRA Increased FMAP expected in FY 2021-22.
- Increased FY 2020-21 ACA adjustments in FY 2021-22 compared to FY 2019-20 ACA adjustments.
- FY 2018-19 UPL Overage payments were completed in FY 2020-21.

#### **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, 2017. However, this was superseded by the passage of Proposition 52, which permanently extended 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).



## HOSPITAL QAF - FFS PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 134

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.
6. The ACA claiming methodology for the FFS supplemental payments was approved in FY 2017-18. In FY 2019-20, FFS ACA payments for FY 2018-19 will be claimed. In FY 2020-21, FFS ACA payments for FY 2019-20 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. QAF V reconciliations for FY 2017-18 are planned in FY 2019-20. The updated methodology assumes that all eligible hospitals can be paid up to the amounts modeled in the HQAF Fee & Payment Model in lieu of the preliminary calculation that relied on the percentage of fees collected.
8. The QAF V UPL overage payback for FY 2018-19 will take place in FY 2020-21. This was calculated in accordance with State Medicaid Director Letter (SMDL) #13-003.
9. QAF VI payments are based on the QAF VI model that was approved by CMS in February 2020. Exact payment timings are still being considered and are subject to change.
10. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
11. For the duration of the PHE period, the FFS supplemental payments will claim for the FFCRA increased FMAP. The additional FFCRA increased FFP claimed during the PHE will be transferred to the Hospital Quality Assurance Revenue Fund for future fee offsets.

## HOSPITAL QAF - FFS PAYMENTS

REGULAR POLICY CHANGE NUMBER: 134

12. On a cash basis, the estimated QAF V- QAF VI payments are:

(Dollars in Thousands)

FY 2020-21	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
<b>QAF V</b>						
FY 2018-19 UPL Overage	\$0	\$217,158	(\$134,022)	(\$83,136)	\$0	\$0
<b>QAF VI</b>						\$0
FY 2019-20	\$1,780,008	\$927,679	\$852,329	\$0	\$0	\$0
FY 2020-21	\$2,837,413	\$1,475,219	\$1,362,194	\$0	\$0	\$0
FY 2019-20 FFCRA	\$82,437	\$0	(\$82,437)	\$0	\$164,874	\$82,437
FY 2020-21 FFCRA	\$87,835	\$0	(\$87,834)	\$0	\$175,669	\$87,835
FY 2019-20 ACA Q1 -Q2	\$209,389	\$0	(\$243,476)	\$452,865	\$0	\$209,389
FY 2019-20 ACA Q3-Q4	\$182,704	\$0	(\$243,476)	\$438,256	(\$12,076)	\$182,704
<b>Total FY 2020-21</b>	<b>\$5,179,786</b>	<b>\$2,620,056</b>	<b>\$1,423,278</b>	<b>\$807,985</b>	<b>\$328,467</b>	\$562,365

(Dollars in Thousands)

FY 2021-22	TF	SF(HQARF)	FF	ACA FF	FFCRA	*Return to Fund 3158
<b>QAF VI</b>						
FY 2020-21	\$945,804	\$491,739	\$454,065	\$0	\$0	\$0
FY 2021-22	\$1,876,489	\$975,920	\$900,569	\$0	\$0	\$0
FY 2020-21 FFCRA	\$87,834	\$0	(\$87,834)	\$0	\$175,668	\$87,834
FY 2020-21 ACA Q1-Q4	\$392,164	\$0	(\$522,606)	\$940,691	(\$25,921)	\$392,164
<b>Total FY 2021-22</b>	<b>\$3,302,291</b>	<b>\$1,467,659</b>	<b>\$744,194</b>	<b>\$940,691</b>	<b>\$149,747</b>	\$479,998

\*The Return to Fund 3158 column is for display purposes only (see QAF V-QAF VI Methodology #6 and #11).

### Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

FFCRA 6.2% Increased FFP (4260-611-0890)

## HOSPITAL QAF - MANAGED CARE PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 135  
**IMPLEMENTATION DATE:** 3/2015  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1761

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,846,100,000	\$1,897,400,000
<b>- STATE FUNDS</b>	\$854,892,000	\$599,483,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,846,100,000	\$1,897,400,000
<b>STATE FUNDS</b>	\$854,892,000	\$599,483,000
<b>FEDERAL FUNDS</b>	\$1,991,208,000	\$1,297,917,000

**Purpose:**

This policy change estimates the Managed Care payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

For more information about the Hospital QAF, see the Hospital QAF – FFS Payments, Managed Care Private Hospital Directed Payments, and Hospital QAF – Children’s Health Care policy changes.

**Authority:**

SB 239 (Chapter 657, Statutes of 2013)  
 Proposition 52 (2016)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

AB 1383, as amended by AB 1653 and SB 208, established the Hospital QAF program 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 from January 1, 2011 through June 30, 2011. This QAF program period is referred to as QAF II.

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 provided instructions for implementation of future program periods and 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).

## HOSPITAL QAF - MANAGED CARE PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 135

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The program period from January 1, 2017, to June 30, 2019, is referred to as QAF V.

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as QAF VI.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency (PHE) on October 23, 2020.

#### **Reason for Change:**

There is no change in the estimated total fund for FY 2020-21 from the prior estimate. The funding splits have been revised based on updated enrollment projections and member mix data for the 18-month Bridge Period (July 1, 2019 through December 31, 2020). In addition, the FFCRA increased FFP has been included for the applicable periods for these payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to 12 months of HQAF VI, Calendar Year (CY) 2021 payments, occurring in FY 2021-22 instead of 18 months of HQAF VI payments occurring in FY 2020-21 for the Bridge Period. In addition, the FFCRA increased FFP is lower due to fewer months are assumed applicable for the increased FFP for the CY 2021 period.

#### **Methodology:**

1. HQAF V payments for the FY 2018-19 rating period occurred in February 2020. HQAF VI payments for the Bridge Period (July 2019 through December 2020) are anticipated to occur in FY 2020-21. The CY 2021 payments are anticipated to occur in FY 2021-22.
2. The Department will collect intergovernmental transfers (IGTs) from the NDPHs and payments will be made from the HQAF Special Fund 3158.
3. The Bridge Period (July 2019 through December 2020) and CY 2021 total amounts are based on the approved HQAF VI fee model.
4. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

## HOSPITAL QAF - MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 135

5. On a cash basis, the estimated QAF payments are:

(Dollars in Thousands)

FY 2020-21	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	FFCRA
<b>Managed Care</b>						
Bridge Period – July 2019 to December 2020	\$2,700,000	\$811,007	\$755,155	\$73,862	\$994,756	\$65,220
Total MC	\$2,700,000	\$811,007	\$755,155	\$73,862	\$994,756	\$65,220
<b>NDPH IGT</b>						
Bridge Period – July 2019 to December 2020	\$146,100	\$43,885	\$40,862	\$3,997	\$53,827	\$3,529
Total NDPH IGT	\$146,100	\$43,885	\$40,862	\$3,997	\$53,827	\$3,529
<b>Total FY 2020-21</b>	<b>\$2,846,100</b>	<b>\$854,892</b>	<b>\$796,017</b>	<b>\$77,859</b>	<b>\$1,048,583</b>	<b>\$68,749</b>

(Dollars in Thousands)

FY 2021-22	TF	SF(HQARF)	FF (TITLE 19)	FF (TITLE 21)	ACA FF	FFCRA
<b>Managed Care</b>						
Calendar Year 2021	\$1,800,000	\$568,710	\$506,768	\$41,893	\$649,811	\$32,818
Total MC	\$1,800,000	\$568,710	\$506,768	\$41,893	\$649,811	\$32,818
<b>NDPH IGT</b>						
Calendar Year 2021	\$97,400	\$30,773	\$27,422	\$2,267	\$35,162	\$1,776
Total NDPH IGT	\$97,400	\$30,773	\$27,422	\$2,267	\$35,162	\$1,776
<b>Total FY 2021-22</b>	<b>\$1,897,400</b>	<b>\$599,483</b>	<b>\$534,190</b>	<b>\$44,160</b>	<b>\$684,973</b>	<b>\$34,594</b>

**Funding:**

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

Title XXI FFP (4260-611-0890)

FFCRA 6.2% Increased FFP (4260-611-0890)

FFCRA 4.34% Increased FFP (4260-611-0890)

## MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 136  
**IMPLEMENTATION DATE:** 9/2019  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2055

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$2,326,556,000	\$3,278,824,000
<b>- STATE FUNDS</b>	\$779,401,000	\$1,067,504,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$2,326,556,000	\$3,278,824,000
<b>STATE FUNDS</b>	\$779,401,000	\$1,067,504,000
<b>FEDERAL FUNDS</b>	\$1,547,155,000	\$2,211,320,000

**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).

For more information about the Hospital QAF, see the Hospital QAF - FFS Payments, Hospital QAF - Managed Care Payments, and Hospital QAF – Children’s Health Care policy changes.

**Authority:**

Proposition 52 (2016)  
 Title 42, Code of Federal Regulations (CFR) 438.6(c)  
 Families First Coronavirus Response Act (FFCRA)

**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 states 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 directed 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 promote 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. The Department will adjust MCP’s per-member-per-month rates to appropriately fund MCPs for the enhanced payment obligation.

## MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS

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On December 17, 2018, the Department received CMS pre-print approval to continue the PHDP for the FY 2018-19 rating period. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. This "pre-print" is typically submitted on an annual basis. On June 30, 2019, the Department submitted a preprint requesting program continuation and approval for the July 1, 2019 through December 31, 2020 rating period. On June 12, 2020, the Department received approval from CMS.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

There is no change in the estimated total fund for FY 2020-21 from the prior estimate. The funding splits and Affordable Care Act (ACA) funding have been revised based on actual FY 2018-19 enrollment and payment data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to a growth in the total pool size. In addition, FFCRA increased FMAP is included for the applicable FY 2019-20 payments occurring in FY 2021-22.

#### Methodology:

1. The total value of the funding for the private hospital directed payment pool is \$2.33 billion total fund and \$3.28 billion total fund for the FY 2018-19 and FY 2019-20 rating periods, respectively.
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. Within each managed care rating period, the payments are issued, separately, for each 6-month service period.
5. Payments are anticipated to occur in September and March of each fiscal year.
6. The first FY 2018-19 rating period payment (July through December 2018) occurred in September 2020. The second FY 2018-19 rating period payment (January through June 2019) is expected to occur in March 2021.
7. The FY 2019-20 rating period payments are anticipated to occur in September 2021 and March 2022.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change.

**MANAGED CARE PRIVATE HOSPITAL DIRECTED PAYMENTS**  
REGULAR POLICY CHANGE NUMBER:136

9. On a cash basis, the estimated payments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>SF (HQARF)</b>	<b>FF (Title 19)</b>	<b>FF (Title 21)</b>	<b>ACA FF</b>
FY 2018-19	\$2,326,556	\$779,401	\$715,614	\$89,460	\$742,081
<b>Total FY 2020-21</b>	<b>\$2,326,556</b>	<b>\$779,401</b>	<b>\$715,614</b>	<b>\$89,460</b>	<b>\$742,081</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>SF (HQARF)</b>	<b>FF (Title 19)</b>	<b>FF (Title 21)</b>	<b>ACA FF</b>	<b>FFCRA</b>
FY 2019-20	\$3,278,824	\$1,067,504	\$1,008,517	\$113,720	\$1,023,446	\$65,637
<b>Total FY 2021-22</b>	<b>\$3,278,824</b>	<b>\$1,067,504</b>	<b>\$1,008,517</b>	<b>\$113,720</b>	<b>\$1,023,446</b>	<b>\$65,637</b>

**Funding:**

Hospital Quality Assurance Revenue Fund (4260-611-3158)

Title XIX FFP (4260-611-0890)

Title XXI FFP (4260-611-0890)

FFCRA 6.2% Increased FFP (4260-611-0890)

FFCRA 4.34% Increased FFP (4260-611-0890)



## GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

**REGULAR POLICY CHANGE NUMBER:** 137  
**IMPLEMENTATION DATE:** 6/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2024

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,287,506,000	\$416,860,000
<b>- STATE FUNDS</b>	\$524,940,000	\$196,847,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,287,506,000	\$416,860,000
<b>STATE FUNDS</b>	\$524,940,000	\$196,847,000
<b>FEDERAL FUNDS</b>	\$762,566,000	\$220,013,000

**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 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)  
 SPA 17-0009  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

IGT Admin. & Processing Fee  
 COVID-19 Increased FMAP Extension – DHCS

**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.

On March 19, 2020, CMS approved SPA 17-0009 with a January 1, 2017 effective date, allowing the Department to make new Medi-Cal GME payments to DPH systems. Building from the Medicare program, the GME payments would recognize the Medi-Cal managed care share of the cost for a combination of the following:

## GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

### REGULAR POLICY CHANGE NUMBER: 137

- 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 IGT Admin. & Processing Fee policy change.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Updated Affordable Care Act (ACA) reimbursement methodology whereby ACA payments will be processed separately as an adjustment in two phases, Quarters 1 and 2 in phase one, and Quarters 3 and 4 in phase two, upon the close of the respective fiscal year,
- Updated data for the FY 2016-17 and FY 2017-18 ACA adjustments,
- Inclusion of FY 2018-19 Quarters 1 through 4, and FY 2019-20 Quarter 1 and Quarter 2 ACA adjustments,
- Application of the FFCRA increased FMAP, and
- Updated payment data for FY 2018-19, FY 2019-20, and FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Retroactive ACA adjustment payments for FY 2016-17, FY 2017-18, and FY 2018-19 included in FY 2020-21,
- Final settlement payments for FY 2018-19 included the retroactive FY 2018-19 payments in FY 2020-21,
- Retroactive FY 2019-20 payments included in FY 2020-21, and
- FY 2021-22 payments assumed a 2% Consumer Price Index (CPI) adjustment over the FY 2020-21 estimated payments.

#### 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).

## GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS

### REGULAR POLICY CHANGE NUMBER: 137

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 GME and IME annual distribution amounts are calculated based on the methodologies outlined in SPA 17-0009.
  - FY 2018-19 payments were calculated based on FY 2018-19 cost report data and are estimated at \$370.9 million TF. FY 2018-19 payments will be processed as a final settlement. The estimated payments for FY 2019-20 are \$373.1 million TF and \$375.4 million TF for FY 2020-21.
  - FY 2021-22 payments assumed an increase from FY 2020-21 estimated payments based on the CP) annual adjustment. FY 2021-22 payments are estimated to provide \$385.6 million TF.
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 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.
6. The ACA allows for 100% 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 and approval is anticipated in the second quarter of FY 2020-21.
7. ACA adjustments will be processed after the close of the respective FY. The ACA adjustment is the result of the original payment made at 50% IGT and 50% FFP to the applicable FMAP for the ACA optional population noted in methodology #6. The nonfederal share of the adjustment amount will be reimbursed to the DPHs.
8. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
9. Assume the FY 2016-17, FY 2017-18, FY 2018-19, and FY 2019-20 Quarter 1 and Quarter 2 ACA adjustments will occur in FY 2020-21.
10. Assume all four quarters and final settlements of FY 2018-19 will be paid in FY 2020-21.
11. Assume all four quarters of FY 2019-20 will be paid in FY 2020-21.
12. Assume all four quarters of FY 2020-21 will be paid in FY 2020-21.
13. Assume FY 2019-20 final settlements will be paid in FY 2021-22.

**GRADUATE MEDICAL EDUCATION PAYMENTS TO DPHS**  
REGULAR POLICY CHANGE NUMBER: 137

14. Assume all four quarters of FY 2021-22 will be paid in FY 2021-22.

15. Assume FY 2019-20 Quarter 3 and Quarter 4 ACA adjustments will occur in FY 2021-22.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FY 2016-17 ACA Adjustment	\$30,480	\$0	(\$33,867)	\$64,347	\$0
FY 2017-18 ACA Adjustment	\$59,289	\$0	(\$66,591)	\$125,880	\$0
FY 2018-19 ACA Adjustment	\$51,987	\$0	(\$59,746)	\$111,733	\$0
FY 2019-20 Q1 & Q2 ACA Adjustment	\$26,172	\$0	(\$30,432)	\$56,604	\$0
FY 2018-19 Final Settlement	\$370,919	\$185,459	\$185,460	\$0	\$0
FY 2019-20 Payment	\$373,177	\$175,020	\$186,589	\$0	\$11,568
FY 2020-21 Payment	\$375,482	\$164,461	\$187,741	\$0	\$23,280
<b>Total</b>	<b>\$1,287,506</b>	<b>\$524,940</b>	<b>\$369,154</b>	<b>\$358,564</b>	<b>\$34,848</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>IGT</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FY 2019-20 Q3 & Q4 ACA Adjustment	\$21,128	\$0	(\$35,130)	\$56,258	\$0
FY 2019-20 Final Settlement	\$10,076	\$4,019	\$4,217	\$1,528	\$312
FY 2021-22 Payment	\$385,656	\$192,828	\$192,828	\$0	\$0
<b>Total</b>	<b>\$416,860</b>	<b>\$196,847</b>	<b>\$161,915</b>	<b>\$57,786</b>	<b>\$312</b>

**Funding:**

Title XIX FFP (4260-101-0890)

DPH Graduate Medical Education Special Fund (4260-601-8113)

Title XIX ACA (4260-101-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

## PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 138  
**IMPLEMENTATION DATE:** 1/2018  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2048

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,276,175,000	\$1,275,228,000
<b>- STATE FUNDS</b>	\$400,453,780	\$426,760,950
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	5.17 %	5.17 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,210,196,800	\$1,209,298,700
<b>STATE FUNDS</b>	\$379,750,320	\$404,697,410
<b>FEDERAL FUNDS</b>	\$830,446,430	\$804,601,300

**Purpose:**

This policy change estimates the expenditures related to providing supplemental payments for certain 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)  
 SPA 19-0021  
 AB 74 (Chapter 23, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased 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 developed 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.

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### **REGULAR POLICY CHANGE NUMBER: 138**

SB 856 authorized supplemental payments for certain physician services in FY 2018-19. The Centers for Medicare and Medicaid Services (CMS) approved SPA 18-0033 for the FY 2018-19 Fee-for-Service (FFS) supplemental payments. Pursuant to AB 74, the CMS approved SPA 19-0021 for the extension of the supplemental payments for the period of July 1, 2019, through December 31, 2021.

The Department will provide supplemental payments for certain physician services in both Medi-Cal FFS and Medi-Cal managed care delivery systems. Providers who are eligible to provide and bill for specified 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.

For the managed care delivery system, the Department has obtained federal approval of an allowable directed payment for the managed care supplemental payments for FY 2017-18, FY 2018-19, and July 1, 2019, through December 31, 2020 (Bridge Period).

#### 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 states flexibility to implement delivery system and provider payment initiatives under Medicaid managed care plans (MCPs) contracts based on allowable directed payments.

Beginning with the July 1, 2017 rating period, the state has directed MCPs to make enhanced supplemental payments to eligible provider types for specified CPT codes upon approval from CMS and availability of federal funding. The enhanced supplemental payment is contingent upon the MCPs' receipt of providers' actual utilization for these codes reported through encounter data.

Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. This "pre-print" is typically submitted on an annual basis. On June 30, 2019, the Department submitted pre-print requesting program continuation and approval for the July 1, 2019, through December 31, 2020, rating period. On May 5, 2020, the Department received approval from CMS.

For FY 2018-19, the directed payments are subject to a minimum medical expenditure percentage (MEP). MCPs that do not achieve a minimum MEP of 95 percent must remit to the Department the difference between their MEP and the 95 percent threshold.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

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### REGULAR POLICY CHANGE NUMBER: 138

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is an increase due to:

- Increased managed care payments and funding assumptions based on updated managed care enrollment projections.
- Updating FFS funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to:

- Decreased managed care payments based on lower enrollment projections in FY 2021-22.
- Less FFCRA funding estimated in FY 2021-22.

#### Methodology:

1. This policy is effective July 1, 2017.

#### FFS Physician Supplemental Payments

2. Payments will be made via supplemental payments.
3. The FY 2017-18 FFS supplemental payments were implemented on December 5, 2017. These supplemental payments were effective from July 1, 2017, through June 30, 2018.
4. 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.
5. Assume the FFS supplemental payments, on an accrual basis, are approximately \$65,965,000 TF for FY 2018-19 dates of service and ongoing.
6. The FFS physician supplemental payments are assumed to continue for dates of service from July 1, 2019, through June 30, 2022.

#### Managed Care Physician Directed Payments

7. Risk-based capitation rates paid to MCPs will be enhanced, based on anticipated utilization of the 23 CPT codes, to fund the required provider payments.
8. Assume that the annual estimated value of enhanced capitation rate increases for MCPs to fund the supplemental rate increase, on an accrual basis, is \$1,217,196,000 TF in FY 2020-21 and \$1,209,263,000 TF in FY 2021-22.
9. Seven (7) months of the Bridge Period (July 1, 2019 through December 31, 2020) capitation rate increases and five (5) months of the Calendar Year (CY) 2021 capitation rate increases are expected to pay in FY 2020-21.
10. Seven (7) months of the CY 2021 capitation rate increases and five (5) months of the CY 2022 capitation rate increases are expected to pay in FY 2021-22.

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### REGULAR POLICY CHANGE NUMBER: 138

11. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.

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

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Title XXI FF</b>	<b>Title XIX FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FFS Pmts (ongoing)	\$65,965,000	\$24,461,000	\$9,288,000	\$21,475,000	\$7,484,000	\$3,257,000
Mgd Care Pmts	\$1,210,210,000	\$375,993,000	\$94,543,000	\$342,251,000	\$348,998,000	\$48,425,000
<b>Total</b>	<b>\$1,276,175,000</b>	<b>\$400,454,000</b>	<b>\$103,831,000</b>	<b>\$363,726,000</b>	<b>\$356,482,000</b>	<b>\$51,682,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Title XXI FF</b>	<b>Title XIX FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FFS Pmts (ongoing)	\$65,965,000	\$26,483,000	\$8,894,000	\$21,475,000	\$7,484,000	\$1,629,000
Mgd Care Pmts	\$1,209,263,000	\$400,278,000	\$88,977,000	\$341,638,000	\$350,190,000	\$28,180,000
<b>Total</b>	<b>\$1,275,228,000</b>	<b>\$426,761,000</b>	<b>\$97,871,000</b>	<b>\$363,113,000</b>	<b>\$357,674,000</b>	<b>\$29,809,000</b>

#### Funding:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$727,452,000	\$363,726,000	\$363,726,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$396,091,000	\$39,609,000	\$356,482,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$45,921,000	\$10,792,000	\$35,129,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$105,695,000	\$36,993,000	\$68,702,000	\$0
100% GF (4260-101-0001)	\$1,016,000	\$1,016,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$6,580,000)	(\$6,580,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$6,580,000	\$0	\$0	\$6,580,000
FFCRA 6.2% GF (4260-101-0001)	(\$45,102,000)	(\$45,102,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$45,102,000	\$0	\$0	\$45,102,000
<b>Total</b>	<b>\$1,276,175,000</b>	<b>\$400,454,000</b>	<b>\$824,039,000</b>	<b>\$51,682,000</b>



**PROP 56 - PHYSICIAN SERVICES SUPPLEMENTAL PAYMENTS**  
**REGULAR POLICY CHANGE NUMBER: 138**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$726,225,000	\$363,112,000	\$363,113,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$397,416,000	\$39,742,000	\$357,674,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$150,571,000	\$52,700,000	\$97,871,000	\$0
100% GF (4260-101-0001)	\$1,016,000	\$1,016,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$3,764,000)	(\$3,764,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$3,764,000	\$0	\$0	\$3,764,000
FFCRA 6.2% GF (4260-101-0001)	(\$26,045,000)	(\$26,045,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$26,045,000	\$0	\$0	\$26,045,000
<b>Total</b>	<b>\$1,275,228,000</b>	<b>\$426,761,000</b>	<b>\$818,658,000</b>	<b>\$29,809,000</b>

## PRIVATE HOSPITAL DSH REPLACEMENT

**REGULAR POLICY CHANGE NUMBER:** 139  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1071

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$608,040,000	\$623,212,000
<b>- STATE FUNDS</b>	\$266,230,000	\$311,606,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$608,040,000	\$623,212,000
<b>STATE FUNDS</b>	\$266,230,000	\$311,606,000
<b>FEDERAL FUNDS</b>	\$341,810,000	\$311,606,000

**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)  
 HR 4378 (2019)  
 HR 3055 (2019)  
 HR 1865 (2019)  
 HR 748 (2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

ACA DSH Reduction  
 COVID-19 Increased FMAP Extension – DHCS

**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, with the federal share of the \$160.00 is funded via the annual DSH allotment, and the non-federal share is via the General Fund (GF). Combined, these payments satisfy the State's payment obligations to private hospitals under the Federal DSH statute.

## PRIVATE HOSPITAL DSH REPLACEMENT

### REGULAR POLICY CHANGE NUMBER: 139

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.

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. Subsequently HR 4378 (2019) and HR 3055 (2019) were enacted, postponing the reduction until November 22, 2019 and December 21, 2019, respectively. On December 20, 2019, HR 1865 was enacted which further delayed the DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020.

The private DSH replacement payments are affected by the ACA DSH 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 and the fiscal impact of the ACA DSH reduction on private DSH replacement funds.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to the inclusion of FY 2019-20 recoupments based on updated data, and applying the FFCRA increased FMAP in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to higher FY 2021-22 payments based on the estimated FY 2021-22 DSH allotment.

#### **Methodology:**

1. The remaining balance of FY 2019-20 final recoupments will be completed in FY 2020-21.
2. The FY 2020-21 DSH allotment assumes a 2% increase over the FY 2019-20 preliminary allotment. The FY 2021-22 estimated DSH allotment assumes a 2% increase over the FY 2020-21 estimated DSH allotment.
3. Assumes 11/12 of the FY 2020-21 DSH replacement payment will occur in FY 2020-21, and the remaining 1/12 will occur in FY 2021-22.
4. Assumes 11/12 of the FY 2021-22 DSH replacement payment will occur in FY 2021-22.

**PRIVATE HOSPITAL DSH REPLACEMENT**  
**REGULAR POLICY CHANGE NUMBER: 139**

5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
FY 2019-20	\$49,356	\$21,526	\$24,678	\$3,152
FY 2020-21	\$558,684	\$244,704	\$279,342	\$34,638
<b>Total FY 2020-21</b>	<b>\$608,040</b>	<b>\$266,230</b>	<b>\$304,020</b>	<b>\$37,790</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2020-21	\$50,790	\$25,395	\$25,395
FY 2021-22	\$572,422	\$286,211	\$286,211
<b>Total FY 2021-22</b>	<b>\$623,212</b>	<b>\$311,606</b>	<b>\$311,606</b>

**Funding:**

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

56.2% Title XIX/ 43.8% GF (4260-101-0001/0890)

## PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

**REGULAR POLICY CHANGE NUMBER:** 140  
**IMPLEMENTATION DATE:** 1/2018  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2049

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$518,839,000	\$514,291,000
<b>- STATE FUNDS</b>	\$180,707,180	\$193,051,600
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	91.03 %	91.84 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$46,539,900	\$41,966,100
<b>STATE FUNDS</b>	\$16,209,430	\$15,753,010
<b>FEDERAL FUNDS</b>	\$30,330,420	\$26,213,140

**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)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**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.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

This policy change assumes the continuation of the Proposition 56 payments through FY 2020-21, on a cash basis. Proposition 56 funding for this supplemental payment is proposed to be eliminated in FY 2020-21. Refer to the Eliminate Proposition 56 Supplemental Payments policy change for the impact of the elimination.

## PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES

### REGULAR POLICY CHANGE NUMBER: 140

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due to lower Prop 56 portions of the Dental Managed Care rates. The change from FY 2020-21 to FY 2021-22, in the current estimate, is decrease due the decrease in the Prop 56 portion of the Dental Managed Care rate.

#### 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. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021, in this policy change.
5. Funds allocated for the supplemental payments are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$343,554,000	\$171,777,000	\$171,777,000
ACA 90% (2020)	\$103,865,000	\$10,386,000	\$93,479,000
Title 21 76.5% FFP/23.5% GF	\$17,855,000	\$4,196,000	\$13,659,000
Title 21 65% FFP/35% GF	\$53,565,000	\$18,748,000	\$34,817,000
FFCRA 6.2% Increased FFP	\$0	\$(21,300,000)	\$21,300,000
FFCRA 4.34% Increased FFP	\$0	\$(3,100,000)	\$3,100,000
<b>Total</b>	<b>\$518,839,000</b>	<b>\$180,707,000</b>	<b>\$338,132,000</b>

**PROP 56-SUPPLEMENTAL PAYMENTS FOR DENTAL SERVICES**  
REGULAR POLICY CHANGE NUMBER: 140

<b>FY 2021-22</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
Regular FMAP T19	\$340,255,000	\$170,128,000	\$170,127,000
ACA 90% FFP/10% GF (2020)	\$102,802,000	\$10,280,000	\$92,522,000
Title 21 65% FFP/35% GF	\$71,234,000	\$24,932,000	\$46,302,000
FFCRA 6.2% Increased FFP	\$0	\$(10,735,000)	\$10,735,000
FFCRA 4.34% Increased FFP	\$0	\$(1,553,000)	\$1,553,000
<b>Total</b>	<b>\$514,291,000</b>	<b>\$193,052,000</b>	<b>\$321,239,000</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)  
90% ACA Title XIX FF / 10% GF (4260-101-001/0890)  
65% Title XXI / 35% GF (4260-113-0890)  
76.5% Title XXI / 23.5% GF (4260-113-0890)  
FFCRA 6.2% Increased FFP (4260-101-0890)  
FFCRA 6.2% GF (4260-101-0001)  
FFCRA 4.34% Increased FFP (4260-113-0890)  
FFCRA 4.34% GF (4260-113-0001)

## PROP 56 - VALUE-BASED PAYMENT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 141  
**IMPLEMENTATION DATE:** 4/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2128

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$364,513,000	\$364,207,000
<b>- STATE FUNDS</b>	\$112,546,900	\$119,865,650
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$364,513,000	\$364,207,000
<b>STATE FUNDS</b>	\$112,546,900	\$119,865,650
<b>FEDERAL FUNDS</b>	\$251,966,100	\$244,341,350

**Purpose:**

This policy change estimates payments to providers made through increased capitation to Managed Care Plans (MCPs) who meet the Department requirements in the Value-Based Payment (VBP) program.

**Authority:**

FY 201920 Budget Bill  
 SB 78 (Chapter 38, Statutes of 2019)  
 AB 80 (Chapter 12, Statutes of 2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a 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.

The VBP program will require MCPs to make value-based enhanced payments to eligible network providers for specific events tied to performance on 17 core measures across the following four domains:

- Prenatal/postpartum care
- Early childhood preventive care
- Chronic disease management
- Behavioral health care

The VBP program is intended to incentivize Medi-Cal managed care network provider behaviors and improvements in individual providers' standards of practice related to the delivery of care in



## PROP 56 - VALUE-BASED PAYMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 141

the four specified domains. This program also incentivizes improved data quality and completeness.

MCPs will be required to participate in the VBP program through a directed payment program. Prior to implementation of a directed payment program, Centers for Medicare and Medicaid Services (CMS) requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. On June 30, 2019, the Department submitted the CMS required pre-print form for the VBP program, seeking to obtain managed care directed payment approval. On May 5, 2020, the Department received approval from CMS.

To address health disparities, this arrangement will also direct MCPs to make enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

The Behavioral Health Integration (BHI) Incentive program was intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Proposition 56 funding, along with federal funds, are used to make these payments. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21 is a decrease due to the shifting of BHI dollars to a separate PC and a decrease of enrollment projections for VBP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to a decrease of enrollment projections.

#### **Methodology:**

1. The (6.2% Title XIX and/or 4.34% Title XXI) FFCRA increased FMAP is assumed for expenditures through December 31, 2021, in this policy change.
2. On a cash basis, the total directed payments are estimated to be \$364,513,000 in FY 2020-21 and \$364,207,000 in FY 2021-22.

**PROP 56 - VALUE-BASED PAYMENT PROGRAM**  
REGULAR POLICY CHANGE NUMBER: 141

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% SF (4260-101-0890/0001)	\$203,484,000	\$101,742,000	\$101,742,000
ACA 93% FFP / 7% GF (2019)	\$4,643,000	\$325,000	\$4,318,000
ACA 90% FFP / 10% GF (2020)	\$118,108,000	\$11,811,000	\$106,297,000
88% Title XXI FF / 12% GF (4260-113-0890/0001)	\$748,000	\$90,000	\$658,000
76.5% Title XXI FF / 23.5% GF (4260-113-0890/0001)	\$11,958,000	\$2,810,000	\$9,148,000
65% Title XXI / 35% GF (4260-113-0890/0001)	\$25,572,000	\$8,950,000	\$16,622,000
FFCRA 4.34% Increased FFP (4260-113-0890)	\$-	\$(1,534,000)	\$1,534,000
FFCRA 6.2% Increased FFP (4260-113-0890)	\$-	\$(11,647,000)	\$11,647,000
<b>Total</b>	<b>\$364,513,000</b>	<b>\$112,547,000</b>	<b>\$251,966,000</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% SF (4260-101-0890/0001)	\$202,673,000	\$101,337,000	\$101,337,000
ACA 90% FFP / 10% GF (2020)	\$123,475,000	\$12,347,000	\$111,127,000
65% Title XXI / 35% GF (4260-113-0890/0001)	\$38,059,000	\$13,321,000	\$24,738,000
FFCRA 4.34% Increased FFP (4260-113-0890)	\$-	\$(831,000)	\$831,000
FFCRA 6.2% Increased FFP (4260-113-0890)	\$-	\$(6,308,000)	\$6,308,000
<b>Total</b>	<b>\$364,207,000</b>	<b>\$119,866,000</b>	<b>\$244,341,000</b>

\*Totals may differ due to rounding

## PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

**REGULAR POLICY CHANGE NUMBER:** 142  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1085

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$429,933,000	\$308,193,000
<b>- STATE FUNDS</b>	\$251,097,000	\$145,315,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$429,933,000	\$308,193,000
<b>STATE FUNDS</b>	\$251,097,000	\$145,315,500
<b>FEDERAL FUNDS</b>	\$178,836,000	\$162,877,500

**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  
 SPA 18-010  
 SPA 19-0023  
 SPA 20-0020  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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).

## PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

### REGULAR POLICY CHANGE NUMBER: 142

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 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 2020-21. 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. CMS approved SPA 18-010 on October 30, 2018 to continue the Private Hospital Supplemental Program through June 30, 2019, and SPA 19-0023 was approved by CMS on July 17, 2019 to continue the Private Hospital Supplemental Program through FY 2019-20. SPA 20-0020 was approved by CMS on June 29, 2020 which extends the Private Hospital Supplemental Program through June 30, 2021. The Department intends to submit another SPA to CMS in the fourth quarter of FY 2020-21 that will include a formulaic payment methodology and language to allow for the expenditure of any remaining funds beginning in FY 2021-22 and beyond.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Updated FY 2019-20 Affordable Care Act (ACA) data,
- FY 2019-20 payment shifted from FY 2019-20 to FY 2020-21,
- Inclusion of FY 2013-14 through FY 2018-19 ACA FFP returned to providers,
- Inclusion of FFCRA increased FMAP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- FY 2019-20 delayed payment shifted from FY 2019-20 to FY 2020-21,
- FY 2013-14 through FY 2018-19 ACA FFP returned to providers in FY 2020-21,
- FY 2013-14, FY 2014-15, and FY 2015-16 FF repayment in FY 2020-21, and
- FY 2015-16 SF repayment in FY 2020-21.

#### 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, and ending in FY 2019-20, the SF included ACA adjustments. Beginning in FY 2020-21, the ACA adjustments will be returned to the providers.

## **PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT**

### **REGULAR POLICY CHANGE NUMBER: 142**

2. IGT payments will be \$51 million TF in FY 2020-21 and \$54 million TF in FY 2021-22.
3. 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%, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA claiming methodology in August 2017.
4. 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 were claimed in FY 2018-19. FY 2018-19 ACA supplemental payments will be claimed in FY 2019-20. FY 2019-20 ACA supplemental payments will be claimed in FY 2020-21, and FY 2020-21 ACA supplemental payments will be claimed in FY 2021-22.
  - 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 providers 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.
5. The Department over-claimed FY 2013-14 through FY 2015-16 ACA FFP and is expected to repay the federal funds in FY 2020-21.
6. The Department erroneously moved \$5.994 million for FY 2015-16 from SF to GF, and is expected to repay the fund 3097 in FY 2020-21.
7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
  - Due to the additional FFCRA increased FMAP, less GF appropriations were used for the non-federal share of payments during this period.
  - The unused GF appropriation for FY 2019-20 Q3 and Q4 in the amount of \$7.8 million was returned to the providers in FY 2020-21 Q1.
  - The unused GF appropriation for FY 2020-21 Q1 through Q4 in the amount of \$14.68 million will be returned to the providers by June 30, 2021.
8. 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.

**PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 142

9. The estimated Private Hospital Supplemental payments and ending balance for FY 2020-21 are shown below:

(Dollars in Thousands)

<b>FY 2020-21 Private Hospital Supplemental Fund Summary</b>	<b>SF</b>
FY 2019-20 Ending Balance	\$98,196
Appropriation (GF)	\$118,400
2020-21 IGT	\$21,552
FY 2019-20 Interest Earned	\$2,287
FY 2013-14 FF Repayment	(\$170)
FY 2014-15 FF Repayment	(\$1,452)
FY 2015-16 SF Repayment	\$14,561
Funds Available	\$253,374
Less: FY 2020-21 Cash Expenditures to Hospitals	(\$247,595)
Est. FY 2020-21 Remaining Balance	\$5,779

**PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 142

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>	<b>Return to Providers*</b>	<b>Return to Counties*</b>
FY 2019-20 Cash Expenditures to Providers**	\$2,120	\$0	\$994	\$1,060	\$0	\$66	\$0	\$0
FY 2020-21 Cash Expenditures to Providers**	\$286,006	\$0	\$125,270	\$143,004	\$0	\$17,732	\$0	\$0
FY 2019-20 ACA FF Adjustment to Providers***	\$17,654	\$0	\$0	(\$22,987)	\$42,066	(\$1,425)	\$17,654	\$0
FY 2019-20 ACA FF Adjustment to Counties***	\$2,822	\$0	\$0	(\$3,675)	\$6,725	(\$228)	\$0	\$2,822
FY 2013-14 FF Repayment	\$0	\$0	\$170	\$0	(\$170)	\$0	\$0	\$0
FY 2014-15 FF Repayment	\$0	\$0	\$1,452	\$0	(\$1,452)	\$0	\$0	\$0
FY 2015-16 FF Repayment	\$1	\$1,881	\$0	\$0	(\$1,880)	\$0	\$0	\$0
FY 2015-16 SF Repayment	\$0	\$5,994	(\$5,994)	\$0	\$0	\$0	\$0	\$0
FFY 2013-14 ACA Return to Providers	\$5,341	\$0	\$5,341	\$0	\$0	\$0	\$0	\$0
FFY 2014-15 ACA Return to Providers	\$12,800	\$0	\$12,800	\$0	\$0	\$0	\$0	\$0
FFY 2015-16 ACA Return to Providers	\$20,308	\$0	\$20,308	\$0	\$0	\$0	\$0	\$0
FFY 2016-17 ACA Return to Providers	\$20,701	\$0	\$20,701	\$0	\$0	\$0	\$0	\$0
FFY 2017-18 ACA Return to Providers	\$19,843	\$0	\$19,843	\$0	\$0	\$0	\$0	\$0
FFY 2018-19 ACA Return to Providers	\$19,852	\$0	\$19,852	\$0	\$0	\$0	\$0	\$0
FY 2019-20 FFCRA Return to Providers	\$7,803	\$0	\$7,803	\$0	\$0	\$0	\$0	\$0
FY 2020-21 FFCRA Return to Providers	\$14,682	\$0	\$14,682	\$0	\$0	\$0	\$0	\$0
<b>Total</b>	<b>\$429,933</b>	<b>\$7,875</b>	<b>\$243,222</b>	<b>\$117,402</b>	<b>\$45,289</b>	<b>\$16,145</b>	<b>\$17,654</b>	<b>\$2,822</b>

**PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 142

10. The estimated Private Hospital Supplemental payments and ending balance for FY 2021-22 are shown below:

(Dollars in Thousands)

<b>FY 2021-22 Private Hospital Supplemental Fund Summary</b>	<b>SF</b>
FY 2020-21 Ending Balance	\$5,779
Appropriation (GF)	\$118,400
2021-22 IGT	\$26,915
Est. FY 2020-21 Interest Earned	\$2,287
Funds Available	\$153,381
Less: FY 2021-22 Cash Expenditures to Hospitals	(\$145,315)
Est. FY 2021-22 Remaining Balance	\$8,066

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>	<b>Return to Providers*</b>	<b>Return to Counties*</b>
FY 2021-22 Cash Expenditures to Providers**	\$290,630	\$145,315	\$145,315	\$0	\$0	\$0	\$0
FY 2020-21 ACA FF Adjustment to Providers***	\$15,539	\$0	(\$22,987)	\$41,376	(\$2,850)	\$15,539	\$0
FY 2020-21 ACA FF Adjustment to Counties***	\$2,023	\$0	(\$2,993)	\$5,387	(\$371)	\$0	\$2,023
<b>Total</b>	<b>\$308,192</b>	<b>\$145,315</b>	<b>\$119,335</b>	<b>\$46,763</b>	<b>(\$3,221)</b>	\$15,539	\$2,023

\*The Return to Providers and Return to Counties columns are for display purposes only (see Methodology #4).



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**PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT**  
**REGULAR POLICY CHANGE NUMBER: 142**

**Funding:**

100% 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)  
100% GF (4260-101-0001)  
6.2% FFCRA Increased FMAP (4260-101-0890)

**DSH PAYMENT**

**REGULAR POLICY CHANGE NUMBER:** 143  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1073

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$327,845,000	\$427,503,000
<b>- STATE FUNDS</b>	\$88,603,500	\$117,534,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$327,845,000	\$427,503,000
<b>STATE FUNDS</b>	\$88,603,500	\$117,534,500
<b>FEDERAL FUNDS</b>	\$239,241,500	\$309,968,500

**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)  
 HR 4378 (2019)  
 HR 3055 (2019)  
 HR 1865 (2019)  
 HR 748 (2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

ACA DSH Reduction  
 COVID-19 Increased FMAP Extension – DHCS

**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:

## **DSH PAYMENT**

### **REGULAR POLICY CHANGE NUMBER: 143**

- 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 Hospitals, receive their allocation of the federal DSH payments through the Global Payment Program. See the Global Payment Program (GPP) policy change for more information and for the portion of DSH budgeted for the GPP. 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. Subsequently, HR 4378 (2019) and HR 3055 (2019) were enacted postponing the reduction until November 22, 2019 and December 21, 2019, respectively. On December 20, 2019, HR 1865 further delayed the DSH reduction until May 23, 2020. On March 27, 2020, HR 748 (2020) was enacted which eliminated the Federal Fiscal Year (FFY) 2020 reduction and postponed the start of the FFY 2021 reduction until December 1, 2020. See the ACA DSH Reduction policy change for more information and for the estimated fiscal impact of the ACA DSH reduction on DSH payments.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP).

## **DSH PAYMENT**

### **REGULAR POLICY CHANGE NUMBER: 143**

The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- FY 2019-20 DPH UC DSH Quarter 4 payment shifted to FY 2019-20,
- Inclusion of final reconciliation payments/recoupments for FY 2008-09 and FY 2009-10,
- Inclusion of FFP returned for Coalinga Regional Medical Center due to the FY 2016-17 NDPH DSH audit,
- Slightly higher NDPH DSH FY 2020-21 estimated allotment amount,
- Slightly lower DPH UC DSH FY 2020-21 estimated allotment amount, and
- Application of the FFCRA increased FMAP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to a higher DSH allotment estimated for FY 2021-22, final reconciliation net recoupments included in FY 2020-21, and the FY 2019-20 DPH UC DSH Quarter 4 payment, which would have been paid in the following fiscal year of FY 2020-21, was accelerated and paid in FY 2019-20.

#### **Methodology:**

1. The FY 2020-21 estimated DSH allotment assumes a 2% increase over the FY 2019-20 preliminary DSH allotment. The FY 2021-22 estimated DSH allotment assumes a 2% increase over the FY 2020-21 estimated DSH allotment. The unreduced FY 2021-22 DSH allotment is estimated to be \$1,333,742,944.
2. Effective July 1, 2019, DPH UC DSH hospitals are paid on a quarterly basis where three quarters are paid in the same fiscal year and the fourth quarter is paid in the following fiscal year. Prior to July 1, 2019, 11/12 of the total annual allotment was paid in the same fiscal year and 1/12 was paid in the following fiscal year.
3. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**DSH PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 143

4. It is assumed that the DSH payments will be made as follows on a cash basis:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF**</b>	<b>IGT*</b>	<b>FF</b>	<b>FFCRA</b>
DSH 2008-09	(\$28,648,000)	\$0	(\$28,648,000)	\$0	\$0
DSH 2009-10	(\$18,219,000)	\$0	(\$18,219,000)	\$0	\$0
DSH 2011-12	(\$5,399,000)	\$0	(\$5,747,000)	\$348,000	\$0
DSH 2012-13	\$2,265,000	\$0	\$707,000	\$1,558,000	\$0
DSH 2014-15	\$62,697,000	\$0	\$60,730,000	\$1,967,000	\$0
DSH 2016-17	\$3,951,000	\$22,000	\$3,900,000	\$29,000	\$0
DSH 2019-20	(\$872,000)	(\$385,000)	\$0	(\$436,000)	(\$51,000)
DSH 2020-21	\$312,070,000	\$20,004,000	\$56,239,000	\$225,035,000	\$10,792,000
<b>Total FY 2020-21</b>	<b>\$327,845,000</b>	<b>\$19,641,000</b>	<b>\$68,962,000</b>	<b>\$228,501,000</b>	<b>\$10,741,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF**</b>	<b>IGT*</b>	<b>FF</b>	<b>FFCRA</b>
DSH 2020-21	\$92,952,000	\$2,076,000	\$18,746,000	\$69,476,000	\$2,654,000
DSH 2021-22	\$334,551,000	\$22,917,000	\$73,796,000	\$237,838,000	\$0
<b>Total FY 2021-22</b>	<b>\$427,503,000</b>	<b>\$24,993,000</b>	<b>\$92,542,000</b>	<b>\$307,314,000</b>	<b>\$2,654,000</b>

**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)\*\*

100% GF (4260-101-0001)

100% Title XIX(4260-101-0890)

100% MIPA Fund (4260-606-0834)

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)

6.2% Title XIX FFCRA GF (4260-101-0001)

## HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 144  
**IMPLEMENTATION DATE:** 4/2004  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 78

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$291,729,000	\$246,989,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$291,729,000	\$246,989,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$291,729,000	\$246,989,000

**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)  
 State Plan Amendment (SPA) 02-018  
 SPA 16-019  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 144

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Final reconciliations for FY 2002-03 and FY 2015-16 added to FY 2020-21.
- FY 2013-14 Affordable Care Act (ACA) warrant will be reissued in FY 2020-21.
- A portion of FY 2018-19 payments originally scheduled for FY 2019-20 were shifted to FY 2020-21 Q1.
- FY 2019-20 payments revised based on updated data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to larger volume of backlogged final reconciliations are scheduled to occur in FY 2021-22.

### Methodology:

1. Payments of \$291,730,000 and \$246,989,000 are expected to be made in FY 2020-21 and FY 2021-22 respectively. These payments are based on CPE claims and are adjusted for the changes in the FMAP.
2. Final reconciliations are expected to begin in FY 2020-21.
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 2018-19 ACA claims are based on actual claims received. FY 2019-20 and FY 2020-21 ACA claims are estimated based on FY 2018-19 actuals further adjusted the estimated percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for outpatient hospital services.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
6. Estimated costs are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>ACA</b>	<b>FFCRA</b>
FY 2002-03 Final Reconciliation	(\$193,000)	(\$193,000)	\$0	\$0
FY 2013-14 Payments	\$71,000	\$0	\$71,000	\$0
FY 2015-16 Final Reconciliation	(\$10,282,000)	(\$12,253,000)	\$1,971,000	\$0
FY 2018-19 Payments	\$55,438,000	\$12,895,000	\$42,543,000	\$0
FY 2019-20 Payments	\$246,695,000	\$123,742,000	\$119,136,000	\$3,817,000
<b>Total</b>	<b>\$291,729,000</b>	<b>\$124,191,000</b>	<b>\$163,721,000</b>	<b>\$3,817,000</b>

## HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 144

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>ACA</b>	<b>FFCRA</b>
FY 2003-04 Final Reconciliation	(\$227,000)	(\$227,000)	\$0	\$0
FY 2004-05 Final Reconciliation	(\$220,000)	(\$220,000)	\$0	\$0
FY 2015-16 Final Reconciliation	(\$5,141,000)	(\$6,126,000)	\$985,000	\$0
FY 2016-17 Final Reconciliation	(\$9,062,000)	(\$11,121,000)	\$2,059,000	\$0
FY 2019-20 Payments	\$1,120,000	\$618,000	\$464,000	\$38,000
FY 2020-21 Payments	\$260,519,000	\$128,675,000	\$123,866,000	\$7,978,000
<b>Total</b>	<b>\$246,989,000</b>	<b>\$111,599,000</b>	<b>\$127,374,000</b>	<b>\$8,016,000</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)



## DPH PHYSICIAN & NON-PHYS. COST

**REGULAR POLICY CHANGE NUMBER:** 145  
**IMPLEMENTATION DATE:** 5/2008  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1078

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$268,004,000	\$349,662,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$268,004,000	\$349,662,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$268,004,000	\$349,662,000

**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  
 Welfare & Institutions Code 14166.4  
 State Plan Amendment (SPA) 05-023  
 SPA 16-020  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

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 using Medicaid Management Information System data and 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: 145

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Revised calculations for FY 2013-14 final reconciliation recoupments and Affordable Care Act (ACA) payments,
- FY 2013-14 Los Angeles (LA) County ACA payments shifted to FY 2021-22,
- Updated interim reconciliation and ACA payment data for FY 2018-19, and
- Updated interim payment data for FY 2019-20 and FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to more prior year interim reconciliation, final reconciliation, and ACA payment years expected to occur in FY 2021-22.

#### Methodology:

1. FY 2019-20 interim payments occur over two years. The interim payment was made to LA County DPHs in FY 2019-20, and the interim payment to non-LA County DPHs will be made in FY 2020-21. Beginning in FY 2020-21, one annual interim payment is expected to occur for all DPHs for the respective fiscal year.
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 2020-21 with first time ACA payments to occur in FY 2020-21 Quarter 3. Upon CMS approval, ACA payments will be retroactive to January 1, 2014. The ACA allows for 100% FMAP for calendar years (CYs) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% FMAP for CY 2019, and 90% FMAP for CY 2020 for newly eligible Medi-Cal beneficiaries.
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.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**DPH PHYSICIAN & NON-PHYS. COST**  
REGULAR POLICY CHANGE NUMBER: 145

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FY 2013-14 Final Reconciliation	(\$4,318,000)	(\$14,068,000)	\$9,750,000	\$0
FY 2013-14 Interim ACA Payment	\$3,928,000	\$0	\$3,928,000	\$0
FY 2018-19 Interim Payment	\$55,075,000	\$55,075,000	\$0	\$0
FY 2018-19 Interim Reconciliation	\$70,762,000	(\$6,211,000)	\$76,973,000	\$0
FY 2019-20 Interim Payment	\$57,123,000	\$53,788,000	\$0	\$3,335,000
FY 2020-21 Interim Payment	\$85,434,000	\$76,009,000	\$0	\$9,425,000
<b>Total</b>	<b>\$268,004,000</b>	<b>\$164,593,000</b>	<b>\$90,651,000</b>	<b>\$12,760,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FY 2013-14 Final Reconciliation	(\$3,548,000)	(\$3,548,000)	\$0	\$0
FY 2014-15 Final Reconciliation	\$37,475,000	(\$7,194,000)	\$44,669,000	\$0
FY 2015-16 Final Reconciliation	\$41,993,000	(\$10,374,000)	\$52,367,000	\$0
FY 2016-17 Final Reconciliation	\$60,603,000	(\$4,067,000)	\$64,670,000	\$0
FY 2017-18 Interim Reconciliation	\$70,237,000	(\$17,233,000)	\$87,470,000	\$0
FY 2019-20 Interim Reconciliation	\$66,893,000	\$399,000	\$66,469,000	\$25,000
FY 2021-22 Interim Payment	\$76,009,000	\$76,009,000	\$0	\$0
<b>Total</b>	<b>\$349,662,000</b>	<b>\$33,992,000</b>	<b>\$315,645,000</b>	<b>\$25,000</b>

**Funding:**

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

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

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)

## FFP FOR LOCAL TRAUMA CENTERS

**REGULAR POLICY CHANGE NUMBER:** 146  
**IMPLEMENTATION DATE:** 2/2006  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 104

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$136,157,000	\$168,229,000
<b>- STATE FUNDS</b>	\$65,639,500	\$68,225,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$136,157,000	\$168,229,000
<b>STATE FUNDS</b>	\$65,639,500	\$68,225,000
<b>FEDERAL FUNDS</b>	\$70,517,500	\$100,004,000

**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  
 SPA 03-032  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- FY 2019-20 payment amount updated based on decreased payment amount requested by Los Angeles County.
- FY 2019-20 ACA adjustment estimate revised based on updated data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

## FFP FOR LOCAL TRAUMA CENTERS

### REGULAR POLICY CHANGE NUMBER: 146

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to federal funds repayment scheduled to occur in FY 2020-21 for FYs 2013-14 through FY 2015-16.

#### 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, and 90% for calendar year 2020 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 2019-20, the ACA supplemental payments will be claimed in FY 2020-21. ACA payments for FY 2020-21 will be claimed in FY 2021-22. 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 for FY 2019-20 Q1 and Q2, and FFCRA 56.2% FMAP for FY 2019-20 Q3 and Q4 and FY 2020-21 Q1 through Q4.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
5. The Department overclaimed FYs 2013-14, 2014-15, and 2015-16 ACA FFP and is expected to repay the federal funds in FY 2020-21.

(Dollars in Thousands)

FY 2020-21	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2019-20 ACA Adjustment to Counties	\$10,918	\$0	(\$14,218)	\$26,018	(\$882)	\$10,918
FY 2019-20	\$125,239	\$58,737	\$62,620	\$0	\$3,882	\$0
Federal Funds Repayment	\$0	\$6,902	\$0	(\$6,902)	\$0	\$0
<b>Total FY 2020-21</b>	<b>\$136,157</b>	<b>\$65,639</b>	<b>\$48,402</b>	<b>\$19,116</b>	<b>\$3,000</b>	<b>\$10,918</b>

(Dollars in Thousands)

FY 2021-22	TF	Special Deposit Fund	FF	ACA FF	FFCRA	*Return to Counties
FY 2020-21 ACA Adjustment to Counties	\$12,465	\$0	(\$18,441)	\$33,193	(\$2,287)	\$12,465
FY 2020-21	\$155,764	\$68,225	\$77,882	\$0	\$9,657	\$0
<b>Total FY 2021-22</b>	<b>\$168,229</b>	<b>\$68,225</b>	<b>\$59,441</b>	<b>\$33,193</b>	<b>\$7,370</b>	<b>\$12,465</b>

\*The Return to Counties column is for display purposes only (see Methodology #3).

**FFP FOR LOCAL TRAUMA CENTERS**  
**REGULAR POLICY CHANGE NUMBER: 146**

**Funding:**

100% GF (4260-101-0001)

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)

FFCRA 6.2% Increased FFP (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

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$121,860,000	\$115,461,000
<b>- STATE FUNDS</b>	\$48,555,270	\$50,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$121,860,000	\$115,461,000
<b>STATE FUNDS</b>	\$48,555,270	\$50,000,000
<b>FEDERAL FUNDS</b>	\$73,304,730	\$65,461,000

### Purpose:

This policy change estimates the 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  
 Families First Coronavirus Response Act (FFCRA)

### 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- Updated FY 2020-21 supplemental payment data,
- Updated FY 2019-20 Affordable Care Act (ACA) optional population payment data,
- Inclusion of FY 2019-20 interim reconciliations,
- Inclusion of FY 2017-18 interim reconciliations,
- Inclusion of FY 2016-17 final reconciliations, and
- Inclusion of FFCRA increased FMAP.



## MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 147

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Increased FY 2020-21 supplemental payment in FY 2020-21,
- Inclusion of FY 2019-20 interim reconciliations in FY 2020-21,
- Inclusion of FY 2017-18 interim reconciliations in FY 2020-21,
- Inclusion of FY 2016-17 final reconciliations in FY 2020-21, and
- Reduced ACA FMAP for FY 2020-21 in FY 2021-22.

#### 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 2020-21 and FY 2021-22.
5. Expenditures for FY 2020-21 and FY 2021-22 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.
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 2020-21 and FY 2021-22, the supplemental payments and DRG add-on payments are limited by the payment cap of \$115.2 million. FY 2020-21 and FY 2021-22 supplemental payments are estimated to be \$103.5 million and \$100 million TF, respectively.
8. 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 2019-20 ACA supplemental payments will be claimed in FY 2020-21. For FY 2020-21, the ACA payment will be claimed in FY 2021-22. 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 reduces again to 93% beginning January 1, 2019, and further reduces to 90% beginning January 1, 2020. CMS approved the ACA supplemental payment methodology in August 2017.
9. Managed care costs for MLK-LA are reflected in the Retro MC Rate Adjustment policy change.
10. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

## MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 147

11. On a cash basis, costs in FY 2020-21 and FY 2021-22 are expected to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>IGT*</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>	<b>Return to County**</b>
Supplemental 2020-21	\$103,539	\$0	\$45,350	\$51,770	\$0	\$6,419	\$0
Supplemental ACA 2019-20	\$17,228	\$0	\$0	(\$22,433)	\$41,052	(\$1,391)	\$17,228
DRG Add-on Interim Recon 2019-20	(\$5,617)	(\$417)	(\$2,420)	(\$3,255)	\$818	(\$343)	\$0
FFCRA 2019-20	\$3,539	\$0	\$1,550	\$1,770	\$0	\$219	\$0
Interim Reconciliation 2017-18	\$3,119	\$1,109	(\$207)	\$820	\$1,397	\$0	\$0
Final Reconciliation 2016-17	\$52	\$395	(\$377)	\$77	(\$43)	\$0	\$0
<b>Total</b>	<b>\$121,860</b>	<b>\$1,087</b>	<b>\$43,896</b>	<b>\$28,749</b>	<b>\$43,224</b>	<b>\$4,904</b>	\$17,228

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>IGT*</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>	<b>Return to County**</b>
Supplemental 2021-22	\$100,000	\$0	\$50,000	\$50,000	\$0	\$0	\$0
Supplemental ACA 2020-21	\$15,461	\$0	\$0	(\$22,872)	\$41,169	(\$2,836)	\$15,461
<b>Total</b>	<b>\$115,461</b>	<b>\$0</b>	<b>\$50,000</b>	<b>\$27,128</b>	<b>\$41,169</b>	<b>(\$2,836)</b>	\$15,461

\*\*The Return to County column is for display purposes only (see methodology #8)

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**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 FF (4260-101-0890)

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

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

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

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

6.2% FFCRA Increased FFP (4260-101-0890)

100% GF (4260-101-0001)

## CAPITAL PROJECT DEBT REIMBURSEMENT

**REGULAR POLICY CHANGE NUMBER:** 148  
**IMPLEMENTATION DATE:** 7/1991  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 82

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$97,776,000	\$97,169,000
<b>- STATE FUNDS</b>	\$22,722,500	\$22,865,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$97,776,000	\$97,169,000
<b>STATE FUNDS</b>	\$22,722,500	\$22,865,000
<b>FEDERAL FUNDS</b>	\$75,053,500	\$74,304,000

**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)  
 State Plan Amendment (SPA) 88-25  
 SPA 13-011  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP).

## **CAPITAL PROJECT DEBT REIMBURSEMENT**

### **REGULAR POLICY CHANGE NUMBER: 148**

The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

For hospitals (SB 1732):

- Updated interim payment, interim reconciliation, and ACA adjustment amounts based on additional months of actual data,
- Updated FY 2015-16 interim reconciliation payments/recoupments shifted from FY 2019-20 to FY 2020-21, and
- Inclusion of prior year final reconciliation adjustments.

For DP-NFs (SB 1128):

- Updated FY 2018-19 and FY 2019-20 interim payment amounts based on additional months of actual data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

For hospitals (SB 1732):

- Lower interim payment amounts in FY 2021-22,
- FY 2021-22 includes final reconciliation payments, and
- Inclusion of FFCRA increased FFP in FY 2021-22.

For DP-NFs (SB 1128):

- Increased interim payments in FY 2021-22, and
- Inclusion of FFCRA increased FFP in FY 2021-22.

#### **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 dates of service (DOS) 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 DOS January 1, 2011, through March 31, 2011, and 56.88% for DOS 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% Federal Medical Assistance Percentage (FMAP) for calendar years (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after, for newly eligible Medi-Cal beneficiaries.
3. 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 2017-18 ACA supplemental payments were claimed in FY 2019-20, and FY 2018-19 and FY 2019-20 ACA supplemental payments will be claimed in FY 2020-21 and FY 2021-22, 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.

## CAPITAL PROJECT DEBT REIMBURSEMENT

### REGULAR POLICY CHANGE NUMBER: 148

4. For SB 1732, capital projects funded by new debt for which final plans were submitted to the Office of the Statewide Architect and the Office of Statewide Health Planning and Development after September 1, 1988 and prior to June 30, 1994 are eligible for this program.

Once the debt service for a project is paid in full the hospital's interim supplemental payments and interim reconciliation will be reconciled using the final MUR data. If during the final reconciliation, it is determined that the eligible hospital has been overpaid, the hospital will repay the Medi-Cal program the overpayment amount. If it is determined that the eligible hospital has been underpaid, the hospital will receive an adjusted supplemental payment amount.

5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
6. The estimated payments on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>ACA</b>
<b>Hospitals (SB 1732)</b>				
Interim Payment				
FY 2018-19	\$2,356,000	\$1,178,000	\$1,178,000	\$0
FY 2019-20	\$55,840,000	\$25,208,000	\$27,920,000	\$0
FY 2020-21	\$26,654,000	\$11,674,000	\$13,327,000	\$0
ACA Adjustment to GF				
FY 2018-19	\$0	(\$12,961,000)	(\$14,925,000)	\$27,886,000
Interim Reconciliation				
FY 2015-16	\$6,913,000	\$2,103,000	\$2,103,000	\$2,707,000
FY 2016-17	(\$12,354,000)	(\$3,939,000)	(\$3,950,000)	(\$4,465,000)
Final Reconciliation				
FY 1994-95 to FY 2014-15	\$0	\$8,000	(\$8,000)	\$0
FY 1995-96 to FY 2015-16	\$0	(\$32,000)	\$32,000	\$0
<b>DP-NFs (SB 1128)</b>				
Interim Payment				
FY 2018-19	\$450,000	\$0	\$450,000	\$0
FY 2019-20	\$17,917,000	\$0	\$16,900,000	\$0
<b>Total FY 2020-21</b>	<b>\$97,776,000</b>	<b>\$23,239,000</b>	<b>\$43,027,000</b>	<b>\$26,128,000</b>

**CAPITAL PROJECT DEBT REIMBURSEMENT**  
REGULAR POLICY CHANGE NUMBER: 148

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>ARRA</b>	<b>ACA</b>
<b>Hospitals (SB 1732)</b>						
Interim Payment						
FY 2019-20	\$2,200,000	\$964,000	\$1,100,000	\$136,000	\$0	\$0
FY 2020-21	\$51,462,000	\$22,540,000	\$25,731,000	\$3,191,000	\$0	\$0
FY 2021-22	\$25,928,000	\$12,964,000	\$12,964,000	\$0	\$0	\$0
ACA Adjustment to GF						
FY 2019-20	\$0	(\$13,982,000)	(\$18,564,000)	(\$1,336,000)	\$0	\$33,882,000
Interim Reconciliation						
FY 2017-18	(\$4,689,000)	(\$489,000)	(\$489,000)	\$0	\$0	(\$3,711,000)
Final Reconciliation						
FY 1989-90 to FY 2018-19	\$2,766,000	\$1,276,000	\$1,193,000	\$0	(\$147,000)	\$444,000
<b>DP-NFs (SB 1128)</b>						
Interim Payment						
FY 2019-20	\$506,000	\$0	\$450,000	\$56,000	\$0	\$0
FY 2020-21	\$18,996,000	\$0	\$16,900,000	\$2,096,000	\$0	\$0
<b>Total FY 2020-21</b>	<b>\$97,169,000</b>	<b>\$23,273,000</b>	<b>\$39,285,000</b>	<b>\$4,143,000</b>	<b>(\$147,000)</b>	<b>\$30,615,000</b>

**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)

6.2% FFCRA GF (4260-101-0001)

6.2% FFCRA Increased FFP (4260-101-0890)

## NDPH IGT SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 149  
**IMPLEMENTATION DATE:** 10/2013  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1600

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$54,971,000	\$44,983,000
<b>- STATE FUNDS</b>	\$28,560,500	\$18,263,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$54,971,000	\$44,983,000
<b>STATE FUNDS</b>	\$28,560,500	\$18,263,000
<b>FEDERAL FUNDS</b>	\$26,410,500	\$26,720,000

**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)  
 SPA 10-026  
 SPA 16-015  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.



## NDPH IGT SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 149

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- FY 2013-14 and FY 2014-15 additional payments and Children's Services adjustments shifted from FY 2019-20 to FY 2020-21,
- FY 2015-16 payment finalization and Children's Services adjustment shifted from FY 2019-20 to FY 2020-21,
- Updated FY 2016-17 payment finalization and FY 2020-21 interim payments based on updated payment data, and
- Updated FY 2017-18 and FY 2018-19 payment finalization and Children's Services adjustments based on the approved UPL room for the respective fiscal year.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to more retroactive payments and adjustments in FY 2020-21.

**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. The FY 2015-16 and FY 2016-17 UPLs were approved by CMS on June 14, 2019 at \$70,124,808 and \$89,869,744, respectively. The FY 2017-18 and FY 2018-19 UPLs were approved by CMS on April 6, 2020 at \$37,039,512 and \$31,855,454, respectively. The FY 2019-20 and FY 2020-21 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. Interim supplemental payments for FY 2015-16 through FY 2018-19 were processed using 80 percent of the UPL room from FY 2014-15, which was the last approved UPL at the date of payment. FY 2019-20 interim supplemental payments were processed using 80 percent of the approved UPL room from FY 2018-19. FY 2020-21 and FY 2021-22 interim payment estimates assume that the UPLs will be approved prior to interim supplemental payments being processed and that the UPL room will be similar to FY 2018-19. Adjustments for FY 2017-18 and FY 2018-19 are estimated using the approved UPL room from the respective fiscal year.
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. FY 2015-16 through FY 2018-19 ACA supplemental payments will be claimed in FY 2020-21. FY 2019-20 and FY 2020-21 ACA supplemental payments will be claimed in FY 2021-22. Traditional overpayments (nonfederal share) will be offset with ACA payments and overpaid administrative costs. An adjustment will be made for the federal share processed at the regular 50% FMAP.

**NDPH IGT SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 149

6. FY 2013-14 through FY 2018-19 Children's Services payments that were collected based on the interim payments amounts for the respective FYs will be reconciled to the respective FY's approved UPL room. FY 2019-20 Children's Services payments will be reconciled upon approval of the FY 2019-20 UPLs.
7. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
8. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF*</b>	<b>IGT**</b>	<b>FF</b>	<b>FFCRA</b>	<b>ACA</b>	<b>***Return to NDPHs</b>
FY 2013-14 Additional Payments	\$11,584	\$0	\$5,792	\$5,792	\$0	\$0	\$0
FY 2013-14 Children's Services (Est.)	\$0	(\$529)	\$529	\$0	\$0	\$0	\$0
FY 2014-15 Additional Payments	\$358	\$0	\$179	\$179	\$0	\$0	\$0
FY 2014-15 Children's Services (Est.)	\$0	\$630	(\$630)	\$0	\$0	\$0	\$630
FY 2015-16 Payment Finalization	\$9,550	\$0	\$0	(\$11,796)	\$0	\$21,346	\$0
FY 2015-16 Children's Services (Est.)	\$1,167	(\$2,316)	\$3,483	\$0	\$0	\$0	\$1,167
FY 2016-17 Payment Finalization	\$22,083	\$0	\$715	(\$6,513)	\$0	\$27,881	\$0
FY 2016-17 Children's Services (Est.)	\$573	(\$3,005)	\$3,578	\$0	\$0	\$0	\$573
FY 2017-18 Payment Finalization	(\$11,011)	\$0	\$702	(\$23,770)	\$0	\$12,057	\$0
FY 2017-18 Children's Services (Est.)	\$2,281	(\$1,174)	\$3,455	\$0	\$0	\$0	\$2,281
FY 2018-19 Payment Finalization	(\$16,001)	\$0	\$667	(\$26,263)	\$0	\$9,595	\$0
FY 2018-19 Children's Services (Est.)	\$2,531	(\$1,038)	\$3,569	\$0	\$0	\$0	\$2,531
FY 2020-21 Interim Payment	\$31,856	\$0	\$13,953	\$15,928	\$1,975	\$0	\$0
<b>Total FY 2020-21</b>	<b>\$54,971</b>	<b>(\$7,432)</b>	<b>\$35,992</b>	<b>(\$46,443)</b>	<b>\$1,975</b>	<b>\$70,879</b>	<b>\$7,182</b>

**NDPH IGT SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 149

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF*</b>	<b>IGT**</b>	<b>FF</b>	<b>FFCRA</b>	<b>ACA</b>	<b>***Return to NDPHs</b>
FY 2019-20 Payment Finalization	\$8,195	\$0	\$872	(\$1,946)	(\$121)	\$9,390	\$0
FY 2019-20 Children's Services (Est.)	\$94	(\$992)	\$1,086	\$0	\$0	\$0	\$94
FY 2020-21 Payment Finalization	\$4,495	\$0	\$1,026	(\$5,131)	(\$636)	\$9,236	\$0
FY 2020-21 Children's Services (Est.)	\$343	(\$941)	\$1,284	\$0	\$0	\$0	\$343
FY 2021-22 Interim Payment	\$31,856	\$0	\$15,928	\$15,928	\$0	\$0	\$0
<b>Total FY 2021-22</b>	<b>\$44,983</b>	<b>(\$1,933)</b>	<b>\$20,196</b>	<b>\$8,851</b>	<b>(\$757)</b>	<b>\$18,626</b>	<b>\$437</b>

\*\*\*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)  
FFCRA 6.2% Increased FFP (4260-101-0890)

## QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 150  
**IMPLEMENTATION DATE:** 4/2014  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 1563

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$81,000,000	\$81,000,000
<b>- STATE FUNDS</b>	\$40,500,000	\$40,500,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$81,000,000	\$81,000,000
<b>STATE FUNDS</b>	\$40,500,000	\$40,500,000
<b>FEDERAL FUNDS</b>	\$40,500,000	\$40,500,000

### 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  
 SPA 19-0043  
 SPA 20-0021  
 AB 81 (Chapter 13, Statutes of 2020)

### 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 (RY) 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.

## QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 150

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 RYs, and also extended the quality assurance fee (QAF) and the QASP at 1% of the overall rate level until July 31, 2015.

AB 119 extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning in RY 2015-16, the annual weighted average rate increase was set at 3.62%, and the General Fund appropriation for the QASP program will continue at RY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning RY 2015-16, the Department is required 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 is an eligibility requirement for the QASP program, beginning in 2019-20 RY. This requirement will have no fiscal impact on the QASP program.

The California Department of Aging (CDA) has direct appropriation authority of \$1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

AB 81 (Chapter 13, Statutes of 2020) extends the QASP program through December 31, 2022, and authorizes the Department to conduct necessary closeout activities after January 1, 2023, to finalize the April 2022 and prior year payments.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to updated penalty collection estimates, increased CDPH administration costs, and decreased supplemental payments based on the estimated funding available.

There is no change from FY 2020-21 to FY 2021-22, in the current estimate.

#### 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 2020-21	FY 2021-22
Penalties on Nursing Facilities	\$501,000	\$500,000
QASP GF Appropriation	\$43,236,000	\$43,236,000
PLI savings	\$3,743,000	\$3,743,000

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

## QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 150

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 \$17,213,000 TF (\$8,607,000 Special Fund) for FY 2020-21 and \$10,014,000 TF (\$5,007,000 Special Fund) FY 2021-22.
5. The GF appropriated QASP funding will continue at RY 2014-15 levels, instead of setting aside a portion of the annual increase.
6. Supplemental payments are estimated to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
Supplemental Payments***	\$81,000	\$0	\$40,500	\$40,500
Transfer from GF* to Special Fund**	\$0	\$46,979	(\$46,979)	\$0
<b>Total</b>	<b>\$81,000</b>	<b>\$46,979</b>	<b>(\$6,479)</b>	<b>\$40,500</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
Supplemental Payments***	\$81,000	\$0	\$40,500	\$40,500
Transfer from GF* to Special Fund**	\$0	\$46,979	(\$46,979)	\$0
<b>Total</b>	<b>\$81,000</b>	<b>\$46,979</b>	<b>(\$6,479)</b>	<b>\$40,500</b>

**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)\*\*\*

## CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS

**REGULAR POLICY CHANGE NUMBER:** 151  
**IMPLEMENTATION DATE:** 6/2002  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 86

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$71,812,000	\$92,298,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$71,812,000	\$92,298,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$71,812,000	\$92,298,000

**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 that are owned or operated by a public entity.

**Authority:**

AB 430 (Chapter 171, Statutes of 2001)  
 State Plan Amendment (SPA) 01-022  
 SPA 12-021  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

DP-NFs are allowed to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays. 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: 151**

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a net decrease due to:

- RY 2012-13 and RY 2013-14 final reconciliations shifted from FY 2019-20 to FY 2020-21;
- RY 2014-15 and RY 2015-16 final reconciliations shifted from FY 2020-21 to FY 2021-22;
- Revised interim reconciliation amounts for RY 2018-19 based on updated data;
- Revised interim payment amounts for RY 2019-20 and RY 2020-21 based on updated data; and
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net increase due to:

- Increased final and interim reconciliations occurring in FY 2021-22; and
- Decreased FFCRA increased FFP in FY 2021-22 based on the applicable periods.

#### **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, and 90% beginning on January 1, 2020, and thereafter. The ACA methodology has been approved by CMS.

Assume half of the interim ACA payments occur in the current fiscal year, and the remaining half will occur in the subsequent fiscal year.



**CPE SUPPLEMENTAL PAYMENTS FOR DP-NFS**  
**REGULAR POLICY CHANGE NUMBER: 151**

4. Assume half of the interim payments occur in the current fiscal year, and the remaining interim payments occur in the subsequent fiscal year.
5. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
RY 2012-13 Final Reconciliation	(\$1,602,000)	(\$1,602,000)	\$0	\$0
RY 2013-14 Final Reconciliation	\$2,835,000	\$2,388,000	\$447,000	\$0
RY 2018-19 Interim Reconciliation	\$7,354,000	\$5,744,000	\$1,610,000	\$0
RY 2019-20 Interim Payment	\$31,039,000	\$24,965,000	\$3,497,000	\$2,577,000
RY 2020-21 Interim Payment	\$32,186,000	\$23,291,000	\$6,488,000	\$2,407,000
<b>Total</b>	<b>\$71,812,000</b>	<b>\$54,786,000</b>	<b>\$12,042,000</b>	<b>\$4,984,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
RY 2014-15 Final Reconciliation	\$9,283,000	\$7,586,000	\$1,697,000	\$0
RY 2015-16 Final Reconciliation	\$6,992,000	\$5,809,000	\$1,183,000	\$0
RY 2019-20 Interim Reconciliation	\$9,347,000	\$6,911,000	\$2,008,000	\$428,000
RY 2020-21 Interim Payment	\$36,897,000	\$26,984,000	\$6,605,000	\$3,308,000
RY 2021-22 Interim Payment	\$29,779,000	\$23,291,000	\$6,488,000	\$0
<b>Total</b>	<b>\$92,298,000</b>	<b>\$70,581,000</b>	<b>\$17,981,000</b>	<b>\$3,736,000</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## GEMT SUPPLEMENTAL PAYMENT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 152  
**IMPLEMENTATION DATE:** 4/2014  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1661

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$55,960,000	\$35,470,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$55,960,000	\$35,470,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$55,960,000	\$35,470,000

**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)  
 State Plan Amendment (SPA) 09-024  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment under the GEMT Supplemental Payment Program 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: 152**

SPA 18-0007, was 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to:

- FY 2009-10 final reconciliations shifted from FY 2020-21 to FY 2021-22 due to pending resolution of the negative fund balance issue.
- FY 2012-13, FY 2015-16, and FY 2016-17 final reconciliations shifted from FY 2019-20 to FY 2020-21.
- FY 2017-18 interim reconciliation was changed to final reconciliation and shifted from FY 2020-21 to FY 2021-22 due to audit timing.
- FY 2018-19 interim payments decreased due to updated data.
- FY 2019-20 interim payments decreased due to updated data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Backlog of interim payments will occur in FY 2020-21. Regular timing of payments will resume in FY 2021-22.
- Backlog of final reconciliations will be completed in FY 2021-22.

#### **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 (CY) 2014 through 2016, 95% FMAP for CY 2017, 94% FMAP for CY 2018, 93% for CY 2019, and 90% for CY 2020 and after for newly eligible Medi-Cal beneficiaries. The ACA methodology has been approved by CMS.
3. 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.
4. 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.

## GEMT SUPPLEMENTAL PAYMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 152

Due to delays in receipt of cost reports, retroactive years are being reconciled in FY 2019-20 and FY 2020-21.

5. SPA 18-0007, when approved, will be retroactive to dates of service beginning July 1, 2018. SPA 18-0007 proposes to expand claimable costs that can be allocated to two or more departmental functions on the basis of shared benefits, for increased GEMT supplemental reimbursement.
6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

The estimated payments on a cash basis are:

<b>FY 2020-21</b>	<b>Total FFP</b>	<b>Regular FFP</b>	<b>ARRA</b>	<b>ACA</b>	<b>FFCRA</b>
FY 2012-13 Final Recon.	(\$386,000)	(\$386,000)	\$0	\$0	\$0
FY 2015-16 Final Recon.	(\$2,112,000)	(\$880,000)	\$0	(\$1,232,000)	\$0
FY 2016-17 Final Recon.	\$842,000	\$228,000	\$0	\$614,000	\$0
FY 2018-19 Interim Payment	\$28,712,000	\$9,536,000	\$0	\$19,176,000	\$0
FY 2019-20 Interim Payment	\$28,904,000	\$9,536,000	\$0	\$18,772,000	\$596,000
<b>Total FY 2020-21</b>	<b>\$55,960,000</b>	<b>\$18,034,000</b>	<b>\$0</b>	<b>\$37,330,000</b>	<b>\$596,000</b>

<b>FY 2021-22</b>	<b>Total FFP</b>	<b>Regular FFP</b>	<b>ARRA</b>	<b>ACA</b>	<b>FFCRA</b>
FY 2009-10 Final Recon.	\$12,769,000	\$10,366,000	\$2,403,000	\$0	\$0
FY 2010-11 Final Recon.	(\$1,756,000)	(\$1,530,000)	(\$226,000)	\$0	\$0
FY 2011-12 Final Recon.	(\$456,000)	(\$456,000)	\$0	\$0	\$0
FY 2013-14 Final Recon.	(\$186,000)	(\$135,000)	\$0	(\$51,000)	\$0
FY 2014-15 Final Recon.	(\$373,000)	(\$106,000)	\$0	(\$267,000)	\$0
FY 2017-18 Final Recon.	(\$3,709,000)	(\$1,173,000)	\$0	(\$2,536,000)	\$0
FY 2020-21 Interim Payment	\$29,181,000	\$9,537,000	\$0	\$18,456,000	\$1,188,000
<b>Total FY 2021-22</b>	<b>\$35,470,000</b>	<b>\$16,503,000</b>	<b>\$2,177,000</b>	<b>\$15,602,000</b>	<b>\$1,188,000</b>

#### Funding:

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 153  
**IMPLEMENTATION DATE:** 5/2021  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2185

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$26,250,000	\$105,000,000
<b>- STATE FUNDS</b>	\$11,497,000	\$52,500,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$26,250,000	\$105,000,000
<b>STATE FUNDS</b>	\$11,497,000	\$52,500,000
<b>FEDERAL FUNDS</b>	\$14,753,000	\$52,500,000

**Purpose:**

This policy change estimates the cost of the Non-Hospital 340B Clinics Supplemental Payment Pool.

**Authority:**

Welfare & Institutions Code Section 14105.467  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Change:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from managed care (MC) to fee-for-service (FFS). The transition of pharmacy services from MC to FFS will be implemented on April 1, 2021. Transitioning pharmacy services from managed care to Fee-For-Service (FFS) delivery system is referred to as Medi-Cal Rx.

Non-hospital 340B clinics that currently receive reimbursement from managed care plans for pharmacy services will begin billing Medi-Cal at their acquisition cost, which will result in cost savings to the State. To mitigate the revenue impact to these 340B clinics, the Department proposes to create a supplemental payment pool.

Supplemental payments will be provided to non-hospital 340B clinics. These payments will continue to support their overall safety net services that might otherwise be limited or eliminated due to the change in billing to a FFS delivery system.

Per Welfare and Institution Code Section 14105.467, the Department convened a stakeholder workgroup to develop the methodology for the distribution of supplemental pool payments to qualifying non-hospital 340B community clinics. The workgroup topics include the eligibility criteria for receipt of supplemental payments, the aggregate amount of pool funding available in a respective fiscal year, and the criteria for apportioning the pool funding among qualifying non-hospital 340B community clinics including the timing, frequency, and amount of the resultant supplemental payments.

## NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 153

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

#### Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from Maximum Allowable Ingredients Cost (MAIC) to FFS
- Medi-Cal Rx- Additional Supplemental Rebates
- Medical Supply Rebates

#### Other Admin

Medi-Cal Rx – Administrative Costs

#### **Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease in costs due to:

- The implementation date of Medi-Cal Rx changing from January 1, 2021, to April 1, 2021, and
- Including FFCRA increased funding in FY 2020-21.

The change from FY 2020-21 to FY 2021-22 in the current estimate is due to:

- Estimating a full year of expenditures, and
- FFCRA increased FFP is not assumed for FY 2021-22.

#### **Methodology:**

1. The estimated Non-hospital 340B Clinic Supplemental Payment Pool annual cost is \$105,000,000 TF.

(Dollars in Thousands)

Annual	TF	GF	FF
Non-hospital 340B Clinic Supplemental Payments	\$105,000	\$52,500	\$52,500

2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**NON-HOSPITAL 340B CLINIC SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 153

3. The estimated cost for FY 2020-21 is \$26,250,000 TF, representing April 1, 2021 to June 30, 2021, with payments starting in May 2021.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX/ 50% GF	\$26,250	\$13,125	\$13,125
FFCRA 6.2% Increased FFP	\$0	(\$1,628)	\$1,628
<b>Total</b>	<b>\$26,250</b>	<b>\$11,497</b>	<b>\$14,753</b>

4. The estimated cost for FY 2021-22 is \$105,000,000 TF.

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX/ 50% GF	\$105,000	\$52,500	\$52,500
<b>Total</b>	<b>\$105,000</b>	<b>\$52,500</b>	<b>\$52,500</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)  
FFCRA 6.2% Increased FMAP (4260-101-0001/0890)

## PROP 56 - DEVELOPMENTAL SCREENINGS

**REGULAR POLICY CHANGE NUMBER:** 154  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2171

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$53,308,000	\$61,960,000
<b>- STATE FUNDS</b>	\$20,954,890	\$25,877,550
<b>PAYMENT LAG</b>	0.9984	1.0000
<b>% REFLECTED IN BASE</b>	6.73 %	7.68 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$49,640,800	\$57,201,500
<b>STATE FUNDS</b>	\$19,513,350	\$23,890,150
<b>FEDERAL FUNDS</b>	\$30,127,460	\$33,311,320

**Purpose:**

This policy change estimates the cost for providing Proposition 56 funded payments for developmental screenings.

**Authority:**

AB 74 (Chapter 23, Statute of 2019)  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a 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.

The Department provides Proposition 56 funded payments for clinically appropriate developmental screening services for children, starting January 1, 2020. In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. On June 30, 2019, the Department submitted the directed payment pre-print (proposal) required by the Centers for Medicare and Medicaid Services, seeking to obtain managed care directed payment approval.

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. Repeated and regular screening is necessary to ensure timely identification of problems and early intervention, especially in later-developing skills such as language.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34



## PROP 56 - DEVELOPMENTAL SCREENINGS

### REGULAR POLICY CHANGE NUMBER: 154

percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a net increase due to the following:

- Fee-for-Service (FFS) cost is lower due to a slight decrease in caseload projections.
- Increase managed care capitation and funding assumptions based on updated managed care enrollment projections.
- Addition of the FFCRA Increased FMAP for payments in FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2021-22 managed care costs including higher monthly rates, and six additional months of FFCRA Increased FMAP for payments in FY 2021-22.

#### Methodology:

1. Fee-for-Service (FFS) and managed care implementation for developmental screenings began January 1, 2020.
2. Developmental screenings are recommended at three specific times in early childhood (9 months, 18 months, and 30 months).
3. 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.

#### Managed Care Directed Payments

4. Risk-based capitation rates paid to managed care plans (MCPs) will be enhanced, based on anticipated utilization of Developmental Screening services, to fund the required provider payments.
5. Seven (7) months of the Bridge Period (July 1, 2019 through December 31, 2020) capitation rate increases and five (5) months of the Calendar Year (CY) 2021 capitation rate increases are expected to pay in FY 2020-21.
6. Seven (7) months of the CY 2021 capitation rate increases and five (5) months of the CY 2022 capitation rate increases are expected to pay in FY 2021-22.
7. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.

**PROP 56 - DEVELOPMENTAL SCREENINGS**  
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8. Total estimated payments in FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Fee-for-Service	\$5,682,000	\$2,420,000	\$2,918,000	\$344,000
Managed Care	\$47,626,000	\$18,535,000	\$26,411,000	\$2,680,000
<b>Total</b>	<b>\$53,308,000</b>	<b>\$20,955,000</b>	<b>\$29,329,000</b>	<b>\$3,024,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Fee-for-Service	\$5,682,000	\$2,592,000	\$2,905,000	\$185,000
Managed Care	\$56,278,000	\$23,286,000	\$30,665,000	\$2,327,000
<b>Total</b>	<b>\$61,960,000</b>	<b>\$25,878,000</b>	<b>\$33,570,000</b>	<b>\$2,512,000</b>

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$39,770,000	\$19,885,000	\$19,885,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$676,000	\$68,000	\$608,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$4,134,000	\$971,000	\$3,163,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$8,728,000	\$3,055,000	\$5,673,000	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$558,000)	(\$558,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$558,000	\$0	\$0	\$558,000
FFCRA 6.2% GF (4260-101-0001)	(\$2,466,000)	(\$2,466,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$2,466,000	\$0	\$0	\$2,466,000
<b>Total</b>	<b>\$53,308,000</b>	<b>\$20,955,000</b>	<b>\$29,329,000</b>	<b>\$3,024,000</b>

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REGULAR POLICY CHANGE NUMBER: 154

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$46,037,000	\$23,019,000	\$23,018,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$808,000	\$81,000	\$727,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$15,115,000	\$5,290,000	\$9,825,000	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$381,000)	(\$381,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$381,000	\$0	\$0	\$381,000
FFCRA 6.2% GF (4260-101-0001)	(\$2,131,000)	(\$2,131,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$2,131,000	\$0	\$0	\$2,131,000
<b>Total</b>	<b>\$61,960,000</b>	<b>\$25,878,000</b>	<b>\$33,570,000</b>	<b>\$2,512,000</b>

## PROP 56 - CBAS SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 155  
**IMPLEMENTATION DATE:** 3/2020  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2145

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$38,648,000	\$30,753,000
<b>- STATE FUNDS</b>	\$16,928,000	\$14,284,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$38,648,000	\$30,753,000
<b>STATE FUNDS</b>	\$16,928,000	\$14,284,500
<b>FEDERAL FUNDS</b>	\$21,720,000	\$16,468,500

**Purpose:**

This policy change estimates the expenditures related to providing supplemental payments for Community-Based Adult Services (CBAS).

**Authority:**

AB 74 (Chapter 23, Statutes of 2019)  
 AB 80 (Chapter 12, Statutes of 2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 the Budget Act of 2019, the Department developed the structure and parameters for supplemental payments for CBAS beginning in FY 2019-20.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

## PROP 56 - CBAS SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 155

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to January 1, 2023.

#### Reason for Change:

The change from the prior estimate for FY 2020-21 is an increase due to updated enrollment projections. The change from FY 2020-21 to FY 2021-22 in the current estimate is a decrease due to updated enrollment projections trending lower and updated draft CY 2021 and CY 2022 rates.

#### Methodology:

1. The Budget Act of 2019 provides for supplemental payments for CBAS in FY 2020-21 and FY 2021-22.
2. Assume Proposition 56 CBAS supplemental payments have a one-month lag.
3. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through December 31, 2021.
4. Estimated supplemental payments are as follows:

Fiscal Year	TF	GF	FF	FFCRA
FY 2020-21	\$38,648,000	\$16,928,000	\$19,324,000	\$2,396,000
FY 2021-22	\$30,753,000	\$14,285,000	\$15,376,000	\$1,092,000

#### Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)  
 FFCRA 6.2% Increased FMAP (4260-101-0890)  
 FFCRA 6.2% GF (4260-101-0001)

## PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 156  
 IMPLEMENTATION DATE: 1/2020  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 2129

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$42,090,000	\$47,682,000
<b>- STATE FUNDS</b>	\$14,909,890	\$18,217,150
<b>PAYMENT LAG</b>	0.9972	1.0000
<b>% REFLECTED IN BASE</b>	11.88 %	13.88 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$36,985,900	\$41,063,700
<b>STATE FUNDS</b>	\$13,101,810	\$15,688,610
<b>FEDERAL FUNDS</b>	\$23,884,050	\$25,375,130

### Purpose:

This policy change estimates the cost for providing Adverse Childhood Experiences (ACEs) screenings.

### Authority:

AB 74 (Chapter 23, Statute of 2019)  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

### Interdependent Policy Changes:

Proposition 56 Funds Transfer

### Background:

On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a 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.

The Department has proposed to begin providing Proposition 56 funded payments for clinically appropriate ACEs services for children and adults, starting January 1, 2020. In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. On June 30, 2019, the Department submitted the directed payment pre-print (proposal) required by the Centers for Medicare and Medicaid Services, seeking to obtain managed care directed payment approval.

Trauma informed care is an organizational transformation process to provide a model of care intended to promote healing and reduce risk for re-traumatization. ACEs evaluates children and adults for trauma that occurred during the first 18 years of life. Early identification of trauma and providing the appropriate treatment is a critical tool for reducing long-term health care costs for both children and adults.

The following Healthcare Common Procedure Coding System (HCPCS) codes are eligible for the Proposition 56 funded payments:

**PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS**  
REGULAR POLICY CHANGE NUMBER: 156

HCPCS Code	Description	Notes
G9919	Screening performed – results positive and provision of recommendations provided	Providers must bill this code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	Providers must bill this code when the patient's ACE score is between 0 and 3 (lower risk).

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net increase due to the following:

- Fee-for-Service (FFS) cost is lower due to a slight decrease in caseload projections.
- Increase managed care capitation and funding assumptions based on updated managed care enrollment projections.
- Addition of the FFCRA Increased FMAP for payments in FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2021-22 managed care costs including higher monthly rates, and six additional months of FFCRA Increased FMAP for payments in FY 2021-22.

**Methodology:**

1. Fee-for-Service (FFS) and managed care implementation for ACEs began January 1, 2020.
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.

## PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS

REGULAR POLICY CHANGE NUMBER: 156

### Managed Care Directed Payments

5. Risk-based capitation rates paid to managed care plans (MCPs) will be enhanced, based on anticipated utilization of ACEs screening services, to fund the required provider payments.
6. Seven (7) months of the Bridge Period (July 1, 2019 through December 31, 2020) capitation rate increases and five (5) months of the Calendar Year (CY) 2021 capitation rate increases are expected to pay in FY 2020-21.
7. Seven (7) months of the CY 2021 capitation rate increases and five (5) months of the CY 2022 capitation rate increases are expected to pay in FY 2021-22.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.
9. Total estimated payments in FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Fee-for-Service	\$7,906,000	\$2,658,000	\$4,903,000	\$345,000
Managed Care	\$34,184,000	\$12,252,000	\$20,224,000	\$1,708,000
<b>Total</b>	<b>\$42,090,000</b>	<b>\$14,910,000</b>	<b>\$25,127,000</b>	<b>\$2,053,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Fee-for-Service	\$7,906,000	\$2,835,000	\$4,899,000	\$172,000
Managed Care	\$39,776,000	\$15,382,000	\$23,235,000	\$1,159,000
<b>Total</b>	<b>\$47,682,000</b>	<b>\$18,217,000</b>	<b>\$28,134,000</b>	<b>\$1,331,000</b>



**PROP 56 - ADVERSE CHILDHOOD EXPERIENCES SCREENINGS**  
REGULAR POLICY CHANGE NUMBER: 156

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$27,960,000	\$13,980,000	\$13,980,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$6,763,000	\$676,000	\$6,087,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$2,364,000	\$556,000	\$1,808,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$5,003,000	\$1,751,000	\$3,252,000	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$320,000)	(\$320,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$320,000	\$0	\$0	\$320,000
FFCRA 6.2% GF (4260-101-0001)	(\$1,733,000)	(\$1,733,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$1,733,000	\$0	\$0	\$1,733,000
<b>Total</b>	<b>\$42,090,000</b>	<b>\$14,910,000</b>	<b>\$25,127,000</b>	<b>\$2,053,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$31,628,000	\$15,814,000	\$15,814,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$7,539,000	\$754,000	\$6,785,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$8,515,000	\$2,980,000	\$5,535,000	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$215,000)	(\$215,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$215,000	\$0	\$0	\$215,000
FFCRA 6.2% GF (4260-101-0001)	(\$1,116,000)	(\$1,116,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$1,116,000	\$0	\$0	\$1,116,000
<b>Total</b>	<b>\$47,682,000</b>	<b>\$18,217,000</b>	<b>\$28,134,000</b>	<b>\$1,331,000</b>

## STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 157  
**IMPLEMENTATION DATE:** 12/2010  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1616

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$14,857,000	\$10,706,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$14,857,000	\$10,706,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$14,857,000	\$10,706,000

**Purpose:**

This policy change estimates the supplemental payments to state veterans' homes.

**Authority:**

AB 959 (Chapter 162, Statutes of 2006)  
 State Plan Amendment 06-017  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 157

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Interim Payments: FY 2019-20 and FY 2020-21 payments were updated to reflect first time traditional Q3 and Q4 payments paid during interim payments, instead of initial reconciliations. Payments also increased as a result of updated data.
- Initial Reconciliation Payments: FY 2019-20 payments were updated to remove the first time traditional Q3 and Q4 payments that will be processed as an interim payment, instead of initial reconciliations.
- Final Reconciliation: FY 2016-17 revised based on updated data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to delayed FY 2019-20 interim payments will be processed in FY 2020-21, whereas FY 2021-22 interim payments are current.

#### 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
  - a. First time (interim) ACA payments occur during initial reconciliations using as filed cost report data to calculate payments, and
3. A final reconciliation payment, if necessary.
4. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

Program payment amounts are estimated to be:

<b>FY 2020-21</b>	<b>TF</b>	<b>Regular FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
<b>Interim Payments</b>				
FY 2019-20	\$4,277,000	\$3,816,000	\$0	\$461,000
FY 2020-21	\$10,089,000	\$8,976,000	\$0	\$1,113,000
<b>Initial Reconciliation</b>				
FY 2019-20	\$1,090,000	\$219,000	\$857,000	\$14,000
<b>Final Reconciliation</b>				
FY 2016-17	(\$599,000)	(\$634,000)	\$35,000	\$0
<b>FY 2020-21 Total</b>	<b>\$14,857,000</b>	<b>\$12,377,000</b>	<b>\$892,000</b>	<b>\$1,588,000</b>

**STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 157

<b>FY 2021-22</b>	<b>TF</b>	<b>Regular FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
<b>Interim Payments</b>				
FY 2021-22	\$9,873,000	\$9,873,000	\$0	\$0
<b>Initial Reconciliation</b>				
FY 2020-21	\$1,432,000	\$277,000	\$1,121,000	\$34,000
<b>Final Reconciliation</b>				
FY 2017-18	(\$599,000)	(\$634,000)	\$35,000	\$0
<b>FY 2021-22 Total</b>	<b>\$10,706,000</b>	<b>\$9,516,000</b>	<b>\$1,156,000</b>	<b>\$34,000</b>

**Funding:**

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

## MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

**REGULAR POLICY CHANGE NUMBER:** 158  
**IMPLEMENTATION DATE:** 1/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1038

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$10,000,000	\$10,000,000
<b>- STATE FUNDS</b>	\$4,380,000	\$5,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$10,000,000	\$10,000,000
<b>STATE FUNDS</b>	\$4,380,000	\$5,000,000
<b>FEDERAL FUNDS</b>	\$5,620,000	\$5,000,000

**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)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change from the prior estimate for FY 2020-21, and from FY 2020-21 to FY 2021-22 within the current estimate, is due to applying the FFCRA increased FMAP in FY 2020-21.

## MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

### REGULAR POLICY CHANGE NUMBER: 158

**Methodology:**

1. The 6.2% FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
2. Assume annual reimbursements for disproportionate share of outpatient services are \$10,000,000 TF (\$5,000,000 GF).

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
CY 2020	\$7,500,000	\$3,285,000	\$3,750,000	\$465,000
CY 2021	\$2,500,000	\$1,095,000	\$1,250,000	\$155,000
<b>Total</b>	<b>\$10,000,000</b>	<b>\$4,380,000</b>	<b>\$5,000,000</b>	<b>\$620,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CY 2021	\$7,500,000	\$3,750,000	\$3,750,000
CY 2022	\$2,500,000	\$1,250,000	\$1,250,000
<b>Total</b>	<b>\$10,000,000</b>	<b>\$5,000,000</b>	<b>\$5,000,000</b>

**Funding:**

- 50% Title XIX / 50% GF (4260-101-0001/0890)  
 56.2% Title XIX / 43.8% GF (4260-101-0001/0890)

## MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

**REGULAR POLICY CHANGE NUMBER:** 159  
**IMPLEMENTATION DATE:** 1/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1039

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,000,000	\$8,000,000
<b>- STATE FUNDS</b>	\$3,504,000	\$4,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$8,000,000	\$8,000,000
<b>STATE FUNDS</b>	\$3,504,000	\$4,000,000
<b>FEDERAL FUNDS</b>	\$4,496,000	\$4,000,000

**Purpose:**

This policy change estimates the supplemental reimbursement to Small and Rural Hospitals (SRHs) that provide outpatient services.

**Authority:**

AB 2617 (Chapter 158, Statutes of 2000)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**Background:**

This program provides eligible SRHs with supplemental reimbursement for 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change from the prior estimate for FY 2020-21, and from FY 2020-21 to FY 2021-22 within the current estimate, is due to applying the FFCRA increased FMAP in FY 2020-21.

## MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

### REGULAR POLICY CHANGE NUMBER: 159

**Methodology:**

1. The 6.2% FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
2. Assume annual reimbursements to SRHs providing outpatient services are \$8,000,000 TF (\$4,000,000 GF).

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
CY 2020	\$6,000,000	\$2,628,000	\$3,000,000	\$372,000
CY 2021	\$2,000,000	\$876,000	\$1,000,000	\$124,000
<b>Total</b>	<b>\$8,000,000</b>	<b>\$3,504,000</b>	<b>\$4,000,000</b>	<b>\$496,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CY 2021	\$6,000,000	\$3,000,000	\$3,000,000
CY 2022	\$2,000,000	\$1,000,000	\$1,000,000
<b>Total</b>	<b>\$8,000,000</b>	<b>\$4,000,000</b>	<b>\$4,000,000</b>

**Funding:**

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

56.2% Title XIX / 43.8% GF (4260-101-0001/0890)



## PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 160  
**IMPLEMENTATION DATE:** 4/2018  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2045

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$25,988,000	\$25,925,000
<b>- STATE FUNDS</b>	\$11,076,500	\$11,781,900
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	71.99 %	72.17 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$7,279,200	\$7,214,900
<b>STATE FUNDS</b>	\$3,102,530	\$3,278,900
<b>FEDERAL FUNDS</b>	\$4,176,710	\$3,936,020

**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  
 SPA 19-022  
 CA-0139.R05.01 HCBA Waiver Amendment  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56), passed by the voters in November 2016, increased 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 \$2.00 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.

AB 120 allocated Proposition 56 funds for supplemental payments for ICF/DDs, ICF/DD-H facilities, ICF/DD-N facilities, and ICF/DD Continuous Nursing Care (CNC) facilities. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-028 for these supplemental payments. Additionally, CMS approved a 1915c Waiver amendment authorizing supplemental payments for ICF/DD-CNCs under the Home and Community-Based Alternatives (HCBA) Waiver.

## PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 160

SB 856 authorized the Department to extend the supplemental payments through FY 2018-19. CMS approved SPA 18-0029 for the extension of the supplemental payments for the period of August 1, 2018, through July 31, 2019.

AB 74 authorized the Department to extend supplemental payments for the period of August 1, 2019, through December 31, 2021. CMS approved SPA 19-0022 for the extension of the supplemental payments for this period.

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 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

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to January 1, 2023.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a net decrease due to:

- The fee-for-service costs for the Prop 56 – Freestanding Pediatric Subacute (FS/PSA) supplemental payments and Prop 56 - ICF/DD supplemental payments are combined in the payment data. To account for Prop 56- ICF/DD costs only, the estimated costs for the Prop 56 FS/PSA supplemental payments have been removed from the FFS ICF/DD estimate.
- Increased managed care payments and funding assumptions based on updated member months projections for both mainstream and CCI dull dual rates.
- Updating FFS funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

## PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 160

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to:

- Decreased managed care payments based on 2021-22 enrollment projections being lower than FY 2020-21 and including the draft rates for Calendar Year (CY) 2021 and CY 2022.
- Less FFCRA funding estimated in FY 2021-22.

#### 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 December 31, 2021.

#### Fee-for-Service Supplemental Payments

3. The FFS supplemental payments were implemented June 25, 2018.
4. The FFS supplemental payments for ICF/DD, ICF/DD-H, and ICF/DD-N facilities are expected to be \$18.273 million TF annually. The FFS supplemental payments for ICF/DD CNC facilities are expected to be \$436,000 annually.

#### Managed Care Supplemental Payments

5. The managed care supplemental payments, including CCI, are estimated to be \$7.27 million TF in FY 2020-21 and \$7.21 million TF in FY 2021-22.
6. For non-CCI managed care payments:
  - Assume one month of the FY 2019-20 capitation rate increases and 11 months of the FY 2020-21 capitation rate increases are expected to occur in FY 2020-21.
  - Assume no rate increases from FY 2020-21 to FY 2021-22.
7. For CCI managed care payments:
  - Assume payments will continue in FY 2020-21 at the same level.
  - Assume no rate increases from FY 2020-21 to FY 2021-22.
8. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021 in this policy change.
9. Funds allocated for the supplemental payments are as follows:

FY 2020-21	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	\$18,273,000	\$7,893,000	\$96,000	\$8,878,000	\$299,000	\$1,107,000
FFS Payments (ICF/DD-CNC)	\$436,000	\$187,000	\$0	\$209,000	\$14,000	\$26,000
CCI Payments	\$1,489,000	\$652,000	\$0	\$745,000	\$0	\$92,000
Managed Care Pmts	\$5,790,000	\$2,344,000	\$25,000	\$2,602,000	\$494,000	\$325,000
<b>Total</b>	<b>\$25,988,000</b>	<b>\$11,076,000</b>	<b>\$121,000</b>	<b>\$12,434,000</b>	<b>\$807,000</b>	<b>\$1,550,000</b>

**PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 160

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Title XXI FF</b>	<b>Title XIX FF</b>	<b>ACA FF</b>	<b>FFCRA</b>
FFS Payments (ICF/DD, ICF/DD-H, ICF/DD-N)	\$18,273,000	\$8,451,000	\$92,000	\$8,878,000	\$299,000	\$554,000
FFS Payments (ICF/DD-CNC)	\$436,000	\$200,000	\$0	\$209,000	\$14,000	\$13,000
CCI Payments	\$1,694,000	\$787,000	\$0	\$847,000	\$0	\$60,000
Managed Care Pmts	\$5,522,000	\$2,344,000	\$22,000	\$2,476,000	\$482,000	\$198,000
<b>Total</b>	<b>\$25,925,000</b>	<b>\$11,782,000</b>	<b>\$114,000</b>	<b>\$12,410,000</b>	<b>\$795,000</b>	<b>\$824,000</b>

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$24,868,000	\$12,434,000	\$12,434,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$896,000	\$89,000	\$807,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$47,000	\$11,000	\$36,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$131,000	\$46,000	\$85,000	\$0
100% GF (4260-101-0001)	\$46,000	\$46,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$8,000)	(\$8,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$8,000	\$0	\$0	\$8,000
FFCRA 6.2% GF (4260-101-0001)	(\$1,542,000)	(\$1,542,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$1,542,000	\$0	\$0	\$1,542,000
<b>Total</b>	<b>\$25,988,000</b>	<b>\$11,076,000</b>	<b>\$13,362,000</b>	<b>\$1,550,000</b>

**PROP 56 - ICF/DD SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 160

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$24,820,000	\$12,410,000	\$12,410,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$883,000	\$88,000	\$795,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$176,000	\$62,000	\$114,000	\$0
100% GF (4260-101-0001)	\$46,000	\$46,000	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$4,000)	(\$4,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$4,000	\$0	\$0	\$4,000
FFCRA 6.2% GF (4260-101-0001)	(\$820,000)	(\$820,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$820,000	\$0	\$0	\$820,000
<b>Total</b>	<b>\$25,925,000</b>	<b>\$11,782,000</b>	<b>\$13,319,000</b>	<b>\$824,000</b>

## PROP 56 - MEDI-CAL FAMILY PLANNING

**REGULAR POLICY CHANGE NUMBER:** 161  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 2130

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$436,844,000	\$431,072,000
<b>- STATE FUNDS</b>	\$43,684,400	\$43,107,200
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	8.78 %	7.20 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$398,489,100	\$400,034,800
<b>STATE FUNDS</b>	\$39,848,910	\$40,003,480
<b>FEDERAL FUNDS</b>	\$358,640,190	\$360,031,330

**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:**

AB 74 (Chapter 23, Statutes of 2019)  
State Plan Amendment (SPA)19-0027

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**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 non-federal share of health care expenditures in accordance with the annual state budget process. SB 104, the Budget Act of 2019, appropriated Proposition 56 funds for specified Department health care expenditures during FY 2019-20.

On August 20, 2019, the Centers for Medicare & Medicaid Services (CMS) approved SPA 19-0027. SPA 19-0027 allows the Department to implement time-limited supplemental payments for specific family planning services delivered in the Medi-Cal FFS delivery system from July 1, 2019, through December 31, 2021. The FFS supplemental payment implemented in January 2020. In FY 2019-20, an Erroneous Payment Correction will deploy to retroactively apply supplemental payments to July 1, 2019.

In the Medi-Cal managed care delivery system, the Department has proposed to implement these payments as directed payments to eligible providers. Prior to implementation of a directed payment program, CMS requires states to seek pre-approval of any requested directed payment program through the standard CMS "pre-print" form. This "pre-print" is typically submitted on an annual basis. On June 30, 2019, the Department submitted the directed payment pre-print required by CMS, seeking to obtain managed care directed payment approval. On May 5, 2020, the Department received approval from CMS.

**PROP 56 - MEDI-CAL FAMILY PLANNING**  
**REGULAR POLICY CHANGE NUMBER: 161**

These supplemental payments for Medi-Cal family planning services are intended to help support the larger Medi-Cal population in accessing and using family planning services as well as the providers delivering such services in the Medi-Cal program. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to a projected increase in FFS expenditures using historical actuals and updated MC expenditure data. The change from FY 2020-21 to 2021-22, in the current estimate, is a slight decrease due to updated enrollment and expenditure projections for MC and FFS in FY 2021-22.

**Methodology:**

1. Assume an effective date of July 1, 2019.
2. Assume the continuation of the Proposition 56 payments through FY 2021-22, on a cash basis.
3. The supplemental payments are paid in both FFS and MC for family planning office visits billed under specified procedure codes for service periods beginning July 1, 2019.
4. Expenditures are estimated to be:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$436,844</b>	<b>\$43,684</b>	<b>\$393,160</b>
<b>FY 2021-22</b>	<b>\$431,072</b>	<b>\$43,107</b>	<b>\$387,964</b>

\*Totals may differ due to rounding.

**Funding:**

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

## PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 162  
**IMPLEMENTATION DATE:** 12/2017  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 2044

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$154,170,000	\$163,957,000
<b>- STATE FUNDS</b>	\$21,476,000	\$22,595,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	97.08 %	97.24 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$4,501,800	\$4,525,200
<b>STATE FUNDS</b>	\$627,100	\$623,620
<b>FEDERAL FUNDS</b>	\$3,874,660	\$3,901,590

**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)  
 SB 856  
 AB 74 (Chapter 23, Budget Act of 2019)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**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 non-federal 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 FY 2017-18. SB 856 extends the appropriation of Proposition 56 funds for FY 2018-19. AB 74 extends the appropriation of Proposition 56 funds for FY 2019-20 through FY 2021-22.

The Centers for Medicare & Medicaid Services (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 was

July 1, 2017, with an end date of June 30, 2018. On September 5, 2018, CMS approved SPA 18-0031, which extended the supplemental reimbursements under Family PACT for the period of July 1, 2018, through June 30, 2019. On August 20, 2019, CMS approved SPA 19-0040, which extends the supplemental reimbursements under Family PACT for the period of July 1, 2019, through December 31, 2021.



## PROP 56-WOMEN'S HEALTH SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 162

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. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is decrease due to less clients utilizing these services during the coronavirus disease 2019 national public health emergency. The change from FY 2020-21 to 2021-22, in the current estimate, is an increase due to projecting more clients using these services in FY 2021-22.

#### 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)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
E&M Office Visits	\$147,438	\$14,744	\$132,694
Medical Pregnancy Termination	\$6,732	\$6,732	\$0
<b>Total</b>	<b>\$154,170</b>	<b>\$21,476</b>	<b>\$132,694</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
E&M Office Visits	\$157,069	\$15,707	\$141,362
Medical Pregnancy Termination	\$6,888	\$6,888	\$0
<b>Total</b>	<b>\$163,957</b>	<b>\$22,595</b>	<b>\$141,362</b>

\*Totals may differ due to rounding.

#### Funding:

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

## NDPH SUPPLEMENTAL PAYMENT

**REGULAR POLICY CHANGE NUMBER:** 163  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1076

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$4,256,000	\$4,201,000
<b>- STATE FUNDS</b>	\$1,664,000	\$1,900,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$4,256,000	\$4,201,000
<b>STATE FUNDS</b>	\$1,664,000	\$1,900,000
<b>FEDERAL FUNDS</b>	\$2,592,000	\$2,301,000

**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  
 SPA 18-017  
 SPA 19-0024  
 SPA 20-0013  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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

## NDPH SUPPLEMENTAL PAYMENT

### REGULAR POLICY CHANGE NUMBER: 163

FY 2016-17 and FY 2017-18. In October 2018, CMS approved SPA 18-017 to continue the NDPH Supplemental program through June 30, 2019. In June 2019, CMS approved SPA 19-0024 to continue the NDPH Supplemental Program through June 30, 2020. In June 2020, CMS approved SPA 20-0013 to continue the NDPH Supplemental Program through June 30, 2021. The Department anticipates a formula based, evergreen SPA will be submitted to CMS for approval to continue the NDPH Supplemental Program beginning FY 2021-22.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to updated ACA data, and the inclusion of the FFCRA increased FMAP.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to a gradual reduction in the ACA optional expansion FMAP and the FFCRA increased 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%, and further reduces to 90% beginning January 1, 2020. 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 2018-19 ACA adjustment will be claimed in FY 2019-20 and the FY 2019-20 ACA adjustment will be claimed in FY 2020-21. 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.
6. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

**NDPH SUPPLEMENTAL PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 163

7. The estimated NDPH Supplemental payments and ending balance for FY 2020-21 are shown below:

<b>FY 2020-21 NDPH Supplemental Fund Summary</b>	<b>SF</b>
FY 2019-20 Ending Balance	\$3,534,000
Appropriation (GF)	\$1,900,000
FY 2019-20 Interest Earned	\$79,000
FY 2019-20 ACA FFP Adjustment to SF	\$456,000
Funds Available	\$5,969,000
Less: FY 2020-21 Cash Expenditures to Hospitals	(\$1,664,000)
Est. FY 2020-21 Remaining Balance	\$4,305,000

<b>FY 2020-21</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA****</b>	<b>Return to Fund 3096*</b>
FY 2020-21 Cash Expenditures to Hospitals**	\$3,800,000	\$1,664,000	\$1,900,000	\$0	\$236,000	\$0
FY 2019-20 ACA FF Adjustment to SF***	\$456,000	\$0	(\$594,000)	\$1,087,000	(\$37,000)	\$456,000
<b>Total</b>	<b>\$4,256,000</b>	<b>\$1,664,000</b>	<b>\$1,306,000</b>	<b>\$1,087,000</b>	<b>\$199,000</b>	<b>\$456,000</b>

8. The estimated NDPH Supplemental payments and ending balance for FY 2021-22 are shown below:

<b>FY 2021-22 NDPH Supplemental Fund Summary</b>	<b>SF</b>
FY 2020-21 Ending Balance	\$4,305,000
Appropriation (GF)	\$1,900,000
Est. FY 2020-21 Interest Earned	\$79,000
FY 2020-21 ACA FFP Adjustment to SF	\$401,000
Funds Available	\$6,685,000
Less: FY 2021-22 Cash Expenditures to Hospitals	(\$1,900,000)
Est. FY 2021-22 Remaining Balance	\$4,785,000

**NDPH SUPPLEMENTAL PAYMENT**  
REGULAR POLICY CHANGE NUMBER: 163

<b>FY 2021-22</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>	<b>ACA FF</b>	<b>FFCRA****</b>	<b>Return to Fund 3096*</b>
FY 2021-22 Cash Expenditures to Hospitals**	\$3,800,000	\$1,900,000	\$1,900,000	\$0	\$0	\$0
FY 2020-21 ACA FF Adjustment to SF***	\$401,000	\$0	(\$594,000)	\$1,069,000	(\$74,000)	\$401,000
<b>Total</b>	<b>\$4,201,000</b>	<b>\$1,900,000</b>	<b>\$1,306,000</b>	<b>\$1,069,000</b>	<b>(\$74,000)</b>	<b>\$401,000</b>

\*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)\*\*\*

6.2% Title XIX FFCRA Increased FFP (4260-101-0890)\*\*\*\*

## PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS

**REGULAR POLICY CHANGE NUMBER:** 164  
**IMPLEMENTATION DATE:** 5/2021  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2147

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$4,000,000	\$0
<b>- STATE FUNDS</b>	\$1,752,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$4,000,000	\$0
<b>STATE FUNDS</b>	\$1,752,000	\$0
<b>FEDERAL FUNDS</b>	\$2,248,000	\$0

**Purpose:**

This policy change estimates the expenditures related to providing supplemental payments to hospital-based pediatric physician services.

**Authority:**

AB 74 (Chapter 23, Statutes of 2019)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 AB 74, the Department shall develop the structure and parameters for supplemental payments for hospital-based pediatric physician services.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**PROP 56 - HOSP-BASED PEDIATRIC PHYS SUPPL PYMTS**  
**REGULAR POLICY CHANGE NUMBER: 164**

**Reason for Change:**

The change for FY 2020-21, from the prior estimate, is an increase due to the inclusion of federal funding for these payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of the one-time payments in FY 2020-21.

**Methodology:**

1. AB 74 provides \$2,000,000 Proposition 56 funds for supplemental payments for hospital-based pediatric physician services.
2. The Department will submit a State Plan Amendment seeking federal funding for these supplemental payments.
3. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021.
4. Payments are expected to occur in FY 2020-21.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
<b>Supplemental Payments</b>	<b>\$4,000,000</b>	<b>\$1,752,000</b>	<b>\$2,000,000</b>	<b>\$248,000</b>

**Funding:**

50% Title XIX/ 50% GF (4260-101-0001/0890)  
 FFCRA 6.2% GF (4260-101-0001)  
 FFCRA 6.2% Increased FFP (4260-101-0890)

## PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 165  
**IMPLEMENTATION DATE:** 3/2019  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2103

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$9,155,000	\$8,943,000
<b>- STATE FUNDS</b>	\$3,831,400	\$4,084,850
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	79.06 %	80.93 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,917,100	\$1,705,400
<b>STATE FUNDS</b>	\$802,300	\$778,980
<b>FEDERAL FUNDS</b>	\$1,114,760	\$926,450

**Purpose:**

This policy change estimates the expenditures related to supplemental payments provided to Freestanding Pediatric Subacute (FS/PSA) Facilities.

**Authority:**

SB 856 (Chapter 30, Statutes of 2018)  
 SPA 18-0042  
 AB 74 (Chapter 23, Statutes of 2019)  
 SPA 19-0042  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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.

SB 856 authorized supplemental payments for FS/PSA facilities in FY 2018-19. On September 18, 2018, the Centers for Medicare and Medicaid Services approved SPA 18-0042 for the supplemental payments to FS/PSAs for the period of August 1, 2018, through July 31, 2019. Pursuant to the AB 74, CMS approved SPA 19-0042 on September 26, 2019, for the extension of the supplemental payments for the period of August 1, 2019, through December 31, 2021.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health



## PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 165

emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to January 1, 2023.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is an increase due to:

- Increased managed care payments and funding assumptions based on updated managed care enrollment projections.
- Updating FFS funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to:

- Decreased managed care payments based on lower enrollment projections in FY 2021-22.
- Less FFCRA funding estimated in FY 2021-22.

#### Methodology:

1. The RY 2018-19 supplemental payments were implemented on February 25, 2019. The EPC for the retroactive period of August 1, 2018, through February 24, 2019, was implemented on March 13, 2019. No managed care impact was assumed for the period of August 1, 2018, through July 31, 2019.
2. AB 74 extended supplemental payments to FS/PSAs through December 2021.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.
4. The following payments are estimated for FY 2020-21 and FY 2021-22:

FY 2020-21	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts (ongoing)	\$7,238,000	\$3,079,000	\$189,000	\$3,411,000	\$124,000	\$435,000
Mgd Care Pmts	\$1,917,000	\$753,000	\$347,000	\$707,000	\$0	\$110,000
<b>Total</b>	<b>\$9,155,000</b>	<b>\$3,832,000</b>	<b>\$536,000</b>	<b>\$4,118,000</b>	<b>\$124,000</b>	<b>\$545,000</b>

FY 2021-22	TF	GF	Title XXI FF	Title XIX FF	ACA FF	FFCRA
FFS Pmts (ongoing)	\$7,238,000	\$3,356,000	\$181,000	\$3,411,000	\$124,000	\$166,000
Mgd Care Pmts	\$1,705,000	\$729,000	\$289,000	\$630,000	\$0	\$57,000
<b>Total</b>	<b>\$8,943,000</b>	<b>\$4,085,000</b>	<b>\$470,000</b>	<b>\$4,041,000</b>	<b>\$124,000</b>	<b>\$223,000</b>

**PROP 56 - FS-PSA SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 165

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$8,236,000	\$4,118,000	\$4,118,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$138,000	\$14,000	\$124,000	\$0
76.5% Title XXI FF / 23.5% GF (4260-113-0001/0890)	\$250,000	\$59,000	\$191,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$531,000	\$186,000	\$345,000	\$0
100% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$34,000)	(\$34,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$34,000	\$0	\$0	\$34,000
FFCRA 6.2% GF (4260-101-0001)	(\$511,000)	(\$511,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$511,000	\$0	\$0	\$511,000
<b>Total</b>	<b>\$9,155,000</b>	<b>\$3,832,000</b>	<b>\$4,778,000</b>	<b>\$545,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	\$8,082,000	\$4,041,000	\$4,041,000	\$0
90% Title XIX FF / 10% GF (4260-101-0001 / 0890)	\$138,000	\$14,000	\$124,000	\$0
65% Title XXI FF / 35% GF (4260-113-0001/0890)	\$723,000	\$253,000	\$470,000	\$0
100% GF (4260-101-0001)	\$0	\$0	\$0	\$0
FFCRA 4.34% GF (4260-113-0001)	(\$168,000)	(\$168,000)	\$0	\$0
FFCRA 4.34% FF (4260-113-0890)	\$168,000	\$0	\$0	\$168,000
FFCRA 6.2% GF (4260-101-0001)	(\$55,000)	(\$55,000)	\$0	\$0
FFCRA 6.2% FF (4260-101-0890)	\$55,000	\$0	\$0	\$55,000
<b>Total</b>	<b>\$8,943,000</b>	<b>\$4,085,000</b>	<b>\$4,635,000</b>	<b>\$223,000</b>

## PROPOSITION 56 FUNDS TRANSFER

**REGULAR POLICY CHANGE NUMBER:** 166  
**IMPLEMENTATION DATE:** 7/2018  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2102

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change budgets the transfer from the Proposition 56 fund to the appropriate General Fund.

**Authority:**

California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)

**Interdependent Policy Changes:**

See Funding Chart Below

**Background:**

Effective April 2017, Proposition 56 (Prop 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.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is based on updated expenditure data for various policy changes. The change from FY 2020-21 to FY 2021-22, in the current estimate, is based on updated expenditure data for various policy changes.

**Methodology:**

1. To allow for proper cash flow timing, Prop 56 items are initially treated as General Fund costs. Subsequently, this policy change transfers the dollars from the Prop 56 fund to the General Fund.
2. Assume \$717,883,000 of Prop 56 funds are available for transfer in FY 2021-22. Any remaining expenditures are assumed to be General Fund.

**PROPOSITION 56 FUNDS TRANSFER**  
REGULAR POLICY CHANGE NUMBER: 166

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Total GF to Prop 56</b>
Prop 56 - Home Health Rate Increase	(\$77,151)
Prop 56 - Pediatric Day Health Care Rate Increase	(\$7,741)
Prop 56 - Physician Services Supplemental Payments	(\$400,454)
Prop 56 - Supplemental Payments for Dental Services	(\$180,707)
Prop 56 - Medi-Cal Family Planning	(\$43,684)
Prop 56 - Value-Based Payment Program	(\$112,547)
Prop 56 - Behavioral Healthcare Incentive Program	(\$24,966)
Prop 56 - Developmental Screenings	(\$20,922)
Prop 56 - CBAS Supplemental Payments	(\$16,928)
Prop 56 - Adverse Childhood Experiences Screenings	(\$14,868)
Prop 56 - NEMT Supplemental Payments	(\$3,665)
Prop 56 - ICF/DD Supplemental Payments	(\$11,077)
Prop 56 - Hosp-Based Ped. Supplemental Payments	(\$1,752)
Prop 56 - FS-PSA Supplemental Payments	(\$3,832)
Prop 56 - Women's Health Supplemental Payments	(\$21,476)
Prop 56 - AIDS Waiver Supplement Payments	(\$2,978)
Prop 56 - Provider ACEs Trainings	(\$30,962)
Total of GF dollars in Prop 56 PCs	(\$975,710)
Prop 56 Fund Transfer	\$975,710
<b>Grand Total</b>	<b>\$0</b>

\*Totals may differ due to rounding

**PROPOSITION 56 FUNDS TRANSFER**  
REGULAR POLICY CHANGE NUMBER: 166

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Total GF to Prop 56</b>
Prop 56 - Home Health Rate Increase	(\$43,338)
Prop 56 - Pediatric Day Health Care Rate Increase	(\$6,655)
Prop 56 - Physician Services Supplemental Payments	(\$426,761)
Prop 56 - Supplemental Payments for Dental Services	(\$193,052)
Prop 56 - Medi-Cal Family Planning	(\$43,107)
Prop 56 - Value-Based Payment Program	(\$119,866)
Prop 56 - Behavioral Healthcare Incentive Program	(\$35,644)
Prop 56 - Developmental Screenings	(\$25,877)
Prop 56 - CBAS Supplemental Payments	(\$14,285)
Prop 56 - Adverse Childhood Experiences Screenings	(\$18,217)
Prop 56 - NEMT Supplemental Payments	(\$3,893)
Prop 56 - ICF/DD Supplemental Payments	(\$11,782)
Prop 56 - Hosp-Based Ped. Supplemental Payments	\$0
Prop 56 - FS-PSA Supplemental Payments	(\$4,085)
Prop 56 - Women's Health Supplemental Payments	(\$22,595)
Prop 56 - AIDS Waiver Supplement Payments	(\$3,189)
Prop 56 - Provider ACEs Trainings	(\$20,856)
Total of GF dollars in Prop 56 PCs	(\$993,202)
Prop 56 Fund Transfer	\$717,883
Cost to General Fund	\$275,319
<b>Grand Total</b>	<b>\$0</b>

\*Totals may differ due to rounding

**Funding:**

Healthcare Treatment Fund (4260-101-3305)

100% Title XIX GF &amp; 100% Title XXI GF (4260-101-0001/ 4260-113-0001)

## PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 167  
**IMPLEMENTATION DATE:** 3/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2139

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$7,925,000	\$7,925,000
<b>- STATE FUNDS</b>	\$3,664,100	\$3,892,450
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	100.00 %	100.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the expenditures related to providing supplemental payments for non-emergency medical transportation (NEMT) services.

**Authority:**

AB 74 (Chapter 23, Statutes of 2019)  
 SPA 19-0044  
 SPA 20-0007  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 AB 74, the Department shall develop the structure and parameters for supplemental payments for NEMT providers in FY 2019-20. On November 19, 2019, the Department received federal approval for SPA 19-0044 to establish a time-limited supplemental payment program for NEMT services, effective July 1, 2019, through December 31, 2021. On April 30, 2020, the Department received approval for SPA 20-0007 to clarify the services eligible for the NEMT supplemental payment.

The supplemental payment amounts are fixed amounts and paid in addition to the base rates for each eligible NEMT service. The supplemental payment amounts will be equivalent to a 10% increase of the current rates for Medi-Cal Fee-for-Service (FFS) NEMT services, except for codes A0130 and A0380, which will receive the equivalent of a 25% increase. Ground Medical

## PROP 56 - NEMT SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 167

Transportation and Air Medical Transportation providers will be eligible for the supplemental payments.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1, 2022.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a net decrease in total funds but an increase in the state share due to:

- Removing costs for additional codes that were to have been effective January 2020. These codes were later determined to not be eligible for these supplemental payments.
- Updating funding assumptions based on actual payment data.
- Including the FFCRA Increased FMAP for payments in FY 2020-21.

There is no change in the total funds from FY 2020-21 to FY 2021-22, in the current estimate. The change in the state share is due less FFCRA funding estimated in FY 2021-22.

#### Methodology:

1. The FFS supplemental payments will be provided for services beginning July 1, 2019. No managed care impact is assumed.
2. The FFS supplemental payments for 17 codes were implemented in March 2020. The retroactive payment, for the July 2019 through February 2020 period, occurred on April 2, 2020.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.
4. Funds allocated for the supplemental payments are as follows:

Fiscal Year	TF	GF	FFP	FFCRA
FY 2020-21	\$7,925,000	\$3,664,000	\$3,806,000	\$455,000
FY 2021-22	\$7,925,000	\$3,892,000	\$3,806,000	\$227,000

**PROP 56 - NEMT SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 167

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>FFCRA</b>
50% Title XIX/ 50% GF	\$7,325,000	\$3,662,000	\$3,663,000	\$0
90% Title XIX / 10% GF	\$151,000	\$15,000	\$136,000	\$0
76.5 Title XXI / 23.5% GF	\$3,000	\$1,000	\$2,000	\$0
65% Title XXI / 35% GF	\$8,000	\$3,000	\$5,000	\$0
FFCRA 4.34% GF	(\$1,000)	(\$1,000)	\$0	\$0
FFCRA 4.34% FF	\$1,000	\$0	\$0	\$1,000
FFCRA 6.2% GF	(\$454,000)	(\$454,000)	\$0	\$0
FFCRA 6.2% FF	\$454,000	\$0	\$0	\$454,000
100% GF	\$438,000	\$438,000	\$0	\$0
<b>Total</b>	<b>\$7,925,000</b>	<b>\$3,664,000</b>	<b>\$3,806,000</b>	<b>\$455,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>FFCRA</b>
50% Title XIX/ 50% GF	\$7,325,000	\$3,662,000	\$3,663,000	\$0
90% Title XIX / 10% GF	\$151,000	\$15,000	\$136,000	\$0
65% Title XXI / 35% GF	\$11,000	\$4,000	\$7,000	\$0
FFCRA 6.2% GF	(\$227,000)	(\$227,000)	\$0	\$0
FFCRA 6.2% FFP	\$227,000	\$0	\$0	\$227,000
100% GF	\$438,000	\$438,000	\$0	\$0
<b>Total</b>	<b>\$7,925,000</b>	<b>\$3,892,000</b>	<b>\$3,806,000</b>	<b>\$227,000</b>



## IGT PAYMENTS FOR HOSPITAL SERVICES

**REGULAR POLICY CHANGE NUMBER:** 168  
**IMPLEMENTATION DATE:** 8/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1158

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$1,510,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$1,510,000	\$0
<b>FEDERAL FUNDS</b>	-\$1,510,000	\$0

**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: 168

This program 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 was not made until FY 2018-19.

#### Reason for Change:

There is no change from the prior estimate for FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of the federal funds and a special fund repayments in FY 2020-21, with no further repayments necessary in FY 2021-22.

#### 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 beyond FY 2017-18.
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.
4. ACA payments were 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. The County was reimbursed for the IGT (nonfederal share), and an adjustment was made for the federal share processed at the regular 50% FMAP.
5. The Department overclaimed FY 2013-14 through FY 2015-16 ACA FFP and repaid the federal funds in FY 2020-21.
6. It was determined that \$8.5 million was erroneously moved from Special Fund 3097 to the General Fund as a result of the ACA adjustments for FY 2013-14 through FY 2015-16 dates of service. The funds were returned to the Special Fund in FY 2020-21.

FY 2020-21	TF	GF	SF	ACA FF
<b>Federal Funds Repayment</b>	<b>\$0</b>	<b>\$10,077,000</b>	<b>(\$8,567,000)</b>	<b>(\$1,510,000)</b>

#### Funding:

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

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

100% Private Hospital Supplemental Fund (4260-601-3097)

**IGT ADMIN. & PROCESSING FEE**

**REGULAR POLICY CHANGE NUMBER:** 169  
**IMPLEMENTATION DATE:** 6/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1601

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the savings to the General Fund due to the intergovernmental transfer (IGT) administrative and processing fees assessed to the counties or other approved public entities for the Graduate Medical Education Payments (GME) to DPHs.

**Authority:**

SB 97 (Chapter 52, Statutes of 2017)  
 SPA 17-0009

**Interdependent Policy Changes:**

Not Applicable

**Background:**

In March 2020, the Centers for Medicare and Medicaid Services (CMS) approved SPA 17-0009, with an effective date of January 1, 2017, for the Department to make new Medi-Cal GME supplemental payments to Designated Public Hospitals (DPHs) participating in the Medi-Cal managed care program. The Department will budget the GME payments to the DPHs and their affiliated governmental entities; IGTs will fund the nonfederal share of the cost. A 5% administrative fee will be assessed on 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 FY 2020-21, from the prior estimate, is due to updated data for FY 2018-19, FY 2019-20, and FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the final settlement for FY 2018-19 included the retroactive FY 2018-19 fee assessments in FY 2020-21.

**IGT ADMIN. & PROCESSING FEE**  
REGULAR POLICY CHANGE NUMBER: 169

**Methodology:**

1. Assume 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 Education Payments to DPHs policy change.

<b>FY 2020-21</b>	<b>IGT Subject to the Fee</b>	<b>Reimbursement to GF</b>
FY 2018-19 Final Settlement	\$185,459,000	\$9,273,000
FY 2019-20	\$186,589,000	\$9,329,000
FY 2020-21	\$187,741,000	\$9,387,000
<b>Total</b>	<b>\$559,789,000</b>	<b>\$27,989,000</b>

<b>FY 2021-22</b>	<b>IGT Subject to the Fee</b>	<b>Reimbursement to GF</b>
FY 2019-20 Final Settlement	\$5,038,000	\$252,000
FY 2020-21	\$192,828,000	\$9,641,000
<b>Total</b>	<b>\$197,866,000</b>	<b>\$9,893,000</b>

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>GME Special Fund</b>
<b>FY 2020-21</b>	<b>\$0</b>	<b>(\$27,989,000)</b>	<b>\$27,989,000</b>
<b>FY 2021-22</b>	<b>\$0</b>	<b>(\$9,893,000)</b>	<b>\$9,893,000</b>

**Funding:**

100% State GF (4260-101-0001)

DPH Graduate Medical Education Special Fund (4260-601-8113)

## PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 170  
**IMPLEMENTATION DATE:** 11/2017  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2050

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$6,800,000	\$6,800,000
<b>- STATE FUNDS</b>	\$2,978,000	\$3,189,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	100.00 %	100.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the expenditures related to providing supplemental payments for specific Acquired Immune Deficiency Syndrome (AIDS) Waiver services.

**Authority:**

AB 120 (Chapter 22, Statutes of 2017)  
 Proposition 56 (2016)  
 AB 74 (Chapter 23, Statutes of 2019)  
 Families First Coronavirus Response Act (FFCRA)  
 AB 80 (Chapter 12, Statutes of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**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 AIDS Waiver Supplemental Payment Program. AB 120 appropriates up to \$4 million from Proposition 56 revenues to provide supplemental payments for specific AIDS Waiver services.

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

In accordance with Chapter 22, Statutes of 2017 (AB 120), the Department of Health Care Services 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 payment program is available only to the extent

## PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 170

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. These payments were effective beginning July 1, 2017, as identified in the approved waiver amendment and will continue through the course of the waiver term unless a separate amendment is submitted to reverse. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the Coronavirus disease 2019 national public health emergency on October 23, 2020.

While AB 80 suspends these Proposition 56 payments, effective July 1, 2021, the Department assumes the continuation of the Proposition 56 AIDS Waiver payments.

#### **Reason for Change:**

There is a state fund decrease for FY 2020-21, from the prior estimate, due to the FFCRA increased FMAP in FY 2020-21. There is a state fund increase from FY 2020-21 to FY 2021-22, in the current estimate, due to FFCRA increase ending in FY 2020-21. There is no change in total funds for FY 2020-21 from the prior estimate or from FY 2020-21 to FY 2021-22 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. Assume the 6.2% Title XIX FFCRA increased FMAP is for expenditures through December 31, 2021.
7. Funds allocated for the supplemental payments are as follows:

**PROP 56-AIDS WAIVER SUPPLEMENTAL PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 170

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Healthcare Treatment Fund Prop. 56	\$3,400,000	\$3,400,000	\$0
100% Title XIX	\$3,400,000	\$0	\$3,400,000
6.2% Increased FMAP	\$0	(\$422,000)	\$422,000
<b>Total</b>	<b>\$6,800,000</b>	<b>\$2,978,000</b>	<b>\$3,822,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Healthcare Treatment Fund Prop. 56	\$3,400,000	\$3,400,000	\$0
100% Title XIX	\$3,400,000	\$0	\$3,400,000
6.2% Increased FMAP	\$0	(\$211,000)	\$211,000
<b>Total</b>	<b>\$6,800,000</b>	<b>\$3,189,000</b>	<b>\$3,611,000</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0890/0001)  
 FFCRA 6.2% Increased FMAP (4260-101-0890)  
 FFCRA 6.2% GF (4260-101-0001)

## COVID-19 CASELOAD IMPACT

**REGULAR POLICY CHANGE NUMBER:** 172  
**IMPLEMENTATION DATE:** 4/2020  
**ANALYST:** Ryan Woolsey  
**FISCAL REFERENCE NUMBER:** 2218

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$5,428,893,000	\$13,531,559,000
<b>- STATE FUNDS</b>	\$1,742,310,580	\$4,336,085,610
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	2.76 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$5,279,055,600	\$13,531,559,000
<b>STATE FUNDS</b>	\$1,694,222,810	\$4,336,085,610
<b>FEDERAL FUNDS</b>	\$3,584,832,740	\$9,195,473,390

**Purpose:**

This policy change estimates the expenditure increase due to an increase in caseload related to the COVID-19 pandemic.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was most recently extended on October 23, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.



## COVID-19 CASELOAD IMPACT

### REGULAR POLICY CHANGE NUMBER: 172

The FFCRA includes a “continuous coverage requirement.” Under the continuous coverage requirement, states must halt most disenrollment of Medicaid eligibles enrolled at the beginning of the enrollment period or who would have enrolled during the emergency period until the end of the month the public health emergency ends in order to receive a temporary increase in the federal medical assistance percentage (FMAP). The Medi-Cal caseload has increased due to reduced disenrollment under the continuous coverage requirement.

Additionally, the COVID-19 pandemic has resulted in increased levels of unemployment in California. A portion of the unemployed are expected to qualify for and enroll in Medi-Cal. As a result of this labor market impact, Medi-Cal enrollment is expected to increase.

There is considerable uncertainty surrounding the magnitude and duration of COVID-19 caseload impacts.

#### **Reason for Change:**

The change for 2020-21 and 2021-22, from the prior estimate, reflects actual data indicating a larger monthly number of additional cases remaining enrolled under the continuous coverage requirement and a more limited labor market impact assumed to begin around January 2021.

#### **Methodology:**

##### 1. Continuous Coverage Requirement

- a. Based on administrative data on the average number of monthly Medi-Cal terminations, assume roughly 155,000 Medi-Cal eligibles lost eligibility each month prior to the FFCRA that will now continue due to the continuous coverage requirement.
- b. Based on administrative data on Medi-Cal terminations, assume that, among eligibles no longer discontinued due to the continuous coverage requirement, 39 percent belong to the newly eligible aid category and 51 percent belong to families and children categories of aid.
- c. Assume that the average monthly cost of each eligible that remains in the program due to the continuous coverage requirement is \$382.
- d. Assume the continuous coverage requirement begins in March 2020 and continues through December 2021.
- e. Assume that, following the end of the continuous coverage requirement, counties gradually redetermine eligibility over a period of 12 months, through December 2022, for individuals not discontinued under the continuous coverage requirement.
- d. Average additional monthly eligibles due to the continuous coverage requirement are:

Time Period	Average Monthly Eligibles
July 2020 – June 2021	1,342,200
July 2021 – June 2022	2,605,500

## COVID-19 CASELOAD IMPACT

### REGULAR POLICY CHANGE NUMBER: 172

#### 2. Labor Market Impact:

- a. Assumes that an average of about 43,500 individuals will be added to Medi-Cal caseload each month beginning in January 2021 through December 2021 due to labor market conditions. This estimate is derived from the number of individuals who lost employment following the start of the pandemic in early 2020 and are assumed to likely have lost employer-sponsored coverage, be at an income level that qualifies for Medi-Cal, and subsequently enroll in Medi-Cal.
- b. Beginning January 2022, assumes the labor market impact population will gradually decrease.
- c. Assumes that, among individuals added to Medi-Cal due to the labor market impact, 36 percent belong to the newly eligible aid category and 62 percent belong to families and children aid categories.
- d. Assumes that the average monthly cost for each eligible individual enrolled in Medi-Cal due to the labor market impact is \$312.
- e. Average monthly eligibles due to the labor market impact are:

Time Period	Average Monthly Eligibles
January 2021 - June 2021	152,400
July 2021 - June 2022	442,600

Total estimated costs related to the impact of COVID-19 on the Medi-Cal caseload are:

#### Continuous Coverage Requirement

(Dollars in Thousands)	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2020-21	\$5,236,172	\$1,685,015	\$1,426,941	\$57,454	\$2,066,762
FY 2021-22	\$11,960,963	\$3,866,741	\$3,276,848	\$127,856	\$4,689,519

#### Labor Market Impact

(Dollars in Thousands)	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2020-21	\$192,721	\$57,296	\$44,929	\$5,408	\$85,088
FY 2021-22	\$1,570,596	\$469,345	\$369,073	\$44,270	\$687,908

#### Total Impact

(Dollars in Thousands)	TF	GF	Title XIX FF	Title XXI FF	ACA FF
FY 2020-21	\$5,428,893	\$1,742,310	\$1,471,870	\$62,861	\$2,151,851
FY 2021-22	\$13,531,559	\$4,336,085	\$3,645,920	\$172,126	\$5,377,427

**COVID-19 CASELOAD IMPACT**  
REGULAR POLICY CHANGE NUMBER: 172

**Funding:**

(Dollars in Thousands)

<b>2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$2,943,741	\$1,471,870	\$1,471,870
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$2,390,945	\$239,095	\$2,151,851
76.5% Title XXI / 23.5% GF (4260-113-0001 / 0890)	\$14,148	\$3,325	\$10,823
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$80,058	\$28,020	\$52,038
<b>Total</b>	<b>\$5,428,893</b>	<b>\$1,742,310</b>	<b>\$3,686,583</b>

<b>2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001 / 0890)	\$7,291,841	\$3,645,920	\$3,645,920
90% Title XIX / 10% GF (4260-101-0001 / 0890)	\$5,974,919	\$597,492	\$5,377,427
76.5% Title XXI / 23.5% GF (4260-113-0001 / 0890)	\$56	\$13	\$43
65% Title XXI / 35% GF (4260-113-0001 / 0890)	\$264,743	\$92,660	\$172,083
<b>Total</b>	<b>\$13,531,559</b>	<b>\$4,336,085</b>	<b>\$9,195,473</b>

COVID-19 funding through June 30, 2021 identified in the COVID-19 Increased FMAP – DHCS policy change.

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change.

## COVID-19 BEHAVIORAL HEALTH

**REGULAR POLICY CHANGE NUMBER:** 173  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2215

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$287,307,000	\$497,815,000
<b>- STATE FUNDS</b>	\$16,677,240	\$28,137,600
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$287,307,000	\$497,815,000
<b>STATE FUNDS</b>	\$16,677,240	\$28,137,600
<b>FEDERAL FUNDS</b>	\$270,629,760	\$469,677,400

**Purpose:**

This policy change estimates the cost of establishing interim rates for certain Behavioral Health Medi-Cal programs due to impacts resulting from the coronavirus disease 2019 (COVID-19) pandemic.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was last extended on October 23, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

Due to COVID-19, there has been a significant decrease in utilization with certain Specialty Mental Health (SMHS) and DMC (non-NTP) outpatient services, while costs per unit of service has increased. In order to account for the higher cost per unit of service and help counties to continue to provide necessary behavioral health services during the pandemic and to maintain their existing provider networks so that they are prepared to provide behavioral health treatment to all Medi-Cal beneficiaries who need services when the public health emergency ends, the Department implemented the following changes to the reimbursement rates:

## COVID-19 BEHAVIORAL HEALTH

### REGULAR POLICY CHANGE NUMBER: 173

#### Specialty Mental Health Services:

For specialty mental health outpatient services delivered by county-owned providers, the current interim reimbursement methodology is the lower of the county's Certified Public Expenditure (CPE) or the county interim rate developed using the most recently filed cost report and an appropriate cost of living adjustment. Effective for March 1 dates of service until the end of the COVID-19 public health emergency, the Department would provide interim reimbursement equal to the lower of the county's CPE or the county interim rate increased by 100%.

#### Drug Medi-Cal:

For non-Narcotic Treatment Program (non-NTP) outpatient services in Drug Medi-Cal (DMC) State Plan counties, the current interim reimbursement methodology is the lower of the county's CPE or the Statewide Maximum Allowance (SMA) rate for the service rendered. Effective March 1, 2020, the Department would provide interim reimbursement equal to the lower of the county's CPE or the SMA rate increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitations of usual and customary charges and the SMA rate.

For non-NTP outpatient services in DMC Organized Delivery System (ODS) counties, counties are required to develop, and the Department reviews and approves, county interim rates on an annual basis. Counties are required to reimburse contract providers at these county interim rates and the Department reimburses counties the non-county share of these county interim rates. Effective March 1, 2020, the Department would provide interim reimbursement equal to the lower of the county's CPE or the county interim rates increased by 100%. In the interim and final reconciliations, these costs would be settled to allowable cost, suspending the limitation of usual and customary charges.

Additionally, Executive Order N-55-20, raises the cap on administrative costs for the program from 15% to 30%. This action is assumed to be budget neutral. While the raising of this cap would allow counties to receive more reimbursement (on a percentage basis) during the emergency period, both county and private providers are reporting lower levels of behavioral health service utilization than before COVID-19 due to various factors such as patients not engaging in services, struggling to adapt to telehealth modalities, etc. The raising of the administrative cap reflects this increase due to the counties' administrative costs remaining the same during the crisis while at the same time that lower utilization may lead to lower reimbursement for direct client services.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is due to the projected extension of the public health emergency through December 31, 2021.

## COVID-19 BEHAVIORAL HEALTH

### REGULAR POLICY CHANGE NUMBER: 173

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to FY 2021-22 including prior year cost due to the payment lag, and six additional months of projected public health emergency extension.

#### Methodology:

1. Interim rate increase for SMHS and DMC State Plan were implemented in July 2020.
2. Interim rate increase for DMC-ODS Waiver counties were implemented in August 2020.
3. The 6.2% Title XIX and 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through December 31, 2021.
4. For SMHS, assume 38% of claims will be paid in the first year, and 68% in the second year. For DMC-ODS Waiver and DMC State plan, assume 75% of claim will be paid in the first year, and 25% in the second year.
5. Total cost for both SMHS and DMC are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>CF</b>
SMHS Interim Rate – Adult	\$162,492,000	\$5,982,000	\$105,175,000	\$6,365,000	\$44,970,000
SMHS Interim Rate - Children	\$158,668,000	\$3,697,000	\$85,214,000	\$8,909,000	\$60,848,000
Non-NTP DMC State Plan Interim Rate	\$6,881,000	\$430,000	\$4,646,000	\$240,000	\$1,565,000
Non-NTP DMC-ODS Interim Rate	\$83,972,000	\$6,568,000	\$57,235,000	\$2,846,000	\$17,323,000
<b>Total</b>	<b>\$412,013,000</b>	<b>\$16,677,000</b>	<b>\$252,270,000</b>	<b>\$18,360,000</b>	<b>\$124,706,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>	<b>CF</b>
SMHS Interim Rate – Adult	\$342,088,000	\$13,001,000	\$223,049,000	\$6,574,000	\$99,464,000
SMHS Interim Rate - Children	\$334,038,000	\$8,833,000	\$175,260,000	\$9,297,000	\$140,648,000
Non-NTP DMC State Plan Interim Rate	\$5,735,000	\$366,000	\$3,872,000	\$100,000	\$1,397,000
Non-NTP DMC-ODS Interim Rate	\$73,793,000	\$5,938,000	\$50,274,000	\$1,251,000	\$16,330,000
<b>Total</b>	<b>\$755,654,000</b>	<b>\$28,138,000</b>	<b>\$452,455,000</b>	<b>\$17,222,000</b>	<b>\$257,839,000</b>

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

**COVID-19 BEHAVIORAL HEALTH**  
**REGULAR POLICY CHANGE NUMBER: 173**

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

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

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

FFCRA 6.2% Increased FFP (4260-101-0890)

FFCRA 6.2% GF (4260-101-0001)

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)

## COVID-19 FFS REIMBURSEMENT RATES

**REGULAR POLICY CHANGE NUMBER:** 174  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Sharisse DeLeon  
**FISCAL REFERENCE NUMBER:** 2246

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$334,768,000	\$251,076,000
<b>- STATE FUNDS</b>	\$167,384,000	\$125,538,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$334,768,000	\$251,076,000
<b>STATE FUNDS</b>	\$167,384,000	\$125,538,000
<b>FEDERAL FUNDS</b>	\$167,384,000	\$125,538,000

**Purpose:**

This policy change estimates the cost of fee-for-service (FFS) reimbursement rate increases resulting from the coronavirus disease 2019 (COVID-19) pandemic.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Funding Adjust.—ACA Opt. Expansion  
 Funding Adjust.—OTLICP  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was last extended on October 23, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency (PHE) and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program. The Department has received federal approvals for the following programs through the State Plan Amendment (SPA) 20-0024.



## COVID-19 FFS REIMBURSEMENT RATES

### REGULAR POLICY CHANGE NUMBER: 174

- **Clinical Lab COVID-19 Reimbursement Rates:** To pay all COVID-19 related laboratory testing and collection procedure codes at 100% of Medicare and exempt those codes from the 10% payment reduction effective for March 1, 2020, dates of service, or the date a procedure code and payment rate is established by CMS for Medicare, and through the duration of the state of emergency.
- **Long Term Care (LTC) COVID-19 Reimbursement Rate:** To provide a 10% per diem rate increase to fully loaded per-diem rates including add-ons and any Proposition 56 supplemental payments effective for March 1, 2020, dates of service and through the duration of the state of emergency, for the following facility types: LTC facilities, Freestanding Nursing Facilities Level-B; Nursing Facilities Level-A; Distinct Part Nursing Facilities Level-B; Freestanding Adult Subacute Facilities; Distinct Part Adult Subacute Facilities; Distinct Part Pediatric Subacute facilities; Freestanding Pediatric Subacute facilities and ICF/DD, including ICF/DDs, ICF/DD-Habilitative, and ICF/DD-Nursing, and excluding state-owned SNFs or ICFs, including Developmental Centers and Veterans Homes and any other supplemental payments or ancillary charges.

The fiscal impact FFS reimbursement rate increases resulting from the public health emergency were previously budgeted as part of a consolidated COVID-19 Additional Impacts policy change. In this estimate, the impacts are budgeted in separate policy changes by programmatic area.

#### Reason for Change:

The change, from the prior estimate, for FY 2020-21 is an increase due to including 12 months of estimated costs, instead of the partial impact from remaining costs estimated for the March 2020 to June 2020 dates of service period. In addition, the LTC rate impact now only include the estimated FFS impact as the managed care impact is already included in the managed care rates.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to including less months of estimated costs based on the assumed end of the PHE period.

#### Methodology:

1. Assume the PHE period ends December 31, 2021.
2. The estimated FY 2020-21 and FY 2021-22 costs for the clinical lab and LTC reimbursement rate increases are estimated at:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>LTC COVID Reimbursement</b>	\$286,804,000	\$143,402,000	\$143,402,000
<b>Clinical Lab COVID Reimbursement</b>			
Diagnostic Testing Cost	\$28,464,000	\$14,232,000	\$14,232,000
Antibody Testing Cost	\$12,204,000	\$6,102,000	\$6,102,000
Specimen Collection Cost	\$7,296,000	\$3,648,000	\$3,648,000
<b>TOTAL</b>	<b>\$334,768,000</b>	<b>\$167,384,000</b>	<b>\$167,384,000</b>

**COVID-19 FFS REIMBURSEMENT RATES**  
REGULAR POLICY CHANGE NUMBER: 174

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>LTC COVID Reimbursement</b>	\$215,103,000	\$107,551,000	\$107,552,000
<b>Clinical Lab COVID Reimbursement</b>			
Diagnostic Testing Cost	\$21,348,000	\$10,674,000	\$10,674,000
Antibody Testing Cost	\$9,153,000	\$4,577,000	\$4,576,000
Specimen Collection Cost	\$5,472,000	\$2,736,000	\$2,736,000
<b>TOTAL</b>	<b>\$251,076,000</b>	<b>\$125,538,000</b>	<b>\$125,538,000</b>

**Funding:**

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

OTLICP funding identified in the Funding Adjust.—OTLICP policy change

ACA Optional Expansion funding identified in the Funding Adjust.—ACA Opt. Expansion policy change

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## COVID-19 BASE RECOVERIES

**REGULAR POLICY CHANGE NUMBER:** 175  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Celine Donaldson  
**FISCAL REFERENCE NUMBER:** 2243

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$216,304,000	-\$34,000,000
<b>- STATE FUNDS</b>	\$91,073,700	-\$14,315,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	6.17 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$202,958,000	-\$34,000,000
<b>STATE FUNDS</b>	\$85,454,450	-\$14,315,300
<b>FEDERAL FUNDS</b>	\$117,503,590	-\$19,684,700

**Purpose:**

This policy change estimates the impacts on the Medi-Cal Recoveries program resulting from the coronavirus disease 2019 (COVID-19) pandemic.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES)

**Interdependent Policy Changes:**

Base Recoveries  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay-at-home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020 and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

There has been a decline in Estate and Medi-Cal Provider recoveries resulting from the economic impact of the public health emergency. The Department has experienced delayed repayments for Estate recoveries due to court closures and deferred repayments due to hardship requests expected from provider audits. The uncertainty related to the public health emergency makes it difficult for the Department to project when these recoveries will return to normal levels.

## COVID-19 BASE RECOVERIES

### REGULAR POLICY CHANGE NUMBER: 175

The Base Recoveries policy change reflects increased savings in FY 2020-21 for planned additional other health insurance recovery efforts related to Mental Health/Substance Use Disorder, Dental, and Managed Care plans that are anticipated to increase recovery amounts and that were planned to be implemented prior to the COVID-19 pandemic. This policy change backs out the increase in recoveries due to expected operational delays in implementation resulting from the stay-at-home order and the public health emergency.

The impact of COVID-19 on recoveries will diminish in FY 2021-22. As a result, the costs budgeted in this policy change will be reduced in FY 2021-22 reflecting an assumption of greater recoveries as the previously planned additional recovery efforts are able to be implemented.

The fiscal impact on recoveries resulting from the public health emergency were previously budgeted as part of a consolidated COVID-19 Additional Impacts policy change. In this estimate, the impacts are budgeted in separate policy changes by programmatic area.

#### Reason for Change:

This is a new policy change. Compared with the former COVID-19 Additional Impacts policy change, the change for 2020-21 is because an estimate of the impact of COVID-19 on general estate and other Medi-Cal provider collections was added.

FY 2021-22 reflects the resumption of the additional other health insurance recovery efforts related to Mental Health/Substance Use Disorder, Dental, and Managed Care plans, although these recoveries are now anticipated to occur at a slower rate.

#### Methodology:

1. The Department estimates the impacts on the following recovery efforts as a result of the COVID-19:

(Dollars in Thousands)

Recovery Type	FY 2020-21	FY 2121-22
General Estate and Medi-Cal Provider Collections	\$126,304	\$0
Health Insurance Recoveries	\$90,000	(\$34,000)
<b>TOTAL</b>	<b>\$216,304</b>	<b>(\$34,000)</b>

**COVID-19 BASE RECOVERIES**  
REGULAR POLICY CHANGE NUMBER: 175

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$173,601	\$86,801	\$86,801
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	\$2,390	\$837	\$1,554
Title XIX FFP (4260-101-0890)	\$5,946	\$0	\$5,946
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	\$34,367	\$3,437	\$30,930
<b>TOTAL</b>	<b>\$216,304</b>	<b>\$91,074</b>	<b>\$125,230</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$27,287)	(\$13,644)	(\$13,644)
Title XIX 65 FF / 35 GF (4260-101-0890/0001)	(\$376)	(\$132)	(\$244)
Title XIX FFP (4260-101-0890)	(\$935)	\$0	(\$935)
90% Title XIX ACA FF / 6% GF (4260-101-0890/0001)	(\$5,402)	(\$540)	(\$4,862)
<b>TOTAL</b>	<b>(\$34,000)</b>	<b>(\$14,315)</b>	<b>(\$19,685)</b>

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## COVID-19 ELIGIBILITY

**REGULAR POLICY CHANGE NUMBER:** 176  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 2211

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$37,637,000	\$17,277,000
<b>- STATE FUNDS</b>	\$25,610,000	\$12,251,000
<b>PAYMENT LAG</b>	0.9650	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$36,319,700	\$17,277,000
<b>STATE FUNDS</b>	\$24,713,650	\$12,251,000
<b>FEDERAL FUNDS</b>	\$11,606,060	\$5,026,000

**Purpose:**

This policy change estimates the cost of certain changes in program eligibility related to the coronavirus disease 2019 (COVID-19), including testing and treatment services to various populations and changes in hospital presumptive eligibility.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was last extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

The Department has requested federal approvals for the various program modifications through the House Resolution (H.R.) 6201 FFCRA, Section 6004, State Plan Amendment (SPA) 20-0024, and waivers. The following program updates will allow individuals to access necessary COVID-19 diagnostic testing, testing related services, and treatment services, including all medically necessary care such as the associated office, clinic, or emergency room visits related to COVID-19 at no cost to the individuals:

## **COVID-19 ELIGIBILITY**

### **REGULAR POLICY CHANGE NUMBER: 176**

- H.R. 6201(FFCRA) – COVID-19 Uninsured Eligibility Group: Provides COVID-19 diagnostic testing, testing related services, and treatment services to individuals who have no insurance or currently have private insurance that does not cover diagnostic testing, testing related services, and treatment service, including all medically necessary care as a result of COVID-19 and are a California resident. Testing and testing-related services are funded at 100% federal funds (FF), and all other services are funded with general funds. However, California has requested federal approval through the 1115 waiver to provide COVID-19 treatment services at no cost to the individual and at 100% FF.
- SPA 20-0024 - Hospital Presumptive Eligibility (HPE) Expansion Group: Expands HPE to include the aged (65 years of age and older), disabled, and blind population. HPE COVID-19 is available to individuals with no insurance or currently have private insurance that does not cover diagnostic testing, testing related services, and treatment service, including all medically necessary care as a result of COVID-19 and are a California resident. This program also expands the current PE period limitations across all PE coverage groups to two periods within a 12-month timeframe.
- California COVID-19 Disaster 1115 waiver - Waive Share of Cost (SOC) for COVID-19 Test and Treatment (Waive SOC Group): Waives costs associated with the testing of the COVID-19 and, for those that test positive, all costs associated with the treatment of this virus for certain beneficiaries in the Medically Needy SOC program. Beneficiaries in this coverage group include children under age 21, pregnant individuals, parents and other caretaker relatives and individuals that are aged 65 or older, disabled, or blind.

The fiscal impact of testing and treatment services for various populations was previously budgeted as part of a COVID-19 Uninsured Eligibility Group policy change. The fiscal impact of the Hospital Presumptive Eligibility Expansion group was previously budgeted as part of a consolidated COVID-19 Additional Impacts policy change.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is an increase primarily due to using actual expenditures to project costs, and due to including expenditures for the Waive SOC and COVID-19 HPE Expansion groups in this policy change. In the May 2020 Estimate, the Waive SOC and COVID-19 HPE Expansion groups were previously budgeted in the COVID-19 Additional Impact policy change, which was deactivated in the November 2020 Estimate.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to assuming the public health emergency ends on December 31, 2021.

#### **Methodology:**

1. Assume the public health emergency period will continue through December 31, 2021.
2. Assume Erroneous Payment Corrections for new CPT codes 86408, 86409, and 86413, which impact COVID-19 Uninsured Eligibility, COVID-19 HPE Expansion, and Waive SOC populations deploy in FY 2020-21.
3. Assume 100% GF Funding for Treatment Services and 100% FF Funding for Testing and Testing-Related Services:

**COVID-19 ELIGIBILITY**  
REGULAR POLICY CHANGE NUMBER: 176

<b>FY 2020-21 Service Type</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Treatment Services	\$25,610,000	\$25,610,000	\$0
Testing and Testing-Related Services	\$12,027,000	\$0	\$12,027,000
<b>Total</b>	<b>\$37,637,000</b>	<b>\$25,610,000</b>	<b>\$12,027,000</b>

<b>FY 2021-22 Service Type</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Treatment Services	\$12,251,000	\$12,251,000	\$0
Testing and Testing-Related Services	\$5,026,000	\$0	\$5,026,000
<b>Total</b>	<b>\$17,277,000</b>	<b>\$12,251,000</b>	<b>\$5,026,000</b>

4. The Department estimates the following Medi-Cal program costs as a result of the COVID-19:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
COVID-19 Uninsured Eligibility	\$20,405,000	\$16,888,000	\$3,517,000
COVID-19 HPE Expansion	\$16,918,000	\$8,459,000	\$8,459,000
Waive SOC	\$284,000	\$262,000	\$22,000
Erroneous Payment Corrections	\$30,000	\$1,000	\$29,000
<b>Total</b>	<b>\$37,637,000</b>	<b>\$25,610,000</b>	<b>\$12,027,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
COVID-19 Uninsured Eligibility	\$8,147,000	\$7,520,000	\$627,000
COVID-19 HPE Expansion	\$8,739,000	\$4,370,000	\$4,369,000
Waive SOC	\$391,000	\$361,000	\$30,000
<b>Total</b>	<b>\$17,277,000</b>	<b>\$12,251,000</b>	<b>\$5,026,000</b>

\*Totals may differ due to rounding.

**Funding:**

100% GF (4260-101-0001)

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



## COVID-19 - SICK LEAVE BENEFITS

**REGULAR POLICY CHANGE NUMBER:** 177  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2233

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$36,900,000	\$18,450,000
<b>- STATE FUNDS</b>	\$101,000	\$50,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$36,900,000	\$18,450,000
<b>STATE FUNDS</b>	\$101,000	\$50,500
<b>FEDERAL FUNDS</b>	\$36,799,000	\$18,399,500

**Purpose:**

This policy change estimates the cost of providing emergency paid sick leave for Waiver Personal Care Services (WPCS) and In-Home Supportive Services (IHSS) providers impacted by the coronavirus disease 2019 (COVID-19) pandemic.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was last extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic. The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impact across policy areas and beneficiary populations within the Medi-Cal program.

The Department requested emergency paid sick leave from the Centers for Medicare and Medicaid Services for IHSS providers through SPA 20-0024, and through an Appendix K Waiver Amendment for the Home and Community Based Alternatives Waiver for WPCS providers. These federal approvals allow WPCS and IHSS providers to receive up to 80 hours of paid emergency sick leave, in certain situations, when it is specifically related to the COVID-19 public health emergency for the period of April 2, 2020, through December 31, 2020, or the end of the COVID-19 public health emergency period if sooner.

## COVID-19 - SICK LEAVE BENEFITS

### REGULAR POLICY CHANGE NUMBER: 177

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid. The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

The fiscal impact of providing emergency paid sick leave were previously budgeted as part of a consolidated COVID-19 Additional Impacts policy change. In this estimate, the impacts are budgeted in separate policy changes by programmatic area.

#### Reason for Change:

This is a new policy change. Compared with the former COVID-19 Additional Impacts policy change, the change for 2020-21 is due to assuming the public health emergency continues through December 2021. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the public health emergency benefits ending in December 2021.

#### Methodology:

1. Assume the public health emergency period will continue through December 31, 2021.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through December 31, 2021.
3. The Department of Social Services budgets expenditures from the non-federal share for IHSS providers.
4. The Department estimates the WPCS and IHSS provider sick leave benefits as a result of the COVID-19:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
WPCS Sick Leave Benefits	\$230,000	\$115,000	\$115,000
IHSS Sick Leave Benefits	\$36,670,000	\$0	\$36,670,000
FFCRA 6.2% Increased FFP	\$0	(\$14,000)	\$14,000
<b>Total</b>	<b>\$36,900,000</b>	<b>\$101,000</b>	<b>\$36,799,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
WPCS Sick Leave Benefits	\$115,000	\$58,000	\$57,000
IHSS Sick Leave Benefits	\$18,335,000	\$0	\$18,335,000
FFCRA 6.2% Increased FFP	\$0	(\$7,000)	\$7,000
<b>Total</b>	<b>\$18,450,000</b>	<b>\$51,000</b>	<b>\$18,399,000</b>

\*Totals do not include CDSS GF expenditures.

#### Funding:

100% Title XIX FF (4260-101-0890)  
 100% Title XIX GF (4260-101-0001)  
 FFCRA 6.2% Increased FFP (4260-101-0890)  
 FFCRA 6.2% GF (4260-101-0890)

## COVID-19 INCREASED FMAP - DHCS

**REGULAR POLICY CHANGE NUMBER:** 178  
**IMPLEMENTATION DATE:** 1/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2217

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$220,134,000	-\$50,094,000
<b>- STATE FUNDS</b>	-\$2,737,892,000	-\$782,920,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$220,134,000	-\$50,094,000
<b>STATE FUNDS</b>	-\$2,737,892,000	-\$782,920,000
<b>FEDERAL FUNDS</b>	\$2,517,758,000	\$732,826,000

### Purpose:

This policy change estimates the impact on benefits expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through June 2021. For the estimated impact of assuming increased FMAP from January 2020 through June 2021 on administrative expenditures, see the COVID-19 Increased FMAP – Other Admin policy change. For the estimated impact of assuming an extension of the availability of increased FMAP from July 2021 through December 2021, see the COVID-19 Increased FMAP Extension - DHCS and COVID-19 Increased FMAP Extension – Other Admin policy changes.

### Authority:

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

### Interdependent Policy Changes:

COVID-19 Increased FMAP Extension – DHCS  
 COVID-19 Increased FMAP Extension - Other Admin

### Background:

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

Medicare Part D is the prescription drug benefit provided to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. 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 referred to as the Medicare Part D phased-down contribution and is funded 100% by State General Funds.

## COVID-19 INCREASED FMAP - DHCS

### REGULAR POLICY CHANGE NUMBER: 178

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

#### **Reason for Change:**

There is an increase in general fund savings from the prior estimate for FY 2020-21 due to updates to policy changes. There is a decrease in general fund savings from FY 2020-21 to FY 2021-22 due to updates and policy changes as well as the end of the public health emergency.

#### **Methodology:**

1. The increased FMAP of 6.2% is applicable on regular Medicaid 50% FMAP expenditures.
2. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures.
3. A Breast and Cervical Cancer Treatment Program (BCCTP) FMAP increase of 4.34% is applicable on BCCTP expenditures.
4. The Medicare Part D increase in FMAP from the FFCRA affected the calculation of the phased-down State contribution per capita rates retroactive to January 1, 2020, producing a General Fund saving for the State through the end of the public health emergency. Two months of General Fund savings are assumed for BY because phased-down payments have a two-month lag.
5. The increased FMAP is assumed to continue through June 30, 2021, in this policy change.
6. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
7. Assume a two-month cash lag.
8. The following estimates reflect a cash basis:

**COVID-19 INCREASED FMAP - DHCS**  
REGULAR POLICY CHANGE NUMBER: 178

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$2,395,838)	\$0	\$2,395,838
FFCRA 4.34% Increased FFP	\$0	(\$121,910)	\$0	\$121,910
BCCTP 4.34% Increased FFP	\$0	(\$10)	\$0	\$10
Medicare Part D FFCRA 6.20% Incr. FFP	(\$220,134)	(\$220,134)	\$0	\$0
<b>Total COVID-19 Incr. FMAP - DHCS:</b>	<b>(\$220,134)</b>	<b>(\$2,737,892)</b>	<b>\$0</b>	<b>\$2,517,758</b>
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,824)	\$0	\$1,824
Total COVID-19 Incr. FMAP - Other Admin:	\$0	(\$1,824)	\$0	\$1,824
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$1,925,194	(\$8,110)	(\$404,736)	\$2,338,040
FFCRA 4.34% Increased FFP	\$14,310	(\$7,371)	(\$4,302)	\$25,983
FFCRA 4.34% Incr. FFP - Other Admin	\$0	(\$925)	\$0	\$925
Medicare Part D FFCRA 6.20% Incr. FFP	(\$165,695)	(\$165,695)	\$0	\$0
Total COVID-19 Incr. FMAP In other PCs:	\$1,773,809	(\$182,101)	(\$409,038)	\$2,364,948
Total of PCs including COVID-19 Increased FMAP	\$1,553,675	(\$2,921,818)	(\$409,038)	\$4,884,531

**COVID-19 INCREASED FMAP - DHCS**  
REGULAR POLICY CHANGE NUMBER: 178

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
<b>COVID-19 Increased FMAP - DHCS:</b>				
FFCRA 6.20% Increased FFP	\$0	(\$692,136)	\$0	\$692,136
FFCRA 4.34% Increased FFP	\$0	(\$40,688)	\$0	\$40,688
BCCTP 4.34% Increased FFP	\$0	(\$2)	\$0	\$2
Medicare Part D FFCRA 6.20% Increased FFP	(\$50,094)	(\$50,094)	\$0	\$0
<b>Total COVID-19 Incr. FMAP - DHCS:</b>	<b>(\$50,094)</b>	<b>(\$782,920)</b>	<b>\$0</b>	<b>\$732,826</b>
<b>COVID-19 Increased FMAP - Other Admin:</b>				
FFCRA 4.34% Increased FFP	\$0	(\$365)	\$0	\$365
<b>Total COVID-19 Incr. FMAP - Other Admin:</b>	<b>\$0</b>	<b>(\$365)</b>	<b>\$0</b>	<b>\$365</b>
<b>COVID-19 Increased FMAP In other PCs:</b>				
FFCRA 6.20% Increased FFP	\$376,229	(\$13,718)	(\$105,227)	\$495,174
FFCRA 4.34% Increased FFP	\$10,086	(\$700)	(\$4,583)	\$15,369
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
<b>Total COVID-19 Incr. FMAP In other PCs:</b>	<b>\$386,315</b>	<b>(\$14,418)</b>	<b>(\$109,810)</b>	<b>\$510,543</b>
<b>COVID-19 Increased FMAP Extension – DHCS</b>	<b>\$513,836</b>	<b>(\$1,433,282)</b>	<b>(\$150,129)</b>	<b>\$2,097,247</b>
<b>COVID-19 Increased FMAP Extension - Other Admin</b>	<b>\$0</b>	<b>(\$1,558)</b>	<b>\$0</b>	<b>\$1,558</b>
<b>Total COVID-19 Increased FMAP Extension</b>	<b>\$513,836</b>	<b>(\$1,434,840)</b>	<b>(\$150,129)</b>	<b>\$2,098,805</b>
<b>Total of PCs including COVID-19 Increased FMAP</b>	<b>\$850,057</b>	<b>(\$2,232,543)</b>	<b>(\$259,939)</b>	<b>\$3,342,539</b>

**Funding:**

FFCRA 6.20% Increased FFP (4260-101-0890)  
FFCRA 4.34% Increased FFP (4260-113-0890)  
FFCRA 6.20% GF (4260-101-0001)  
FFCRA 4.34% GF (4260-113-0001)  
FFCRA BCCTP 4.34% Increase FFP (4260-101-0890)  
FFCRA BCCTP 4.34% GF (4260-101-0001)

## COVID-19 UTILIZATION CHANGE

**REGULAR POLICY CHANGE NUMBER:** 179  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Jerrold Anub  
**FISCAL REFERENCE NUMBER:** 2213

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$947,400,000	-\$22,141,000
<b>- STATE FUNDS</b>	-\$377,752,700	-\$8,925,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	25.77 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$703,255,000	-\$22,141,000
<b>STATE FUNDS</b>	-\$280,405,830	-\$8,925,500
<b>FEDERAL FUNDS</b>	-\$422,849,190	-\$13,215,500

**Purpose:**

This policy change estimates savings due to Medical and Dental Fee-for-Service (FFS) utilization decreases resulting from coronavirus disease 2019 (COVID-19).

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

As a result of the statewide stay at home order, the Department estimates a decrease in the Medical and Dental Fee-for-Service (FFS) utilization of services.

## COVID-19 UTILIZATION CHANGE

### REGULAR POLICY CHANGE NUMBER: 179

**Reason for Change:**

For 2020-21, estimates are updated to reflect initial data on changes in medical and dental FFS utilization that the Department estimates are associated with COVID-19 and the related stay at home order.

For the change from 2020-21 to 2021-22, the Department projects no utilization impact for medical FFS due to COVID-19 or stay-at-home orders in 2021-22. Additionally, there is a utilization impact related to the Dental Transformation Initiative (DTI) based on payment timing.

**Methodology:**

1. Estimated decreased medical FFS utilization in 2020-21 is based on initial data on utilization through July 2020. Decreased utilization is observed across a number of categories of services, with the largest reduction observed in the "Other Medical" category.
2. Estimated decreased dental FFS utilization in 2020-21 is based on initial data on utilization through July 2020.
3. Assume that reduced medical and dental FFS utilization continues, but gradually diminishes, such that expenditures are reduced through December 2020. Assume no further medical or dental FFS expenditure impacts from reduced utilization impact after December 2020.
4. Assume a utilization decrease related to the DTI for Program Year 5 (PY 5).

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Medical FFS Reduction	(\$806,030)	(\$322,472)	(\$483,558)
Dental FFS Reduction	(\$121,642)	(\$47,566)	(\$74,076)
Dental – DTI Reduction (PY 5)	(\$19,728)	(\$7,714)	(\$12,014)
<b>Total</b>	<b>(\$947,400)</b>	<b>(\$377,752)</b>	<b>(569,648)</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dental – DTI Reduction (PY 5)	(\$22,141)	(\$8,926)	(\$13,215)
<b>Total</b>	<b>(\$22,141)</b>	<b>(\$8,926)</b>	<b>(\$13,215)</b>

**Funding:**

100% State GF (4260-101-0001)  
 100% Federal Funds (4260-101-0890)  
 100% FF Title XXI (4260-113-0890)  
 100% GF Title XXI (4260-113-0001)



## ELECTRONIC VISIT VERIFICATION FED PENALTIES

**REGULAR POLICY CHANGE NUMBER:** 180  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2163

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$20,248,000	-\$21,517,000
<b>- STATE FUNDS</b>	\$417,000	\$417,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$20,248,000	-\$21,517,000
<b>STATE FUNDS</b>	\$417,000	\$417,000
<b>FEDERAL FUNDS</b>	-\$20,665,000	-\$21,934,000

**Purpose:**

This policy change estimates the cost to budget reduced federal funds and the use of general funds to supplant the reduced federal funding in several programs due to the Electronic Visit Verification (EVV) Phase I and Phase II implementation delay.

**Authority:**

42 U.S.C. 1396b  
 Social Security Act (SSA) Section 1903, subsection (l)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Pursuant to the SSA section 1903, subsection (l) (42 U.S.C. 1396b), all states must implement the EVV for Medicaid-funded personal care services (PCS) by January 2020 and home health care services by January 2023. In October 2019, the Department received approval from the Centers for Medicare & Medicaid Services for a Good Faith Effort Exemption to extend the EVV implementation date without penalty for PCS to January 2021.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to including additional federal penalties for EVV Phase I from January through June 2021. The change from FY 2020-21 to FY 2021-22 is an increase due to increased Phase I penalties occurring in FY 2021-22.

**Methodology:**

1) Assume the Department will receive reduced federal funding beginning January 2021.

**ELECTRONIC VISIT VERIFICATION FED PENALTIES**  
REGULAR POLICY CHANGE NUMBER: 180

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dept. of Social Services	(\$14,831,000)	\$0	(\$14,831,000)
Dept. of Developmental Services	(\$5,376,000)	\$0	(\$5,376,000)
Dept. of Health Care Services	\$0	\$417,000	(\$417,000)
Dept. of Aging	(\$31,000)	\$0	(\$31,000)
Dept. of Public Health	(\$11,000)	\$0	(\$11,000)
<b>Total</b>	<b>(\$20,248,000)</b>	<b>\$417,000</b>	<b>(\$20,665,000)</b>

\*Totals may differ due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dept. of Social Services	(\$16,100,000)	\$0	(\$16,100,000)
Dept. of Developmental Services	(\$5,376,000)	\$0	(\$5,376,000)
Dept. of Health Care Services	\$0	\$417,000	(\$417,000)
Dept. of Aging	(\$31,000)	\$0	(\$31,000)
Dept. of Public Health	(\$11,000)	\$0	(\$11,000)
<b>Total</b>	<b>(\$21,517,000)</b>	<b>\$417,000</b>	<b>(\$21,934,000)</b>

\*Totals may differ due to rounding.

**Funding:**

100% GF (4260-101-0001)

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

## CCI IHSS RECONCILIATION

**REGULAR POLICY CHANGE NUMBER:** 187  
**IMPLEMENTATION DATE:** 6/2021  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1942

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$142,263,000	\$100,000,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$142,263,000	\$100,000,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$142,263,000	\$100,000,000

**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 Coordinated Care Initiative (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.

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 IHSS, into managed care. IHSS was removed from capitation rate payments as of January 1, 2018.

## **CCI IHSS RECONCILIATION**

### **REGULAR POLICY CHANGE NUMBER: 187**

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to the IHSS reconciliation for CY 2015 and CY 2016 shifting from FY 2019-20 to FY 2020-21. This shift is due to the timing of contract package and Good Cause Waiver approvals by the Centers for Medicare and Medicaid Services. Additionally, there are processing constraints and dependencies that the Department is working through in order to process the outstanding IHSS invoices. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to reimbursement for CY 2015 and CY 2016 being completed in FY 2020-21 and reimbursement for CY 2017 being completed in FY 2021-22.

**Methodology:**

1. Assume the 2015 and 2016 reconciliation for CY 2015 and CY 2016 service months and reimbursement for overpayments and underpayments will be completed in FY 2020-21.
2. Assume the 2017 reconciliation for calendar year CY 2017 service months and reimbursement for overpayments and underpayments will be completed in FY 2021-22.
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 \$100,000,000 TF for IHSS managed care in the seven CCI counties.

**Funding:**

100% Title XIX (4260-101-0890)

## ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

**REGULAR POLICY CHANGE NUMBER:** 188  
**IMPLEMENTATION DATE:** 6/2011  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 1232

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$102,878,000	\$63,974,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$102,878,000	\$63,974,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$102,878,000	\$63,974,000

**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  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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.

## ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

### REGULAR POLICY CHANGE NUMBER: 188

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to increased expenditures related to COVID-19.

The change from FY 2020-21 to FY 2021-22, is due to outstanding invoices will be paid in FY 2020-21.

#### Methodology:

1. FY 2020-21 includes a portion of payments for FY 2018-19, FY 2019-20, and FY 2020-21 expenditures. FY 2021-22 includes a portion of payments for FY 2019-20, FY 2020-21, and FY 2021-22 expenditures.
2. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
3. The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FFP Regular	FFCRA	Total FFP
<b>FY 2020-21</b>	\$189,656	\$86,778	\$94,508	\$8,370	<b>\$102,878</b>
<b>FY 2021-22</b>	\$122,496	\$60,339	\$62,157	\$1,817	<b>\$63,974</b>

#### Funding:

100% Title XIX (4260-101-0890)

FFCRA 6.2% Increased FFP (4260-101-0890)

## PROP 56 - PROVIDER ACES TRAININGS

**REGULAR POLICY CHANGE NUMBER:** 190  
**IMPLEMENTATION DATE:** 12/2019  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2138

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$61,924,000	\$41,712,000
<b>- STATE FUNDS</b>	\$30,962,000	\$20,856,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$61,924,000	\$41,712,000
<b>STATE FUNDS</b>	\$30,962,000	\$20,856,000
<b>FEDERAL FUNDS</b>	\$30,962,000	\$20,856,000

**Purpose:**

This policy change estimates the cost to train providers on delivering Adverse Childhood Experiences (ACEs) screenings.

**Authority:**

AB 74 (Chapter 23, Statute of 2019)  
 AB 80 (Chapter 12, Statute of 2020)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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.

The Department proposes to allocate Proposition 56 funds to train providers on delivering trauma screenings in a sensitive and appropriate manner. This policy change identifies the use of the General Fund (GF) for these Proposition 56 payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments, effective July 1, 2021, the Department assumes the suspension for these Proposition 56 payments to be delayed to July 1 2022, at which point available funding for this purpose will be fully expended.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to a decline in provider training payments in FY 2021-22 because of the three-year allocation limit authority cap for ACEs provider trainings.

**PROP 56 - PROVIDER ACES TRAININGS**  
REGULAR POLICY CHANGE NUMBER: 190

**Methodology:**

1. Payments began in December 2019.
2. The provider trainings costs are estimated to be \$61,924,000 TF (\$30,962,000 GF) in FY 2020-21 and \$41,712,000 TF (\$20,856,000 GF) in FY 2021-22.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2019-20	\$2,856	\$1,428	\$1,428
FY 2020-21	\$59,068	\$29,534	\$29,534
<b>Total</b>	<b>\$61,924</b>	<b>\$30,962</b>	<b>\$30,962</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2020-21	\$6,282	\$3,141	\$3,141
FY 2021-22	\$35,430	\$17,715	\$17,715
<b>Total</b>	<b>\$41,712</b>	<b>\$20,856</b>	<b>\$20,856</b>

**Funding:**

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



## INFANT DEVELOPMENT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 193  
**IMPLEMENTATION DATE:** 7/2016  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2009

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$48,322,000	\$35,974,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$48,322,000	\$35,974,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$48,322,000	\$35,974,000

**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  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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 the Department 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## INFANT DEVELOPMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 193

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Decrease in FY 2020-21 expenditures associated with COVID-19 due to observed decrease in population within this program as a result of lower referrals to Regional Centers (RC) for this population; and
- Increase in FY 2020-21 expenditures due to invoices to be paid in FY 2019-20 were paid in FY 2020-21.

The change from FY 2021 to FY 2021-22, in the current estimate, is due to:

- Increase in FY 2021-22 expenditures as population growth returns to normal; and
- Decrease in FY 2021-22 expenditures because outstanding invoices are expected to be paid in FY 2020-21.

#### Methodology:

1. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.

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

(Dollars in Thousands)

Fiscal Year	TF	CDDS GF	FF	FFCRA
<b>FY 2020-21</b>	\$84,409	\$36,087	<b>\$42,707</b>	<b>\$5,615</b>
<b>FY 2021-22</b>	\$70,388	\$34,414	<b>\$35,194</b>	<b>\$780</b>

#### Funding:

100% Title XIX FFP (4260-101-0890)  
 FFCRA 6.2% Increased FFP (4260-101-0890)

## MINIMUM WAGE INCREASE FOR HCBS WAIVERS

**REGULAR POLICY CHANGE NUMBER:** 194  
**IMPLEMENTATION DATE:** 1/2017  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1975

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$62,775,000	\$78,616,000
<b>- STATE FUNDS</b>	\$31,387,500	\$39,308,000
<b>PAYMENT LAG</b>	0.8360	0.8360
<b>% REFLECTED IN BASE</b>	37.73 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$32,679,200	\$65,723,000
<b>STATE FUNDS</b>	\$16,339,620	\$32,861,490
<b>FEDERAL FUNDS</b>	\$16,339,620	\$32,861,490

**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  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 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 homelike and community settings 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: 194

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase due to slightly higher enrollment in the ALW and AIDS Waiver attendant care users. The change from FY 2020-21 to FY 2021-22, 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, 2020, the minimum wage will increase \$.50 from \$11.50 to \$12.00 per hour. Beginning January 1, 2021, the minimum wage will increase \$1.00 from \$12.00 to \$13.00 per hour. Beginning January 1, 2022, the minimum wage will increase \$1.00 from \$13.00 to \$14.00 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 5,744 in calendar year (CY) 2020, CY 2021, and CY 2022.
- For FY 2020-21, assume the total care coordination and assisted living cost minimum wage increase is \$62,670,000 TF. For FY 2021-22, assume the total care coordination and assisted living cost minimum wage increase is \$78,476,000 TF.

#### AIDS MCWP

- For CY 2020, assume there are 48 attendant care users. For CY 2021, assume there are 49 attendant care users. For CY 2022, assume there are 50 attendant care users.
- A unit is counted as 15 minutes of time.
- For CY 2020, assume a participant uses 1,007 units of attendant care services annually. For CY 2021, assume a participant uses 1,027 units of attendant care services annually. For CY 2022, assume a participant uses 1,047 units of attendant care services annually.
- For CY 2020, assume the estimated attendant care service rate is \$6.47 per unit. For CY 2021, assume the estimated attendant care service rate is \$7.06 per unit. For CY 2022, assume the estimated attendant care service rate is \$7.67 per unit.
- Assume the FY 2020-21 cost for AIDS MCWP Waiver minimum wage is \$105,000 TF. Assume the FY 2021-22 cost for the AIDS MCWP Waiver minimum wage increase is \$140,000 TF.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>ALW</b>	\$62,670,000	\$31,335,000	\$31,335,000
<b>HIV/AIDS</b>	\$105,000	\$53,000	\$52,000
<b>Total</b>	<b>\$62,775,000</b>	<b>\$31,388,000</b>	<b>\$31,387,000</b>

**MINIMUM WAGE INCREASE FOR HCBS WAIVERS**  
**REGULAR POLICY CHANGE NUMBER: 194**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>ALW</b>	\$78,476,000	\$39,238,000	\$39,238,000
<b>HIV/AIDS</b>	\$140,000	\$70,000	\$70,000
<b>Total</b>	<b>\$78,616,000</b>	<b>\$39,308,000</b>	<b>\$39,308,000</b>

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## SELF-DETERMINATION PROGRAM - CDDS

**REGULAR POLICY CHANGE NUMBER:** 196  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2208

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,365,000	\$10,424,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$8,365,000	\$10,424,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$8,365,000	\$10,424,000

**Purpose:**

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Self Determination Program Waiver.

**Authority:**

Interagency Agreement (IA) 19-96260

**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 Self Determination Program 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, community living and integration supports, non-medical transportation, communication support, family and consumer training, homemaker, nutritional consultation, specialized medical equipment/supplies, respite services, personal emergency response system, crisis intervention and support, employment and prevocational supports, vehicle and environmental accessibility adaptations, skilled nursing, financial management services, independent facilitator 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 in FY 2020-21, from the prior estimate, is due to pending Interagency Agreement resulting in CDDS not able to seek FFP for services provided in FY 2019-20. DDS now anticipates claiming this FFP in FY 2020-21. Also, estimate for FY 2020-21 has been updated to reflect slower than expected enrollment in this program.

The change from FY 2020-21 to FY 2021-22, is due to anticipated increases in enrollment in this program.

**SELF-DETERMINATION PROGRAM - CDDS**  
REGULAR POLICY CHANGE NUMBER: 196**Methodology:**

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

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>
<b>FY 2020-21</b>	\$16,730	\$8,365	<b>\$8,365</b>
<b>FY 2021-22</b>	\$20,848	\$10,424	<b>10,424</b>

**Funding:**

100% Title XIX (4260-101-0890)

## ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

**REGULAR POLICY CHANGE NUMBER:** 197  
**IMPLEMENTATION DATE:** 7/2010  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 1526

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$16,891,000	\$11,039,000
<b>- STATE FUNDS</b>	\$7,731,000	\$5,041,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$16,891,000	\$11,039,000
<b>STATE FUNDS</b>	\$7,731,000	\$5,041,000
<b>FEDERAL FUNDS</b>	\$9,160,000	\$5,998,000

**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.



## ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

### REGULAR POLICY CHANGE NUMBER: 197

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 2019-20 and FY 2020-21. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDs.

#### Reason for Change:

The change for FY 2020-21, from the prior estimate, is due to a slight increase in population growth.

The change from FY 2020-21 to FY 2021-22, is a due to a significant number of unpaid prior year invoices.

#### Methodology:

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
<b>FY 2020-21</b>	\$1,428	\$7,732	\$18,319	\$1,428	<b>\$7,731</b>	<b>\$9,160</b>
<b>FY 2021-22</b>	\$956	\$5,042	\$11,995	\$956	<b>\$5,041</b>	<b>\$5,998</b>

#### Funding:

100% GF (4260-101-0001)

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

## PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG

**REGULAR POLICY CHANGE NUMBER:** 199  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2097

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$15,108,000	\$29,092,000
<b>- STATE FUNDS</b>	\$15,108,000	\$29,092,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$15,108,000	\$29,092,000
<b>STATE FUNDS</b>	\$15,108,000	\$29,092,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the cost of the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.

**Authority:**

SB 849 (Chapter 47, Statutes of 2018)  
2019 Budget Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

SB 849 establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which will be developed by the State Department of Health Care Services to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of Medi-Cal and other specified health care programs using moneys from the Healthcare Treatment Fund.

Previously, the Department planned to administer five cohorts each receiving payments over five years. The Department proposes to revert funding for planned cohorts three through five.

The Department will administer payments to two cohorts of participating physicians and dentists. Each cohort will receive the payments over five years.

The Department has contracted with Physicians for a Healthy California (PHC) to implement and administer the Proposition 56 funded Physicians and Dentist Loan Repayment Program pursuant to Welfare and Institutions Code section 14114(g).

**Reason for Change:**

The change from the previous estimate, for FY 2020-21, is a decrease to better align with the administration contract payment schedule. The difference from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the additional cohort of awarded loan repayments beginning payments in FY 2021-22.

**PROP 56 PHYSICIANS & DENTISTS LOAN REPAYMENT PROG**  
**REGULAR POLICY CHANGE NUMBER: 199**

**Methodology:**

1. Cohort 1 is expected to receive \$13.5 million each year for 5 years, with payments beginning in FY 2020-21. Cohort 2 is expected to receive \$13.9 million each year for 5 years, with payment beginning in FY 2021-22. Awardee payments are issued retrospectively and annually for 5 years for each Cohort and once the awardees annual review is complete and indicates they are within compliance per the program administrator.
2. The contract for the administrative costs is \$1.6 million in FY 2020-21 and \$1.7 million in FY 2021-22, with the payments being retrospective and invoices processed the month after services have been provided.

<b>Fiscal Years</b>	<b>TF</b>	<b>GF</b>
<b>FY 2020-21</b>	\$15,108,000	\$15,108,000
<b>FY 2021-22</b>	\$29,092,000	\$29,092,000

**Funding:**

100% Prop 56 Loan Forgiveness Program (4260-102-3305)

100% Prop 56 Loan Repayment Program (4260-101-3375)

## INDIAN HEALTH SERVICES

**REGULAR POLICY CHANGE NUMBER:** 200  
**IMPLEMENTATION DATE:** 4/1998  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 111

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$9,525,000	\$18,436,000
<b>- STATE FUNDS</b>	\$3,191,000	\$6,176,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	3.38 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$9,203,100	\$18,436,000
<b>STATE FUNDS</b>	\$3,083,140	\$6,176,000
<b>FEDERAL FUNDS</b>	\$6,119,910	\$12,260,000

**Purpose:**

This policy change estimates the annual rate change posted in the Federal Register for services in Indian Health facilities.

**Authority:**

Public Law 93-638

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

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS

COVID-19 Increased FMAP Extension – DHCS

**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 American Indians (AIs) through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% federal financial participation (FFP) to the date of the MOA, July 11, 1996, or at whatever later date a facility qualifies and elects to participate as an IHS facility under the MOA.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

The per visit rate payable to the Indian health facilities is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

## INDIAN HEALTH SERVICES

### REGULAR POLICY CHANGE NUMBER: 200

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a decrease due a drop in the annual increase per claim in calendar year (CY) 2020. In the prior estimate for CY 2020, the annual increase per claim was \$33 and the increase per claim this estimate is \$24. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the rate increase from current year to budget year.

#### Methodology:

1. Currently, there are 95 Indian health clinics participating in Medi-Cal and 7 YRTC. The YRTC costs were previously budgeted in a separate policy change.
2. Effective CY 2020, the rate increased from \$455 to \$479. The annual increase of \$24 per claim resulted in \$6,350,000 TF. This includes a \$37,000 TF rate adjustment paid to YRTCs in CY 2020.
3. It is estimated, effective CY 2021, the updated per visit rate payable to the Indian health clinics will increase by \$29, from \$479 to \$508. The annual rate increase for the additional \$29 is estimated at \$8,057,000 TF. This estimate includes a \$46,000 TF rate adjustment paid to YRTCs in CY 2021.
4. It is estimated, effective CY 2022, the updated per visit rate payable to the Indian health clinics will increase by \$32, from \$508 to \$540. The annual rate increase for the additional \$32 is estimated at \$9,224,000 TF. This estimate includes a \$54,000 TF rate adjustment paid to YTRCs in CY 2022.
5. On a cash basis, the FY 2020-21 and FY 2021-22 estimates are:

Rate Increase	FY 2020-21	FY 2021-22
CY 2020 rate increase	\$6,350,000	\$6,350,000
CY 2021 rate increase	\$0	\$8,057,000
Retro Jan – June 2020 Increase	\$3,175,000	\$0
Retro Jan – June 2021 Increase	\$0	\$4,029,000
<b>Total Rate increase</b>	<b>\$9,525,000</b>	<b>\$18,436,000</b>

Fiscal Year	TF	GF	FF
<b>FY 2020-21</b>	<b>\$9,525,000</b>	<b>\$3,191,000</b>	<b>\$6,334,000</b>
<b>FY 2021-22</b>	<b>\$18,436,000</b>	<b>\$6,176,000</b>	<b>\$12,260,000</b>

\*Totals may differ due to rounding.

#### Funding:

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## ARRA HITECH - PROVIDER PAYMENTS

**REGULAR POLICY CHANGE NUMBER:** 201  
**IMPLEMENTATION DATE:** 12/2011  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1488

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$8,651,000	\$5,101,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$8,651,000	\$5,101,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$8,651,000	\$5,101,000

**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, now known as the Promoting Interoperability Program, is scheduled to sunset in 2021, with program and audit closeouts expected to continue beyond 2021. 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.

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

## ARRA HITECH - PROVIDER PAYMENTS

### REGULAR POLICY CHANGE NUMBER: 201

State's Health Information Technology program are budgeted separately in the ARRA HITECH Incentive Program policy change.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a decrease due to less providers qualifying for incentive payments as a result of COVID-19 impacts. This has resulted in a minor shift in the timing of incentive payments.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due fewer providers qualifying for incentive payments. The California Provider Technical Assistance Program (CTAP) program ended September 30, 2020. Additionally, the number of providers successfully implementing later stages of MU have reached maximum incentive payments and will no longer be able to participate.

#### 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 and year-two payments for hospitals as of FY 2019-20 beyond what are referenced below.

For FY 2020-21, there are a few outstanding hospital payments. In addition, there are approximately 13 hospitals whom have attested and not been paid due to protracted audits, pending appeals and litigation or discrepancies in taxpayer ID information. Four hospitals were approved in July 2020, though two did not receive payment due to audit findings of overpayment. One hospital has not been audited yet. A total of \$1,425,291 will be paid out to 10 hospitals in FY 2020-21. This amount has been distributed amongst the FY as a monthly average since exact payment dates cannot be determined at this time.

5. The estimated payments for FY 2020-21 and FY 2021-22 are on a cash-basis.

**ARRA HITECH - PROVIDER PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 201

<b>FY 2020-21 Professional Incentive Payments</b>			
<b>Eligibility Year</b>	<b>Professionals</b>	<b>Incentive Payments</b>	<b>FF</b>
2	17	\$8,500	\$145,000
3	42	\$8,500	\$357,000
4	170	\$8,500	\$1,445,000
5	366	\$8,500	\$3,111,000
6	255	\$8,500	\$2,168,000
<b>Total FY 2020-21 Professional Payments</b>			<b>\$7,226,000</b>

<b>FY 2020-21 Hospital Incentive Payments</b>			
<b>Eligibility Year</b>	<b>Hospitals</b>	<b>Incentive Payments</b>	<b>FF</b>
2	0	\$0	\$0
3	0	\$0	\$0
4	10	\$0	\$1,425,291
Potential OIG Overpayments			\$0
<b>Total FY 2020-21 Hospital Payments</b>			<b>\$1,425,291</b>

<b>FY 2021-22 Professional Incentive Payments</b>			
<b>Eligibility Year</b>	<b>Professionals</b>	<b>Incentive Payments</b>	<b>FF</b>
2	5	\$8,500	\$43,000
3	10	\$8,500	\$85,000
4	120	\$8,500	\$1,020,000
5	240	\$8,500	\$2,040,000
6	225	\$8,500	\$1,913,000
<b>Total FY 2021-22 Professional Payments</b>			<b>\$5,100,000</b>



**ARRA HITECH - PROVIDER PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 201

<b>FY 2021-22 Hospital Incentive Payments</b>			
<b>Eligibility Year</b>	<b>Hospitals</b>	<b>Incentive Payments</b>	<b>FF</b>
1	0	\$0	\$0
2	0	\$0	\$0
3	0	\$0	\$0
4	0	\$0	\$0
Potential OIG Overpayments			\$0
<b>Total FY 2021-22 Hospital Payments</b>			<b>\$0</b>

<b>Fiscal Year</b>	<b>Professional Payments</b>	<b>Hospital Payments</b>	<b>FF</b>
<b>FY 2020-21</b>	\$7,226,000	\$1,425,000	\$8,651,000
<b>FY 2021-22</b>	\$5,101,000	\$0	\$5,101,000

**Funding:**

100% Title XIX (4260-101-0890)

## QAF WITHHOLD TRANSFER

**REGULAR POLICY CHANGE NUMBER:** 202  
**IMPLEMENTATION DATE:** 7/2017  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2092

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$7,816,000	\$47,076,000
<b>- STATE FUNDS</b>	-\$3,468,000	\$19,729,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$7,816,000	\$47,076,000
<b>STATE FUNDS</b>	-\$3,468,000	\$19,729,000
<b>FEDERAL FUNDS</b>	\$11,284,000	\$27,347,000

**Purpose:**

This policy change budgets for withheld Fee-for-Service payments (FFS) associated with the Hospital Quality Assurance Fee (HQAF), AB 1629 Skilled Nursing Facilities (SNF) QAF, Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) QAF, and Ground Emergency Medical Transportation (GEMT) QAF.

**Authority:**

Welfare & Institutions (W&I) Code, Section 14169.52(h)  
 W&I Code, Section 14129.2(d)(2)  
 Health and Safety Code, Section 1324.22(e)(2)  
 Provider Bulletin LTC June 2009, #388, Code Section 103  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Long Term Care Quality Assurance Fund Expenditures  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

To recover past due QAF from delinquent providers, the Department currently withholds portions of the delinquent provider's FFS payments, applies those payments to the delinquent QAF debt, and transfers the withheld portion. As Medi-Cal is on a cash basis, these expenditures were originally budgeted in the fiscal year the claim was processed.

For the HQAF, the withheld portion is transferred to the Hospital Quality Assurance Revenue Fund.

For AB 1629 SNF and ICF/DD QAF, the withheld portions are transferred to the Long Term Care Quality Assurance Fund (LTC QAF), and subsequently to the General Fund (GF), providing savings once the transfer occurs. The fund adjustment from the LTC QAF to the GF is budgeted in the Long Term Care Quality Assurance Fund Expenditures policy change.

For GEMT QAF, the withheld portion is transferred to the Medi-Cal Emergency Medical Transport Fund.

## QAF WITHHOLD TRANSFER

### REGULAR POLICY CHANGE NUMBER: 202

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is due to estimating a fiscal impact from the QAF withholds and withhold transfers in FY 2020-21. Specifically,

- The prior estimate assume the prior year QAF withholds were offset by the QAF withhold transfers occurring in the same year. In the current estimate, costs are estimated from prior year withhold transfers for HQAF and LTC QAF and a net General Fund (GF) offset is estimated for GEMT QAF.
- In addition, FY 2020-21 includes the impact of the FFCRA funding adjustments for FY 2019-20 withhold transfers, shifting funding from the GF to federal funds.
- FFCRA increased FMAP was included for applicable withholds from FY 2019-20 and FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate is due to:

- HQAF VI payments and withholds occurring in late FY 2020-21. The withhold transfer for the withholds occurring at the end of FY 2020-21, are estimated to be transferred in FY 2021-22. This results in an increase impact for prior year HQAF withholds in FY 2021-22.
- No prior year FFCRA funding adjustments in FY 2021-22, and
- Net GF offsets expected for LTC QAF and GEMT QAF in FY 2021-22.

#### Methodology:

##### HQAF

1. Prior year FY 2019-20 HQAF withheld payments totaling \$56.76 million TF will be transferred in FY 2020-21.
2. An estimated \$50.89 million TF in HQAF withholds will occur in FY 2020-21. These withholds are pending transfer in the next FY and offsets a portion of the \$56.76 million HQAF withhold transfer.
3. An estimated \$50.89 million of FY 2020-21 HQAF withheld payments will be paid in FY 2021-22. This prior year withhold transfer is offset by \$2.57 million withholds that are estimated to occur in FY 2021-22, but are pending transfer in FY 2022-23.

##### LTC QAF

4. Prior year FY 2019-20 LTC QAF withheld payments totaling \$12.49 million TF will be transferred in FY 2020-21.
5. An estimated \$10.24 million in LTC QAF withholds will occur in FY 2020-21. These withholds are pending transfer in the next FY and offsets a portion of the \$12.49 million LTC QAF withhold transfer.

**QAF WITHHOLD TRANSFER**  
REGULAR POLICY CHANGE NUMBER: 202

6. An estimated \$10.24 million of FY 2020-21 LTC QAF withheld payments will be paid in FY 2021-22. This prior year withhold transfer is offset by \$11.47 million withholds that are estimated to occur in FY 2021-22, but are pending transfer in FY 2022-23.

GEMT QAF

7. An estimated \$0.31 million in GEMT QAF withholds will occur in FY 2020-21. These withholds are pending transfer in FY 2021-22.
8. An estimated \$0.31 million of FY 2020-21 GEMT QAF withholds will be paid in FY 2021-22. This prior year withhold transfer is offset by \$0.32 million withholds that are estimate to occur in FY 2021-22, but are pending transfer in FY 2022-23.

FFCRA

9. The 6.2% Title XIX FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
10. FY 2019-20 HQAF and LTC QAF withhold transfers that occurred in FY 2019-20 were processed at 50% / 50% FMAP. For the period applicable to receive FFCRA increased FMAP, funding adjustments were processed in FY 2020-21.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
<b>HQAF</b>				
HQAF Prior Year Withhold Transfers	\$56,764	\$24,863	\$28,382	\$3,519
HQAF Prior Year Withholds FFCRA FMAP Adjustment	\$0	(\$6,071)	\$0	\$6,071
HQAF FY 2020-21 New Withholds Pending Transfer	(\$50,886)	(\$22,288)	(\$25,443)	(\$3,155)
Subtotal HQAF for FY 2020-21	\$5,878	(\$3,496)	\$2,939	\$6,435
<b>LTC QAF</b>				
LTC QAF Prior Year Withhold Transfers	\$12,496	\$5,741	\$6,248	\$507
LTC QAF Prior Year Withholds FFCRA FMAP Adjustment	\$0	(\$1,088)	\$0	\$1,088
LTC QAF FY 2020-21 New Withholds Pending Transfer	(\$10,244)	(\$4,487)	(\$5,122)	(\$635)
Subtotal LTC QAF for FY 2020-21	\$2,252	\$166	\$1,126	\$960
<b>GEMT QAF</b>				
GEMT QAF Prior Year Withhold Transfers	\$0	\$0	\$0	\$0
GEMT QAF FY 2020-21 New Withholds Pending Transfer	(\$314)	(\$138)	(\$157)	(\$19)
Subtotal GEMT QAF for FY 2020-21	(\$314)	(\$138)	(\$157)	(\$19)
<b>Total FY 2020-21</b>	<b>\$7,816</b>	<b>(\$3,468)</b>	<b>\$3,908</b>	<b>\$7,376</b>

**QAF WITHHOLD TRANSFER**  
**REGULAR POLICY CHANGE NUMBER: 202**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
<b>HQAF</b>				
HQAF Prior Year Withhold Transfers	\$50,886	\$22,288	\$25,443	\$3,155
HQAF FY 2021-22 New Withholds Pending Transfer	(\$2,570)	(\$1,285)	(\$1,285)	\$0
Subtotal HQAF for FY 2021-22	\$48,316	\$21,003	\$24,158	\$3,155
<b>LTC QAF</b>				
LTC QAF Prior Year Withhold Transfers	\$10,244	\$4,487	\$5,122	\$635
LTC QAF FY 2021-22 New Withholds Pending Transfer	(\$11,474)	(\$5,737)	(\$5,737)	\$0
Subtotal LTC QAF for FY 2021-22	(\$1,230)	(\$1,250)	(\$615)	\$635
<b>GEMT QAF</b>				
GEMT QAF Prior Year Withhold Transfers	\$314	\$138	\$157	\$19
GEMT QAF FY 2021-22 New Withholds Pending Transfer	(\$324)	(\$162)	(\$162)	\$0
Subtotal GEMT QAF for FY 2021-22	(\$10)	(\$24)	(\$5)	\$19
<b>Total FY 2021-22</b>	<b>\$47,076</b>	<b>\$19,729</b>	<b>\$23,538</b>	<b>\$3,809</b>

**Funding:**

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

FFCRA 6.2% GF (4260-101-0001)

FFCRA 6.2% Increased FFP (4260-101-0890)

## CCS SAR EPC

**REGULAR POLICY CHANGE NUMBER:** 203  
**IMPLEMENTATION DATE:** 10/2020  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2235

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$6,166,000	\$6,166,000
<b>- STATE FUNDS</b>	\$3,029,240	\$3,029,240
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$6,166,000	\$6,166,000
<b>STATE FUNDS</b>	\$3,029,240	\$3,029,240
<b>FEDERAL FUNDS</b>	\$3,136,760	\$3,136,760

**Purpose:**

This policy change estimates the cost of processing an erroneous payment correction (EPC) to reimburse providers for services related to California Children's Services (CCS) Service Authorization Request (SAR).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Hospital providers deliver necessary medical services under the assumption that they will get reimbursed for those services, assuming they submit an accurate claim in a timely manner. Due to a technical error in the Children's Medical Services Network system, claims filed between August 13, 2013, and May 17, 2019, were rejected. The information technology system was fixed for claims submitted after May 17, 2019.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume the Department processed one EPC in October 2020 and will process a second EPC in October 2021.
2. Assume each EPC is valued at \$6,166,000 TF.

Fiscal Year	TF	FF	GF	GF Reimbursement	CF*
<b>FY 2020-21</b>	<b>\$6,166,000</b>	<b>\$3,195,000</b>	<b>\$3,240,000</b>	<b>(\$269,000)</b>	\$269,000
<b>FY 2021-22</b>	<b>\$6,166,000</b>	<b>\$3,195,000</b>	<b>\$3,240,000</b>	<b>(\$269,000)</b>	\$269,000

\*County Funds are not included in the Total Fund.

\*\*Totals may differ due to rounding.

**CCS SAR EPC**  
**REGULAR POLICY CHANGE NUMBER: 203**

**Funding:**

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

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

100% State GF (4260-101-0001)

100% State GF (4260-113-0001)

GF Reimbursement

## HOME & COMMUNITY-BASED ALTERNATIVES WAIVER

**REGULAR POLICY CHANGE NUMBER:** 204  
**IMPLEMENTATION DATE:** 10/2017  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2010

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$168,175,000	\$154,044,000
<b>- STATE FUNDS</b>	\$84,087,500	\$77,022,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$168,175,000	\$154,044,000
<b>STATE FUNDS</b>	\$84,087,500	\$77,022,000
<b>FEDERAL FUNDS</b>	\$84,087,500	\$77,022,000

**Purpose:**

This policy change estimates the cost of the Home and Community-Based Alternatives (HCBA) Waiver.

**Authority:**

Welfare & Institutions Code, Section 14132.991

**Interdependent Policy Changes:**

HCBA Waiver Renewal Administrative Cost  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 2017 HCBA waiver authorization, 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

### REGULAR POLICY CHANGE NUMBER: 204

- 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 primary model for the administration and operation of the Waiver is through contracted Waiver Agencies. The Waiver Agencies are responsible for local Waiver Administration functions and for the delivery of the Comprehensive Care Management Waiver services. The reimbursement structure for Waiver Administration services will be a per member per month rate. 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 medically 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 2020-21, is an increase in costs due to an update in the methodology. The policy change only accounts for new enrollments into the waiver with savings from the transition of beneficiaries in a skilled nursing facility to the waiver. Previously, the policy change accounted for savings cumulatively. It is now assumed that the prior savings are in the base estimates. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to the additional enrollment from institutional facilities to the HCBA Waiver.

#### Methodology:

1. The renewed waiver was approved on May 16, 2017, with an effective date of January 1, 2017.
2. Currently, there are 5,062 participants in the HCBA Waiver.
3. Assume Comprehensive Care Management costs \$10,983,000 TF annually.
4. Assume the annual cost per user is \$41,669.
5. Assume 1,200 new participants will transition in FY 2020-21 and 1,800 in FY 2021-22.
6. Assume 60% will be from long-term skilled nursing facilities and 40% participants will be from the community.
7. Assume the average monthly cost in a skilled nursing facility is \$10,736.

**HOME & COMMUNITY-BASED ALTERNATIVES WAIVER**  
REGULAR POLICY CHANGE NUMBER: 204

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Waiver Costs	\$260,934	\$130,467	\$130,467
Savings from SNF	(\$92,759)	(\$46,380)	(\$46,379)
<b>Net Cost</b>	<b>\$168,175</b>	<b>\$84,087</b>	<b>\$84,088</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Waiver Costs	\$385,942	\$192,971	\$192,971
Savings from SNF	(\$231,898)	(\$115,949)	(\$115,949)
<b>Net Cost</b>	<b>\$154,044</b>	<b>\$77,022</b>	<b>\$77,022</b>

\*Totals may differ due to rounding.

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## WPCS WORKERS' COMPENSATION

**REGULAR POLICY CHANGE NUMBER:** 205  
**IMPLEMENTATION DATE:** 11/2016  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1866

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$3,324,000	\$3,325,000
<b>- STATE FUNDS</b>	\$1,662,000	\$1,662,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$3,324,000	\$3,325,000
<b>STATE FUNDS</b>	\$1,662,000	\$1,662,500
<b>FEDERAL FUNDS</b>	\$1,662,000	\$1,662,500

**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  
 IA 19-96325

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

The WPCS benefit is designed to assist the Home and Community-Based Alternatives 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. WPCS providers receive payment via the Case Management Information Payrolling System. 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 effective July 1, 2019, and will remain in effect until June 30, 2021, at which point it will be renewed for a new contract term.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to a slight increase in administrative costs.

## WPCS WORKERS' COMPENSATION

### REGULAR POLICY CHANGE NUMBER: 205

#### Methodology:

1. The current workers' compensation contract, IA 16-93498, went into effect July 1, 2017, and will be in effect until June 30, 2021. The estimated costs are based on the assumption that a new or amended contract will be implemented effective July 1, 2021.
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 In-Home Supportive Services 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 2020-21 is \$3,324,000 TF and \$3,325,000 TF in FY 2021-22.

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$3,324,000</b>	<b>\$1,662,000</b>	<b>\$1,662,000</b>
<b>FY 2021-22</b>	<b>\$3,325,000</b>	<b>\$1,663,000</b>	<b>\$1,662,000</b>

#### Funding:

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## TRIBAL FEDERALLY QUALIFIED HEALTH CENTER

**REGULAR POLICY CHANGE NUMBER:** 206  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2195

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$1,780,000	\$12,827,000
<b>- STATE FUNDS</b>	\$462,300	\$3,330,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$1,780,000	\$12,827,000
<b>STATE FUNDS</b>	\$462,300	\$3,330,300
<b>FEDERAL FUNDS</b>	\$1,317,700	\$9,496,700

**Purpose:**

This policy change estimates the cost to create a Tribal Federally Qualified Health Center (FQHC) provider type in Medi-Cal to allow for payment of services provided outside of tribal clinics.

**Authority:**

Not applicable

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**Background:**

The Department is pursuing the development of the Tribal FQHC provider type in Medi-Cal, effective January 1, 2021. The Centers for Medicare and Medicaid Services provided guidance to establish the provider type in Medicaid by January 2021. The Tribal FQHC provider type option will allow Tribal health clinics to provide services outside the four walls of the facility to Medi-Cal patients other than homeless individuals. Additionally, it will allow Tribal health clinics to bill for optional benefits similar to the existing FQHC provider type.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to an estimated higher per visit rate. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to capturing a full year of expenditures in FY 2021-22.

**Methodology:**

1. Assume the Department will reimburse Tribal FQHCs for providing optional benefits beginning January 1, 2021.
2. Assume the cost to reimburse Tribal FQHC providers is \$1,780,000 TF in FY 2020-21 and \$12,827,000 TF in FY 2021-22.

**TRIBAL FEDERALLY QUALIFIED HEALTH CENTER**  
REGULAR POLICY CHANGE NUMBER: 206

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$835,000	\$417,000	\$418,000
100% Title XIX FFP	\$587,000	\$0	\$587,000
65% Title XXI / 35% GF	\$36,000	\$13,000	\$23,000
90% Title XIX ACA / 10% GF	\$322,000	\$32,000	\$290,000
<b>FY 2020-21 Total</b>	<b>\$1,780,000</b>	<b>\$462,000</b>	<b>\$1,318,000</b>

\*Totals may differ due to rounding

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$6,016,000	\$3,008,000	\$3,008,000
100% Title XIX FFP	\$4,233,000	\$0	\$4,233,000
65% Title XXI / 35% GF	\$258,000	\$90,000	\$168,000
90% Title XIX ACA / 10% GF	\$2,320,000	\$232,000	\$2,088,000
<b>FY 2021-22 Total</b>	<b>\$12,827,000</b>	<b>\$3,330,000</b>	<b>\$9,497,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## AUDIT SETTLEMENTS

**REGULAR POLICY CHANGE NUMBER:** 209  
**IMPLEMENTATION DATE:** 7/2016  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 110

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$47,589,000	\$69,588,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$47,589,000	\$69,588,000
<b>FEDERAL FUNDS</b>	-\$47,589,000	-\$69,588,000

**Purpose:**

This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services.

**Authority:**

Public Law 95-452  
42, Code of Federal Regulations 433.302

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Internal Audits monitors the issuance of final audit reports by state and federal auditors (e.g., the California State Auditor, the Office of Inspector General, etc.). Audit reports will typically contain audit findings and recommendations which can include unallowable amounts due from the Department. Internal Audits reaches out to Divisions within the Department periodically to ensure findings and recommendations identified in the audit are addressed and corrective action is taken, including whether a Division will repay or appeal reported overpayments. Internal Audits confirms amounts owed and anticipated repayment dates.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, in an overall increase due to additional audit findings requiring repayment and one PERM recovery to be paid. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to additional audit findings anticipated to be paid.

## AUDIT SETTLEMENTS

### REGULAR POLICY CHANGE NUMBER: 209

**Methodology:**

List of audit settlements anticipated to be repaid in FY 2020-21:

No.	Audit Number	Audit Title & Status	Program Responsible	Original Audit Amount	Adjusted Amount
1	A-09-12-02047	<p>Noninstitutional Providers In California Did Not Always Reconcile Invoice Records With Credit Balances and Refund to State Agency the Associated Medicaid Overpayments</p> <p>The Office of Inspector General recommended the Department conduct further audits to determine the actual amount of overpayments. In a separate, unrelated process, A&amp;I contracted an audit which identified \$13,467 in total overpayments. CMS was shown the audit and agreed to reduce the original estimate from \$618,749 to \$13,467.</p>	Audits & Investigations (A&I)	\$618,749	<b>\$13,467</b>
2	A-09-15-02035	<p>California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations</p> <p>Original amount due was \$42,564,416. CMS agreed to reduce the amount of \$41,609,810 upon completion of the appeals process.</p>	Pharmacy Benefits Division (PBD)	\$42,564,416	<b>\$41,609,810</b>
3	A-09-16-02004	<p>California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</p> <p>Original amount due was \$22,043,300. Based on research, Enterprise Data and Information Management (EDIM) believes the amount can be reduced to \$5,855,300 due to offsets and accounting refunds. EDIM began submitting</p>	Enterprise Data and Information Management (EDIM)	\$22,043,300	<b>\$5,855,300</b>



**AUDIT SETTLEMENTS**  
REGULAR POLICY CHANGE NUMBER: 209

		documentation in September 2020 and will meet with CMS to discuss.			
4	State Audit 2019-002	Annual Single Audit FY 2018-19  No appeal requested for the State Audit.	Medi-Cal Eligibility	\$26,400	<b>\$26,400</b>
5	Payment Error Rate Measurement (PERM) Recovery FY 2016-17	California Medicaid Error Rates for Federal Fiscal Year 2016-17  No appeal requested for PERM Recovery.	A&I	\$84,000	<b>\$84,000</b>
				<b>Total</b>	<b>\$47,588,977</b>

List of audit settlements outstanding and anticipated to be repaid in FY 2021-22:

No.	Audit Number	Audit Title	Program Responsible	Estimated Amount
1	A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement By Not Billing Manufactures For Rebates For Some Physician-Administered Drugs	PBD	\$65,812,528
2	A-09-15-02020	California Improperly Claimed Federal Medicaid Reimbursement for Nonemergency Services Provided to Some Qualified Aliens	Medi-Cal Eligibility Division	\$3,775,832
			<b>Total</b>	<b>\$69,588,360</b>

Fiscal Year	TF	GF	FF
FY 2020-21	\$0	\$47,589,000	(\$47,589,000)
FY 2021-22	\$0	\$69,588,000	(\$69,588,000)

**Funding:**

100% GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

## IMD ANCILLARY SERVICES

**REGULAR POLICY CHANGE NUMBER:** 210  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 35

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$15,930,000	\$12,322,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$15,930,000	\$12,322,000
<b>FEDERAL FUNDS</b>	-\$15,930,000	-\$12,322,000

**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: 210**

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 2020-21 is a decrease due to repayment of one quarter of FY 2018-19 FFS repayments and two quarters of FY 2019-20 FFS and MC repayments in FY 2019-20.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to fewer quarters of repayments estimated in FY 2021-22.

#### **Methodology:**

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.
2. For FY 2020-21, the Department estimates to repay FFS deferrals from October 2019 through December 2020 and managed care deferrals from January 2020 to December 2020.
3. For FY 2021-22, the Department estimates to repay FFS deferrals from January 2021 through December 2021 and managed care deferrals from January 2021 through December 2021.

**IMD ANCILLARY SERVICES**  
REGULAR POLICY CHANGE NUMBER: 210

## 4. The estimated IMD repayments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2019-20 Q2 (Oct-Dec 2019)	\$0	\$1,927	(\$1,927)
FY 2019-20 Q3 (Jan-Mar 2020)	\$0	\$2,315	(\$2,315)
FY 2019-20 Q4 (Apr-Jun 2020)	\$0	\$2,315	(\$2,315)
Subtotal FY 2019-20	\$0	\$6,557	(\$6,557)
FY 2020-21 Q1 (Jul-Sep 2020)	\$0	\$3,000	(\$3,000)
FY 2020-21 Q2 (Oct-Dec 2020)	\$0	\$3,000	(\$3,000)
Subtotal FY 2020-21	\$0	\$6,000	(\$6,000)
Subtotal FFS	\$0	\$12,557	(\$12,557)
Managed Care			
FY 2019-20 Q3 and Q4 (Jan-Jun 2020)	\$0	\$2,102	(\$2,102)
FY 2020-21 Q1 and Q2 (Jul- Dec 2020)	\$0	\$1,271	(\$1,271)
Subtotal Managed Care		\$3,373	(\$3,373)
<b>Total FY 2020-21</b>		<b>\$15,930</b>	<b>(15,930)</b>

**IMD ANCILLARY SERVICES**  
REGULAR POLICY CHANGE NUMBER: 210

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Fee-For-Service (FFS)			
FY 2020-21 Q3 (Jan-Mar 2021)	\$0	\$1,705	(\$1,705)
FY 2020-21 Q4 (Apr-Jun 2021)	\$0	\$2,315	(\$2,315)
Subtotal FY 2020-21	\$0	\$4,010	(\$4,010)
FY 2021-22 Q1 (Jul-Sep 2021)	\$0	\$3,000	(\$3,000)
FY 2021-22 Q2 (Oct-Dec 2021)	\$0	\$3,000	(\$3,000)
Subtotal FY 2021-22	\$0	\$6,000	(\$6,000)
Subtotal FFS	\$0	\$10,010	(\$10,010)
Managed Care			
FY 2020-21 Q3 and Q4 (Jan-Jun 2021)	\$0	\$1,271	(\$1,271)
FY 2021-22 Q1 and Q2 (Jul-Dec 2021)	\$0	\$1,041	(\$1,041)
Subtotal Managed Care		\$2,312	(\$2,312)
<b>Total FY 2021-22</b>		<b>\$12,322</b>	<b>(\$12,322)</b>

**Funding:**

100% General Fund (4260-101-0001)

Title XIX FFP (4260-101-0890)

## CIGARETTE AND TOBACCO SURTAX FUNDS

**REGULAR POLICY CHANGE NUMBER:** 211  
**IMPLEMENTATION DATE:** 1/2006  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1087

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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: 211

**Methodology:**

<b>FY 2020-21</b>	
Hospital Services Account	\$92,170,000
Physicians' Services Account	\$26,639,000
Unallocated Account	\$41,848,000
<b>Total CTPS/Prop. 99</b>	<b>\$160,657,000</b>
<b>GF</b>	<b>(\$160,657,000)</b>
<b>Net Impact</b>	<b>\$0</b>

<b>FY 2021-22</b>	
Hospital Services Account	\$77,295,000
Physicians' Services Account	\$22,072,000
Unallocated Account	\$32,503,000
<b>Total CTPS/Prop. 99</b>	<b>\$131,870,000</b>
<b>GF</b>	<b>(\$131,870,000)</b>
<b>Net Impact</b>	<b>\$0</b>

**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)

## FUNDING ADJUST.—ACA OPT. EXPANSION

**REGULAR POLICY CHANGE NUMBER:** 212  
**IMPLEMENTATION DATE:** 7/2015  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1915

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$1,898,984,800	-\$1,948,043,200
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$1,898,984,800	-\$1,948,043,200
<b>FEDERAL FUNDS</b>	\$1,898,984,800	\$1,948,043,200

**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:**

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  
 Prop 56 - CBAS Supplemental Payments  
 COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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. 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 change from the prior estimate, for FY 2020-21, is an increase in general fund savings due to updates and additional policy changes. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase in general fund savings due to updated policy changes.



**FUNDING ADJUST.—ACA OPT. EXPANSION**  
REGULAR POLICY CHANGE NUMBER: 212

**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 2020-21 and FY 2021-22 is 90%.
- 3) The total amount of unadjusted ACA optional expansion funding for all policy changes in FY 2020-21 is estimated as \$4,747,461,846 and \$4,870,107,673 in FY 2021-22. These amounts are credited to the Title XIX fund.
- 4) The amounts adjusted by this policy change are as follows:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>GF</b>	<b>FF</b>
Fee-For-Service Base Expenditures	(\$1,834,517)	\$1,834,517
DPH Interim Rate Growth	(\$31,289)	\$31,289
AB 1629 Annual Rate Adjustments	(\$2,281)	\$2,281
LTC Rate Adjustment	(\$629)	\$629
Hospice Rate Increases	(\$183)	\$183
Reduction To Radiology Rates	\$347	(\$347)
Laboratory Rate Methodology Change	\$3,350	(\$3,350)
Prop 56 - CBAS Supplemental Payments	(\$8,275)	\$8,275
COVID-19 FFS Reimbursement Rates	(\$25,508)	\$25,508
<b>Total</b>	<b>(\$1,898,985)</b>	<b>\$1,898,985</b>

\*Totals may differ due to rounding

<b>FY 2021-22</b>	<b>GF</b>	<b>FF</b>
Fee-For-Service Base Expenditures	(\$1,891,302)	\$1,891,302
DPH Interim Rate Growth	(\$42,881)	\$42,881
AB 1629 Annual Rate Adjustments	(\$4,562)	\$4,562
LTC Rate Adjustment	(\$1,099)	\$1,099
Hospice Rate Increases	(\$300)	\$300
Reduction To Radiology Rates	\$1,100	(\$1,100)
Laboratory Rate Methodology Change	\$4,441	(\$4,441)
Prop 56 - CBAS Supplemental Payments	(\$7,065)	\$7,065
COVID-19 FFS Reimbursement Rates	(\$6,375)	\$6,375
<b>Total</b>	<b>(\$1,948,043)</b>	<b>\$1,948,043</b>

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**FUNDING ADJUST.—ACA OPT. EXPANSION**  
**REGULAR POLICY CHANGE NUMBER: 212****Funding:**

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

**FUNDING ADJUST.—OTLICP**

**REGULAR POLICY CHANGE NUMBER:** 213  
**IMPLEMENTATION DATE:** 7/2015  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1926

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$105,944,100	-\$90,361,050
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$105,944,100	-\$90,361,050
<b>FEDERAL FUNDS</b>	\$105,944,100	\$90,361,050

**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  
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  
GDSP Newborn Screening Program Fee Increase  
COVID-19 FFS Reimbursement Rates  
COVID-19 Increased FMAP – DHCS  
COVID-19 Increased FMAP Extension – DHCS

**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.—OTLICP**  
**REGULAR POLICY CHANGE NUMBER: 213**

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a general fund savings decrease due to updates and additional policy changes. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a general fund savings decrease due to the changes in the Federal Medical Assistance Percentage and updates to policy changes.

**Methodology:**

- 1) The Department identified funds allocated to CHIP beneficiaries in the OTLICP 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 2020-21 is estimated as \$591,097,136 and \$602,407,333 in FY 2021-22. 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 2020-21, the Department estimates the additional CHIP funding will offset general fund spending by \$105.9M.
  - b. In FY 2021-22, the Department estimates the additional CHIP funding will offset general fund spending by \$90.4M.
- 4) The amounts adjusted by policy change are as follows:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Fee-For-Service Base Expenditures	\$0	(\$102,979)	\$102,979
Rate Increase for FQHCs/RHCs/CBRCs	\$0	(\$1,039)	\$1,039
FQHC/RHC/CBRC Reconciliation Process	\$0	(\$304)	\$304
AB 1629 Annual Rate Adjustments	\$0	(\$20)	\$20
LTC Rate Adjustment	\$0	(\$5)	\$5
Hospice Rate Increases	\$0	(\$54)	\$54
10% Provider Payment Reduction	\$0	\$109	(\$109)
Laboratory Rate Methodology Change	\$0	\$287	(\$287)
Reduction to Radiology Rates	\$0	\$25	(\$25)
GDSP Newborn Screening Program Fee Increase	\$0	(\$16)	\$16
COVID-19 FFS Reimbursement Rates	\$0	(\$1,948)	\$1,948
<b>Total</b>	<b>\$0</b>	<b>(\$105,944)</b>	<b>\$105,944</b>

**FUNDING ADJUST.—OTLCP**  
**REGULAR POLICY CHANGE NUMBER: 213**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Fee-For-Service Base Expenditures	\$0	(\$89,026)	\$89,026
Rate Increase for FQHCs/RHCs/CBRCs	\$0	(\$987)	\$987
FQHC/RHC/CBRC Reconciliation Process	\$0	(\$267)	\$267
AB 1629 Annual Rate Adjustments	\$0	(\$37)	\$37
LTC Rate Adjustment	\$0	(\$9)	\$9
Hospice Rate Increases	\$0	(\$88)	\$88
10% Provider Payment Reduction	\$0	\$95	(\$95)
Laboratory Rate Methodology Change	\$0	\$331	(\$331)
Reduction to Radiology Rates	\$0	\$69	(\$69)
GDSP Newborn Screening Program Fee Increase	\$0	(\$19)	\$19
COVID-19 FFS Reimbursement Rates	\$0	(\$423)	\$423
<b>Total</b>	<b>\$0</b>	<b>(\$90,361)</b>	<b>\$90,361</b>

**Funding:**

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

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

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

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CMS DEFERRED CLAIMS

**REGULAR POLICY CHANGE NUMBER:** 214  
**IMPLEMENTATION DATE:** 4/2017  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2034

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$567,553,000	\$200,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$567,553,000	\$200,000,000
<b>FEDERAL FUNDS</b>	-\$567,553,000	-\$200,000,000

**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 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.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to the updated FFY 2019 Quarter 3, FFY 2019 Quarter 4, FFY 2020 Quarter 1, and FFY 2020 Q2 repayment amounts based on the actual CMS deferrals.

## CMS DEFERRED CLAIMS

### REGULAR POLICY CHANGE NUMBER: 214

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to actual CMS deferral repayment amounts in FY 2020-21 and expected number of quarterly CMS deferrals to be current by FY 2021-22.

#### Methodology:

1. The Department received CMS deferrals for FFY 2015 Quarter 1 through FFY 2020 Quarter 2.
2. The Department repaid the FFY 2015 Quarters 1 and 2 deferrals in FY 2016-17, the FFY 2015 Quarters 3 and 4 and FFY 2016 Quarters 1 through 3 deferrals in FY 2017-18, the FFY 2016 Quarter 4 through FFY 2018 Quarter 2 deferrals in FY 2018-19, and the FFY 2018 Quarter 3 through FFY 2019 Quarter 2 and the disallowance of TCM claims from FFY 2003 Quarter 4 through FFY 2010 Quarter 4 in FY 2019-20. 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 2020-21, the Department estimates to repay a total of \$567.553 million FF, which includes \$417.553 million of actual CMS deferrals issued for the quarters from FFY 2019 Quarter 3 through FFY 2020 Quarter 2.
4. Repayments for state-only costs deferrals totaling \$43.473 million FF (FFY 2020 Quarter 1) and \$272.662 million FF (FFY 2020 Quarter 2) are in the FY 2020-21 totals.
5. In FY 2021-22, the Department estimates to repay \$200 million FF for projected repayments.
6. The Department will repay the following estimated deferred claims:

(Dollars in Thousands)

FY 2020-21	Total Estimated Repayment
FFY 2019 Quarter 3 (Apr-Jun 2019)	\$11,485
FFY 2019 Quarter 4 (Jul-Sep 2019)	\$11,183
FFY 2020 Quarter 1 (Oct-Dec 2019)	\$70,296
FFY 2020 Quarter 2 (Jan-Mar 2020)	\$324,589
FFY 2020 Quarter 3 (Apr-Jun 2020)	\$50,000
FFY 2020 Quarter 4 (Jul-Sep 2020)	\$50,000
FFY 2021 Quarter 1 (Oct-Dec 2020)	\$50,000
<b>Total FY 2020-21</b>	<b>\$567,553</b>

**CMS DEFERRED CLAIMS**  
**REGULAR POLICY CHANGE NUMBER: 214**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>Total Estimated Repayment</b>
FFY 2021 Quarter 2 (Jan-Mar 2020)	\$50,000
FFY 2021 Quarter 3 (Apr-Jun 2020)	\$50,000
FFY 2021 Quarter 4 (Jul-Sep 2020)	\$50,000
FFY 2022 Quarter 1 (Oct-Dec 2020)	\$50,000
<b>Total FY 2021-22</b>	<b>\$200,000</b>

**Funding:**

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

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

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

100% Title XXI GF (4260-113-0001)



**CLPP FUND**

**REGULAR POLICY CHANGE NUMBER:** 215  
**IMPLEMENTATION DATE:** 7/2005  
**ANALYST:** Sasha Jetton  
**FISCAL REFERENCE NUMBER:** 1633

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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 105285,105295,105305 and 105310  
 Interagency Agreement (IA) # 19-96093

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Medi-Cal provides blood lead tests to children at ages 12 and 24 months of age, or at any age at which the child is identified as at risk for lead poisoning and consistently offered to families for children age 24 to 72 months who were not tested earlier, or if there is no record of a previous test, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnostic, 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 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: 215**

The new IA establishes the Childhood Lead Poisoning Prevention (CLPP) program activities to be completed by the county staff of the Child Health and Disability Prevention (CHDP) program. The three-year agreement provides for annual costs.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21 or between fiscal years.

**Methodology:**

The CLPP Funding for FY 2020-21 and FY 2021-22 is assumed to be \$916,000.

**Funding:****FY 2020-21**

100% CLPP Fund (4260-111-0080)	\$ 916,000
<b>100% GF (4260-101-0001)</b>	<b>\$ (916,000)</b>
<b>Net Impact</b>	<b>\$ -</b>

**FY 2021-22**

100% CLPP Fund (4260-111-0080)	\$ 916,000
<b>100% GF (4260-101-0001)</b>	<b>\$ (916,000)</b>
<b>Net Impact</b>	<b>\$ -</b>

## HOSPITAL QAF - CHILDREN'S HEALTH CARE

**REGULAR POLICY CHANGE NUMBER:** 216  
**IMPLEMENTATION DATE:** 4/2015  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1760

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to the permanent extension of a quality assurance fee (QAF) for hospitals authorized under Proposition 52.

For more information about the Hospital QAF, see the Hospital QAF - FFS Payments, Hospital QAF - Managed Care Payments, and Managed Care Private Hospital Directed Payments policy changes.

**Authority:**

SB 239 (Chapter 657, Statutes of 2013)  
Proposition 52 (2016)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

SB 335 (Chapter 286, Statutes of 2011) established the Hospital QAF program from July 1, 2011, through December 31, 2013, which provided 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 and provided instructions for implementation of future program periods. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014 and received approval for these SPAs in December 2014.

SB 239 also requires the Department to increase capitation payments for the actuarial equivalent of AB 113 (Chapter 20, Statutes of 2011) payments to non-designated public hospitals (NDPH).

## HOSPITAL QAF - CHILDREN'S HEALTH CARE

### REGULAR POLICY CHANGE NUMBER: 216

Proposition 52, approved by California voters on November 8, 2016, permanently extended the Hospital QAF program. The HQAF V program period was approved in December 2017 with a retroactive effective date of January 1, 2017, and an end date of June 30, 2019.

The Department received federal approval for the QAF VI program period (July 1, 2019 through December 31, 2021) in February 2020. This QAF program period is referred to as HQAF VI.

#### Reason for Change:

The change for FY 2020-21, from the prior estimate, is a net increase in savings due to:

- Updated FY 2019-20 and FY 2020-21 HQAF VI savings based on the available funding estimated for the payments, and
- Increased savings from the delay of the HQAF IV reconciliation payments to FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease in savings due to:

- Fewer quarters of payments estimated in FY 2021-22, and
- Completion of the HQAF IV reconciliation in FY 2020-21.

#### Methodology:

1. Payments for children's health care are estimated through the period ending December 31, 2021 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 for HQAF V are based on the approved HQAF V Fee & Payment Model.
6. HQAF VI payments are based on the HQAF VI model that was approved by CMS on February 20, 2020. In February 2020, the payment schedule is still under development, so timings are subject to change.
7. HQAF VI children's coverage payments for FY 2019-20 and 2020-21 have been fully or partially postponed due to the COVID-19 emergency. Partial payments will be made when possible, as long as FFS payments can be made in full. The children's coverage payments will be reconciled and paid in full at a later date.

## HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 216

8. 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

(Dollars in Thousands)

Fiscal Year	Authority	HQAF V Period (30 months)	Amount
FY 2016-17	Proposition 52 (1/1/17 and forward)	1/1/17 to 6/30/17	\$513,154
FY 2017-18	Proposition 52	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 (30 months)	Amount
FY 2019-20	Proposition 52	7/1/19 to 6/30/20	\$978,000
FY 2020-21	Proposition 52	7/1/20 to 6/30/21	\$1,009,200
FY 2021-22	Proposition 52	7/1/21 to 12/31/21	\$509,250

9. 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 2020-21.
10. Five quarters of HQAF VI children's health care payments will be paid in FY 2020-21. The payments have been reduced in response to the COVID-19 emergency and will be reconciled at a later date.
11. Three quarters of HQAF VI children's health care payments will be paid in FY 2021-22.
12. On a cash basis, the payments to health care coverage for children and the funding adjustment are:

(Dollars in Thousands)

FY 2020-21	TF	GF	Hosp. QA Rev Fund
HQAF IV (FY 2014-15 through FY 2016-17)	\$0	(\$107,845)	\$107,845
FY 2019-20	\$0	(\$489,000)	\$489,000
FY 2020-21	\$0	(\$555,060)	\$555,060
<b>Total FY 2020-21</b>	<b>\$0</b>	<b>(\$1,151,905)</b>	<b>\$1,151,905</b>

**HOSPITAL QAF - CHILDREN'S HEALTH CARE**  
REGULAR POLICY CHANGE NUMBER: 216

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Hosp. QA Rev Fund</b>
FY 2020-21	\$0	(\$252,300)	\$252,300
FY 2021-22	\$0	(\$509,250)	\$509,250
<b>Total FY 2021-22</b>	<b>\$0</b>	<b>(\$761,550)</b>	<b>\$761,550</b>

**Funding:**

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

## REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS

**REGULAR POLICY CHANGE NUMBER:** 217  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2192

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$10,370,000	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$10,370,000	\$0
<b>FEDERAL FUNDS</b>	-\$10,370,000	\$0

**Purpose:**

This policy change estimates the repayment of over-claimed federal financial participation (FFP) for contingency fee offsets reported for the period October 2016 to September 2018.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department contracts with a safety net recovery vendor, Health Management Systems, Inc. (HMS), to pursue recovery of Medi-Cal paid claims when a liable third party is identified post-payment. HMS is paid on a contingency fee basis, receiving 8.5% of all recovered funds. On a monthly basis, HMS submits invoices to the Department for services performed. The invoiced amounts are identified in the Medi-Cal Recovery Contracts policy change.

During the period from October 2016 to February 2019, the Department double-reported the HMS contract's contingency fee payments to the Centers for Medicare and Medicaid Services (CMS). CMS deferred contingency fee offsets from October 2018 to February 2019; see the CMS Deferred Claims policy change for information on the repayments of the deferred payments from Federal Fiscal Year (FFY) 2019 Quarters 1 and 2.

CMS has also requested the return of federal funds from October 2016 to September 2018.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of this repayment to CMS in FY 2020-21.

## REPAYMENT TO CMS FOR CONTINGENCY FEE OFFSETS

REGULAR POLICY CHANGE NUMBER: 217

**Methodology:**

1. The Department returned \$10,370,142 FFP that was over-claimed for the period from October 2016 to September 2018 in July 2020.

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Repayment to CMS	\$0	\$10,370	(\$10,370)

**Funding:**

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

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



## INDIAN HEALTH SERVICES FUNDING SHIFT

**REGULAR POLICY CHANGE NUMBER:** 218  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2156

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	-\$12,500,000	-\$13,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$12,500,000	-\$13,000,000
<b>FEDERAL FUNDS</b>	\$12,500,000	\$13,000,000

**Purpose:**

This policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health facilities to American Indians (AIs) eligible for Fee-For-Service (FFS) Medi-Cal.

**Authority:**

Public Law 93-638  
Public Law 102-573

**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.

The Department implemented the enrollment and reimbursement of Youth Regional Treatment Centers (YRTCs) for services rendered to AI youths. Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance use disorder treatment. The Department receives 100% FFP for YRTC services provided to eligible AI Medi-Cal members under the age of 21.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian health clinics is adjusted annually through changes posted in the Federal Register. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

## INDIAN HEALTH SERVICES FUNDING SHIFT

### REGULAR POLICY CHANGE NUMBER: 218

**Reason for Change:**

The change from the prior estimate for FY 2020-21, is a decrease due to prior year expenditures decreasing slightly. Base expenditures decreased from \$26,000,000 TF in FY 2018-19 to \$23,300,000 TF in FY 2019-20. YRTCs are now budgeted in this policy change. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to projected growth from Indian health facilities.

**Methodology:**

1. Currently, there are 95 Indian health clinics participating in Medi-Cal and 7 YRTCs. The YRTC costs were previously budgeted in a separate policy change.
2. In FY 2020-21, it is estimated the Department will spend \$25,000,000 TF (\$12,500,000 GF). The total includes \$735,000 TF (\$368,000 GF) to be paid to YRTCs.
3. In FY 2021-22, it is estimated the Department will spend \$26,000,000 TF (\$13,000,000 GF). The total includes \$772,000 (\$386,000 GF) to be paid to YRTCs.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
IHS FY 2020-21 Base exp. (50% GF / 50% FF)	(\$25,000)	(\$12,500)	(\$12,500)
IHS total expenditures (100% FF)	\$25,000	\$0	\$25,000
<b>FY 2020-21 Total</b>	<b>\$0</b>	<b>(\$12,500)</b>	<b>\$12,500</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
IHS FY 2021-22 Base exp. (50% GF / 50% FF)	(\$26,000)	(\$13,000)	(\$13,000)
IHS total expenditures (100% FF)	\$26,000	\$0	\$26,000
<b>FY 2021-22 Total</b>	<b>\$0</b>	<b>(\$13,000)</b>	<b>\$13,000</b>

**Funding:**

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

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

## FUND 3156 TRANSFER TO THE GENERAL FUND

**REGULAR POLICY CHANGE NUMBER:** 219  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2227

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change transfers dollars from Fund 3156 to the General Fund.

**Authority:**

SBx2 2 (Chapter 2, Statutes of 2016)

**Interdependent Policy Changes:**

Not applicable

**Background:**

SB 78 was signed by the Governor on June 27, 2013, and provided 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). The tax revenue was used to increase capitation rates for health care services provided to children, seniors, persons with disabilities, and dual eligible in the Medi-Cal program.

This MCO tax was effective July 1, 2013, through June 30, 2016. A portion of the remaining funds will be transferred to the General Fund. The remaining funds are subject to final reconciliation of amounts paid by Medi-Cal Managed Care plans to amounts due. The reconciliation has been delayed due to retroactive revenue adjustments such as the ACA Optional Expansion Medical Loss Ratio Risk Corridor.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Estimated funds to be transferred to the General Fund in FY 2020-21 is \$100,000,000.

**Funding:**

100% State GF (4260-101-0001)  
 \*3156 MCO (Non-GF) (4260-601-3156)

## FUND 3311 TRANSFER TO THE GENERAL FUND

**REGULAR POLICY CHANGE NUMBER:** 220  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2228

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change transfers dollars from Fund 3311 to the General Fund.

**Authority:****Interdependent Policy Changes:**

Not applicable

**Background:**

The Health Care Services Plans Fines and Penalties Fund is used to deposit various fines and administrative penalties for the licensing and regulation of health care service plans by the Department of Managed Health Care (DMHC). Funds are used to support coverage for individuals remaining in the Major Risk Medical Insurance Program (MRMIP) and Medi-Cal program. Residual dollars remaining in the fund will be transferred to the State General Fund.

**Reason for Change:**

The change from the prior estimate for 2020-21 is due to updated estimates of MRMIP expenditures for the current year and budget year.

**Methodology:**

1. Estimated funds to be transferred to the General Fund in FY 2020-21 are \$20,000,000.

**Funding:**

Health Care Services Plans Fines and Penalties Fund (4260-601-3311)  
 Title XIX GF (4260-101-0001)

## STATE ONLY CLAIMING ADJUSTMENTS

**REGULAR POLICY CHANGE NUMBER:** 221  
**IMPLEMENTATION DATE:** 10/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2210

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$145,571,000
<b>- STATE FUNDS</b>	\$293,749,000	\$260,102,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$145,571,000
<b>STATE FUNDS</b>	\$293,749,000	\$260,102,000
<b>FEDERAL FUNDS</b>	-\$293,749,000	-\$114,531,000

### Purpose:

This policy change estimates (1) the return of Federal Financial Participation (FFP) to the federal government for claiming for non-emergency or non-pregnancy related services provided to individuals without satisfactory immigrant status in full scope Medi-Cal coverage; (2) the claiming of FFP for certain immigrant populations for which the state has previously underclaimed; and (3) the fiscal impact of prospective adjustments for these populations. This policy change relates to state only claiming adjustments for managed care, pharmacy, dental, services provided by the California Department of Developmental Services (CDDS), and underclaiming related to immigration status change.

For information on the state only claiming adjustments for the Medi-Cal Specialty Mental Health Services programs (SMHS) and Drug Medi-Cal (DMC) programs, please see the State Only Claiming Adjustments – SMHS and DMC policy change. For information on the state only claiming adjustments for the Medi-Cal Targeted Case Management (TCM) program, please see the State Only Claiming Adjustments – TCM policy change.

### Authority:

Not Applicable

### Interdependent Policy Changes:

State Only Claiming Adjustments – SMHS and DMC

State Only Claiming Adjustments – TCM

### Background:

California provides state only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and non-emergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

## STATE ONLY CLAIMING ADJUSTMENTS

### REGULAR POLICY CHANGE NUMBER: 221

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department has estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

The Department has also identified underclaiming for individuals who have a change in immigration status such that they now meet the five-year bar and become eligible for non-emergency and non-pregnancy related FFP claiming, but for which state systems lack business rules to appropriately identify and claim FFP.

#### CMS Deferral

On July 23, 2020, CMS issued a deferral for the state only claiming issue, for the Federal Fiscal Year (FFY) 2020 Quarter 1. On October 5, 2020, CMS issued a deferral for FFY 2020 Quarter 2. The Department anticipates that these deferrals will ultimately be reconciled against the Department's total estimated repayments owed to the federal government. See the CMS Deferred Claims policy change for details on CMS deferral payments.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is due to the following changes:

- The policy change now includes separate displays for the FFP repayments and prospective adjustments.
- The pharmacy rebates, dental, and CDDS retroactive repayments and prospective estimates have been updated based on more recent data.
- Retroactive repayments for managed care were identified and have been added to this policy change.
- Underclaiming of federal funds related to change in immigration status was identified and has been added to this policy change.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the assumed completion of most retroactive federal repayments in FY 2020-21.

#### **Methodology:**

##### **Retroactive FFP Adjustments**

1. Federal repayments are estimated for Managed Care, Pharmacy Rebates, Dental Fee-for-Service (FFS), Dental Managed Care (MC), and California Department of Developmental Services (CDDS) programs.
2. The Department identified that the proxy used to adjust managed care capitation payments for state only populations had not been applied consistently, resulting in the need for retroactive repayments in managed care estimated at \$92 million, for payments from January 2013 through December 2020.
3. Estimates of FFP repayments for Pharmacy Rebates cover claims from May 2016 to March 2021.
4. Estimates of FFP repayments for Dental FFS and Dental Managed Care cover claims from July 2010 through September 2020.
5. Estimates of FFP repayments for CDDS cover prior claims from July 2010 through June 2020.

**STATE ONLY CLAIMING ADJUSTMENTS**  
REGULAR POLICY CHANGE NUMBER: 221

6. The estimated repayments are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$126,756	\$0	(\$126,756)	\$0
Drug Medi-Cal	\$0	\$4,840	\$0	(\$4,840)	\$0
Subtotal (In PC 244)	\$0	\$131,596	\$0	(\$131,596)	\$0
Managed Care	\$0	\$92,383	\$0	(\$92,383)	\$0
Pharmacy Rebates	\$0	\$47,200	\$0	(\$47,200)	\$0
Dental FFS and Managed Care	\$0	\$114,352	\$0	(\$114,352)	\$0
CDDS	\$0	\$0	\$227,753	(\$227,753)	\$0
Immigration Status Change	\$0	(\$155,716)	\$0	\$155,716	\$0
<b>Subtotal (In PC 221)</b>	<b>\$0</b>	<b>\$98,219</b>	<b>\$227,753</b>	<b>(\$325,972)</b>	<b>\$0</b>
Targeted Case Management	\$0	\$42,652	\$0	(\$42,652)	\$0
Subtotal (In PC 245)	\$0	\$42,652	\$0	(\$42,652)	\$0
<b>Grand Total</b>	<b>\$0</b>	<b>\$272,467</b>	<b>\$227,753</b>	<b>(\$500,220)</b>	<b>\$0</b>

\*County Funds are not included in Total Funds

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0	\$0
Subtotal (In PC 244)	\$0	\$0	\$0	\$0	\$0
Managed Care	\$0	\$0	\$0	\$0	\$0
Pharmacy Rebates	\$0	\$12,000	\$0	(\$12,000)	\$0
Dental FFS and Managed Care	\$0	\$0	\$0	\$0	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0	\$0	\$0
<b>Subtotal (In PC 221)</b>	<b>\$0</b>	<b>\$12,000</b>	<b>\$0</b>	<b>(\$12,000)</b>	<b>\$0</b>
Targeted Case Management	\$0	\$0	\$0	\$0	\$0
Subtotal (In PC 245)	\$0	\$0	\$0	\$0	\$0
<b>Grand Total</b>	<b>\$0</b>	<b>\$12,000</b>	<b>\$0</b>	<b>(\$12,000)</b>	<b>\$0</b>

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS**  
REGULAR POLICY CHANGE NUMBER: 221

\*County Funds are not included in Total Funds

**Prospective Adjustments**

7. Prospective adjustments are estimated for Managed Care, Pharmacy Rebates, Pharmacy Claims, Dental FFS, Dental Managed Care, and Immigration Status Change. No prospective impact is assumed for CDDS in this policy change, as these adjustments are already reflected in other policy changes that budget ongoing CDDS funding.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	(\$2,970)	\$6,863	\$0	(\$9,833)	\$2,970
Drug Medi-Cal	(\$199)	\$666	\$0	(\$865)	\$199
Subtotal (In PC 244)	(\$3,169)	\$7,529	\$0	(\$10,698)	\$3,169
Managed Care	\$0	\$59,100	\$0	(\$59,100)	\$0
Pharmacy Rebates	\$0	\$0	\$0	\$0	\$0
Pharmacy Claims	\$0	\$16,406	\$0	(\$16,406)	\$0
Dental FFS and Managed Care	\$0	\$19,327	\$0	(\$19,327)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,056)	\$0	\$127,056	\$0
<b>Subtotal (In PC 221)</b>	<b>\$0</b>	<b>(\$32,223)</b>	<b>\$0</b>	<b>\$32,223</b>	<b>\$0</b>
Targeted Case Management	\$0	\$1,979	\$0	(\$1,979)	\$0
Subtotal (In PC 245)	\$0	\$1,979	\$0	(\$1,979)	\$0
<b>Grand Total</b>	<b>(\$3,169)</b>	<b>(\$22,715)</b>	<b>\$0</b>	<b>\$19,546</b>	<b>\$3,169</b>

\*County Funds are not included in Total Funds



## STATE ONLY CLAIMING ADJUSTMENTS

### REGULAR POLICY CHANGE NUMBER: 221

(Dollars in Thousands)

FY 2021-22	TF	GF	Reimbursement (SF)	FF	CF*
SMHS	(\$5,941)	\$13,726	\$0	(\$19,667)	\$5,941
Drug Medi-Cal	(\$398)	\$1,331	\$0	(\$1,729)	\$398
Subtotal (In PC 244)	(\$6,339)	\$15,057	\$0	(\$21,396)	\$6,339
Managed Care	\$0	\$151,582	\$0	(\$151,582)	\$0
Pharmacy Rebates	\$145,571	\$145,571	\$0	\$0	\$0
Pharmacy Claims	\$0	\$52,723	\$0	(\$52,723)	\$0
Dental FFS and Managed Care	\$0	\$25,770	\$0	(\$25,770)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,544)	\$0	\$127,544	\$0
<b>Subtotal (In PC 221)</b>	<b>\$145,571</b>	<b>\$248,102</b>	<b>\$0</b>	<b>(\$102,531)</b>	<b>\$0</b>
Targeted Case Management	\$0	\$3,958	\$0	(\$3,958)	\$0
Subtotal (In PC 245)	\$0	\$3,958	\$0	(\$3,958)	\$0
<b>Grand Total</b>	<b>\$139,232</b>	<b>\$267,117</b>	<b>\$0</b>	<b>(\$127,885)</b>	<b>\$6,339</b>

\*County Funds are not included in Total Funds

8. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
SMHS and DMC (PC 244)	(\$3,169)	\$139,125	\$0	(\$142,294)	\$3,169
<b>MC, Pharmacy, Dental, CDDS, Immigration (PC 221)</b>	<b>\$0</b>	<b>\$65,996</b>	<b>\$227,753</b>	<b>(\$293,749)</b>	<b>\$0</b>
TCM (PC 245)	\$0	\$44,631	\$0	(\$44,631)	\$0
FY 2020-21	(\$3,169)	\$249,752	\$227,753	(\$480,674)	\$3,169

\*County Funds are not included in Total Funds

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
SMHS and DMC (PC 244)	(\$6,339)	\$15,057	\$0	(\$21,396)	\$6,339
<b>MC, Pharmacy, Dental, CDDS, Immigration (PC 221)</b>	<b>\$145,571</b>	<b>\$260,102</b>	<b>\$0</b>	<b>(\$114,531)</b>	<b>\$0</b>
TCM (PC 245)	\$0	\$3,958	\$0	(\$3,958)	\$0
FY 2021-22	\$139,232	\$279,117	\$0	(\$139,885)	\$6,339

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS**  
**REGULAR POLICY CHANGE NUMBER: 221**

**Funding:**

100% Title XIX GF (4260-101-0001)  
100% Title XXI GF (4260-113-0001)  
100% Title XIX FF (4260-101-0890)  
100% Title XXI FF (4260-113-0890)  
Reimbursement GF (4260-601-0995)

## ASSISTED LIVING WAIVER EXPANSION

**REGULAR POLICY CHANGE NUMBER:** 222  
**IMPLEMENTATION DATE:** 10/2018  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2054

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$55,933,000	-\$58,075,000
<b>- STATE FUNDS</b>	-\$27,966,500	-\$29,037,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	68.60 %	69.10 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$17,563,000	-\$17,945,200
<b>STATE FUNDS</b>	-\$8,781,480	-\$8,972,590
<b>FEDERAL FUNDS</b>	-\$8,781,480	-\$8,972,590

**Purpose:**

This policy change estimates the cost to increase the capacity of the Assisted Living Waiver (ALW).

**Authority:**

SB 840 (Chapter 29, Statutes of 2018)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS  
 COVID-19 Increased FMAP Extension – DHCS

**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 received approval from the Centers for Medicare and Medicaid Services to expand the ALW by 2,000 waiver slots from 3,744 slots to 5,744 slots for FY 2017-18, FY 2018-19, FY 2019-20, and FY 2020-21 to accommodate current and anticipated need. A reserve capacity is set for new enrollments which will require that 60% of all new enrollments be reserved for individuals transitioning from institutional settings.

**Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease in savings due to lower estimated enrollment based on actuals through December 2019. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in savings due to additional participants transitioning into the ALW.

**Methodology:**

1. Assume 2,000 new participants will be phased in by FY 2020-21.
2. Of the new 2,000 participants, assume 1,200 will be from an institution and 800 will be from the community.

**ASSISTED LIVING WAIVER EXPANSION**  
REGULAR POLICY CHANGE NUMBER: 222

3. Assume the average annual cost for waiver services is \$16,477.
4. Assume the average annual cost in an SNF is \$77,280.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Total Cost from Waiver Services	\$36,360	\$18,180	\$18,180
Total Savings from SNF Transitions	(\$92,293)	(\$46,147)	(\$46,146)
<b>Net Impact Savings</b>	<b>(\$55,933)</b>	<b>(\$27,967)</b>	<b>(\$27,966)</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Total Cost from Waiver Services	\$37,752	\$18,876	\$18,876
Total Savings from SNF Transitions	(\$95,827)	(\$47,914)	(\$47,913)
<b>Net Impact Savings</b>	<b>(\$58,075)</b>	<b>(\$29,038)</b>	<b>(\$29,037)</b>

**Funding:**

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

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – DHCS policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## COUNTY SHARE OF OTLICP-CCS COSTS

**REGULAR POLICY CHANGE NUMBER:** 223  
**IMPLEMENTATION DATE:** 7/2014  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1906

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$22,168,000	-\$25,748,000
<b>- STATE FUNDS</b>	-\$22,168,000	-\$25,748,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$22,168,000	-\$25,748,000
<b>STATE FUNDS</b>	-\$22,168,000	-\$25,748,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**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)  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS

**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. From October 1, 2015, to September 30, 2019, CCS-HFP is funded with 88% FFP, 6% GF, and 6% county funds. Effective October 1, 2019, to September 30, 2020, CCS-HFP will be funded with 76.5% FFP, 11.75% GF, and 11.75% county funds. Effective October 1, 2020 CCS-HFP will be funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under OTLICP.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) 4.34% for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## COUNTY SHARE OF OTLICIP-CCS COSTS

### REGULAR POLICY CHANGE NUMBER: 223

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is a slight decrease in GF savings due to increased FMAP from the FFCRA reducing the county share of reimbursement by 2.17%. The change from FY 2020-21 to 2021-22, in the current estimate, is an increase in GF savings due to Title XXI FMAP decreases through FY 2021-22, including elimination of the increased FMAP for the FFCRA on December 31, 2021.

#### Methodology:

1. The county share reimbursement for OTLICIP-CCS in FY 2020-21, at 11.75% for quarter 1 and 17.5% for quarters 2 through 4, is estimated to be \$22,660,000.
2. The county share reimbursement for OTLICIP-CCS in FY 2021-22, at 17.5% for quarter 1 through 4, is estimated to be \$25,748,000.
3. For FY 2020-21, assume the increased FMAP for COVID-19 is 4.34% for Title XXI. The increased FMAP reduces the county share of reimbursement for OTLICIP-CCS costs by \$492,000.
4. For FY 2021-22, assume the increased FMAP for COVID-19 is 4.34% for Title XXI. The increased FMAP reduces the county share of reimbursement for OTLICIP-CCS costs by \$279,000. This reduction is assumed to continue through December 31, 2021, and is included in the COVID-19 Increased FMAP Extension – DHCS policy change.
5. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021, for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – DHCS policy change.
6. The county share of OTLICIP-CCS costs is estimated in the table below:

Fiscal Year	TF	GF	CF*
FY 2020-21	(\$22,168,000)	(\$22,168,000)	\$22,168,000
FY 2021-22	(\$25,748,000)	(\$25,748,000)	\$25,748,000

\* County Funds are not included in the Total Fund.

#### Funding:

100% Title XXI State GF (4260-113-0001)  
 FFCRA 4.34% Increased GF (4260-113-0001)  
 COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS policy change

## CALAIM ECM-ILOS-PLAN INCENTIVES

**REGULAR POLICY CHANGE NUMBER:** 225  
**IMPLEMENTATION DATE:** 2/2022  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 2245

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$535,417,000
<b>- STATE FUNDS</b>	\$0	\$267,708,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$535,417,000
<b>STATE FUNDS</b>	\$0	\$267,708,500
<b>FEDERAL FUNDS</b>	\$0	\$267,708,500

**Purpose:**

This policy change estimates the costs to implement a statewide Enhanced Care Management (ECM) benefit, In Lieu of Services (ILOS), and plan incentives to build infrastructure linked to reform within the Medi-Cal managed care delivery system.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Effective January 1, 2022, the Department proposes to implement a new ECM benefit and 14 ILOS in the Medi-Cal managed care delivery system in order to build upon and transition several successful elements from the Whole Person Care pilot and the Health Homes Program, and to establish Medi-Cal managed care health plan (MCP) incentives linked to delivery system reform through investments in ILOS and enhanced care management. Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs will implement the new ECM benefit on July 1, 2022, for most mandated target populations. The target population of individuals transitioning from incarceration will be implemented on January 1, 2023 in all counties.

The new ECM benefit transitions successful elements from the current Health Homes Program benefit and the Whole Person Care pilots to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need/high-cost Medi-Cal beneficiaries.

The ECM benefit will be available for Medi-Cal managed care members at the highest risk level who need long-term and intensive coordination for multiple chronic conditions, including behavioral health conditions, as well as utilization of multiple service types and delivery systems. The benefit aims to improve care coordination, integrate services, facilitate access to and utilization of community resources, improve health outcomes, address social determinants of health and decrease inappropriate utilization.

## **CALAIM ECM-ILOS-PLAN INCENTIVES**

### **REGULAR POLICY CHANGE NUMBER: 225**

ILOS are voluntary non-traditional services that are deemed medically appropriate and cost-effective alternatives to existing State Plan benefits. These services will be effective statewide within the managed care delivery system effective January 1, 2022. ILOS provide for flexible wrap-around services that Medi-Cal MCPs would be able to offer as a part of their overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care. Medium to high-risk and/or high-cost Medi-Cal beneficiaries who experience, or are at risk of experiencing, poor health outcomes may benefit from accessing non-traditional alternatives to State Plan benefits.

The proposed ILOS are:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Nursing Facility Transition to a Home
- Personal Care (beyond In-Home Supportive Services) and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Incentive payments complement ILOS and enhanced care management and are intended to incentivize MCPs to invest in voluntary ILOS delivery and partner with community-based organizations and on-the-ground providers such as Federally Qualified Health Centers, Rural Health Clinics, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers. The proposed time-limited incentive funding (January 1, 2022, through June 30, 2024) will be focused on building a pathway for Medi-Cal MCPs and providers to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable care management and ILOS capacity, and achieve improvements in quality performance that can inform future policy decisions to align with the goal of managed long-term services and supports by 2026.

**Reason for Change:**

This is a new policy change.



**CALAIM ECM-ILOS-PLAN INCENTIVES**  
REGULAR POLICY CHANGE NUMBER: 225**Methodology:**

1. Costs are estimated to be:

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
ILOS	\$47,917	\$23,959	\$23,959
Plan Incentives	\$300,000	\$150,000	\$150,000
Enhanced Care Management	\$187,500	\$93,750	\$93,750
<b>Total for FY 2021-22</b>	<b>\$535,417</b>	<b>\$267,709</b>	<b>\$267,709</b>

\*Totals may differ due to rounding.

**Funding:**

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

## CALAIM - DENTAL PREVENTIVE SERVICES

**REGULAR POLICY CHANGE NUMBER:** 226  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2188

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$59,384,000
<b>- STATE FUNDS</b>	\$0	\$29,692,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$59,384,000
<b>STATE FUNDS</b>	\$0	\$29,692,000
<b>FEDERAL FUNDS</b>	\$0	\$29,692,000

**Purpose:**

This policy change estimates the cost of the incentive payments related to preventive services covered under California Advancing and Innovating Medi-Cal (CalAIM) policy.

**Authority:**

**Interdependent Policy Changes:**

None

**Background:**

Starting January 1, 2022, CalAIM policy will provide supplemental payments to improve dental health for Medi-Cal children and adults by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

The Department has set an initial goal to achieve a 60 percent dental utilization rate for eligible Medi-Cal children and adults. In order to progress towards achieving that goal, DHCS proposes to offer a performance payment at 75% of the Schedule of Maximum Allowances (SMA) for each paid preventive oral care service billed by a service office location. These performance payments are only applicable to specific preventive services Current Dental Terminology (CDT) codes for children and adults.

**Reason for Change:**

This policy change was last included in the November 2019 Medi-Cal Estimate. The change from the prior estimate for incentive payments for preventive services is an increase due to the performance payment changing from 25% to 75% of the SMA amount.

**Methodology:**

1. A flat rate performance payment equivalent to 75% of the SMA will be paid for specific preventive services rendered.

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2021-22</b>	<b>\$59,384,000</b>	\$29,692,000	\$29,692,000

**CALAIM - DENTAL PREVENTIVE SERVICES**  
REGULAR POLICY CHANGE NUMBER: 226

**Funding:**

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

## CALAIM - DENTAL CARIES RISK ASSESSMENT

**REGULAR POLICY CHANGE NUMBER:** 227  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2239

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$8,991,000
<b>- STATE FUNDS</b>	\$0	\$4,495,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$8,991,000
<b>STATE FUNDS</b>	\$0	\$4,495,500
<b>FEDERAL FUNDS</b>	\$0	\$4,495,500

**Purpose:**

This policy change estimates the cost of the dental benefits related to the Caries Risk Assessment covered under California Advancing and Innovating Medi-Cal (CalAIM) policy.

**Authority:**

**Interdependent Policy Changes:**

None

**Background:**

Starting January 1, 2022, CalAIM policy will provide supplemental payments to improve dental health for Medi-Cal children and adults by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

The Department has set an initial goal to achieve a 60 percent dental utilization rate for eligible Medi-Cal children and adults. In order to progress towards achieving that goal, DHCS proposes to pay Fee-for-Service (FFS) providers statewide for utilizing codes D0601, D0602 and D0603 for children ages 0 to 6.

**Reason for Change:**

This policy change was last included in the November 2019 Medi-Cal Estimate. The change from the prior estimate for Caries Risk Assessment payments is an increase due to updated data about the eligible population.

**Methodology:**

1. Payment for utilizing codes D0601, D0602 and D0603 will be offered for children ages 0-6 based on risk level associated with each member and varying frequencies of service.

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2021-22</b>	<b>\$8,991,000</b>	\$4,495,500	\$4,495,500

**Funding:**

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

## CALAIM - MANAGED CARE SMHS CARVE-OUT

**REGULAR POLICY CHANGE NUMBER:** 228  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2200

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	-\$4,773,000
<b>- STATE FUNDS</b>	\$0	-\$2,290,300
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	-\$4,773,000
<b>STATE FUNDS</b>	\$0	-\$2,290,300
<b>FEDERAL FUNDS</b>	\$0	-\$2,482,700

**Purpose:**

This policy change estimates the savings from carving out Specialty Mental Health Services (SMHS) from managed care plans (MCP) for Partnership members in Solano who are sub-delegated to Kaiser and for Sacramento Kaiser members (direct).

**Authority:**

California Advancing and Innovating Medi-Cal (CalAIM) Initiative

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Under the CalAIM initiative, the Department is proposing to standardize the benefits provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

Effective January 1, 2022 the SMHS benefits that are currently within the scope of the Medi-Cal managed care plans will be carved out from their responsibility and be provided through the Fee-For-Service (FFS) delivery system. The carve-outs will occur for Partnership members in Solano who are sub-delegated to Kaiser and Kaiser members in Sacramento.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. The estimated savings for managed care annually on an accrual basis is estimated to be \$16,712,000 TF to remove SMHS from the capitated payments to the Solano and Sacramento Kaiser MCP. Beginning January 1, 2022, the estimated savings for five months, on a cash basis is estimated to be \$6,963,000 TF for FY 2021-22.
2. It is assumed that the services would shift to be paid through the SMHS County Mental Health Plans at the same level, \$16,712,000 TF annual costs. In FY 2021-22, six months of costs totaling \$8,356,000 are assumed from January 2022 to June 2022. Applying a 38%

## CALAIM - MANAGED CARE SMHS CARVE-OUT

### REGULAR POLICY CHANGE NUMBER: 228

lag to FY 2021-22 claims, \$3,175,000 TF costs are assumed on a cash basis for FY 2021-22. Assume the SMHS funding as follows:

- Reimbursements at Title XIX 50% CF/50% FF and Title XXI 65% FF/35% CF.
- ACA newly funding assumes 90% Title XIX FF/ 10% GF.

(Dollars in Thousands)

Managed Care SMHS Carve-Out	Annual TF	FY 2021-22 TF
Managed Care	(\$16,712)	(\$6,963)
SMHS	\$16,712	\$3,175
<b>Total</b>	<b>\$0</b>	<b>(\$3,788)</b>

3. The net savings assumed in FY 2021-22, not including County Funds, are estimated to be \$4,773,000 TF savings:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF	CF
Managed Care SMHS Carve-Out	(\$6,963)	(\$2,398)	(\$4,565)	\$0
SMHS	\$3,175	\$108	\$2,082	\$985
<b>Total</b>	<b>(\$3,788)</b>	<b>(\$2,290)</b>	<b>(\$2,483)</b>	<b>\$985</b>

#### Funding:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$3,706)	(\$1,853)	(\$1,853)
65% Title XXI / 35% GF (4260-113-0001/0890)	(\$880)	(\$308)	(\$572)
ACA 90% FFP / 10% GF (2020)	(\$1,293)	(\$129)	(\$1,164)
100% Title XIX FF (4260-101-0890)	\$845	\$0	\$845
100% Title XXI FF (4260-113-0890)	\$261	\$0	\$261
<b>Total</b>	<b>(\$4,773)</b>	<b>(\$2,290)</b>	<b>(\$2,483)</b>

## CALAIM - DENTAL SILVER DIAMINE FLUORIDE

**REGULAR POLICY CHANGE NUMBER:** 229  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2240

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$1,637,000
<b>- STATE FUNDS</b>	\$0	\$818,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$1,637,000
<b>STATE FUNDS</b>	\$0	\$818,500
<b>FEDERAL FUNDS</b>	\$0	\$818,500

**Purpose:**

This policy change estimates the cost of adding coverage of Silver Diamine Fluoride as a dental benefit for specific populations covered under California Advancing and Innovating Medi-Cal (CalAIM) policy.

**Authority:**

**Interdependent Policy Changes:**

None

**Background:**

Starting January 1, 2022, CalAIM policy will provide supplemental payments to improve dental health for Medi-Cal children and adults by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

The Department has set an initial goal to achieve a 60 percent dental utilization rate for eligible Medi-Cal children and adults. In order to progress towards achieving that goal, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and adults living in a skilled nursing facility/intermediate care facility or persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include the Department of Developmental Services population.

**Reason for Change:**

This policy change was last included in the November 2019 Medi-Cal Estimate. The change from the prior estimate for adding SDF coverage is an increase due to updated data relating to potential utilization of this benefit.

**Methodology:**

1. SDF will be covered for children 0-6 as well as skilled nursing facilities, intermediate care facilities, disabled children ages 0-6, and disabled adults. The SDF benefit would provide two visits per member per year, up to ten teeth per visit, at a per tooth rate of \$12.

**CALAIM - DENTAL SILVER DIAMINE FLUORIDE**  
REGULAR POLICY CHANGE NUMBER: 229

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2021-22</b>	<b>\$1,637,000</b>	<b>\$818,500</b>	<b>\$818,500</b>

**Funding:**

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



## CALAIM - DENTAL CONTINUITY OF CARE

**REGULAR POLICY CHANGE NUMBER:** 230  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2241

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$43,485,000
<b>- STATE FUNDS</b>	\$0	\$21,742,500
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$43,485,000
<b>STATE FUNDS</b>	\$0	\$21,742,500
<b>FEDERAL FUNDS</b>	\$0	\$21,742,500

**Purpose:**

This policy change estimates the cost of performance payments intended to promote continuity of dental care under the California Advancing and Innovating Medi-Cal policy.

**Authority:**

**Interdependent Policy Changes:**

None

**Background:**

Starting January 1, 2022, CalAIM policy will provide supplemental payments to improve dental health for Medi-Cal children and adults by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

The Department has set an initial goal to achieve a 60 percent dental utilization rate for eligible Medi-Cal children and adults. In order to progress towards achieving that goal, DHC proposes to pay providers a flat rate performance payment when the same service office location bills a recall exam for the same beneficiary for at least two consecutive years and on an annual basis, when utilizing codes D0120, D0145, or D0150. The performance payment will not increase each consecutive year. The baseline year is calendar year (CY) 2020.

**Reason for Change:**

This policy change was last included in the November 2019 Medi-Cal Estimate. The change from the prior estimate for continuity of care is a decrease due to updated data relating to potential utilization of this benefit.

**Methodology:**

- To establish and maintain continuity of care, a flat rate performance payment of \$55 will be paid to service office locations for each returning beneficiary once per year period for exam codes D0120, D0150, or D0145. The performance payment will be paid the second consecutive year.

**CALAIM - DENTAL CONTINUITY OF CARE**  
REGULAR POLICY CHANGE NUMBER: 230

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2021-22</b>	<b>\$43,485,000</b>	<b>\$21,742,500</b>	<b>\$21,742,500</b>

**Funding:**

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

## BH QUALITY IMPROVEMENT PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 231  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2187

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$21,750,000
<b>- STATE FUNDS</b>	\$0	\$21,750,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$21,750,000
<b>STATE FUNDS</b>	\$0	\$21,750,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the payments to counties under the Behavioral Health Quality Improvement Program (BH-QIP).

**Authority:**

Proposed FY 2021-22 Budget Bill

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The BH-QIP will help prepare county mental health and substance use disorder (SUD) plans for some of the critical changes required for success in California Advancing and Innovating Medi-Cal (CalAIM):

- To convert county-level billing to Healthcare Common Procedure Coding Systems (HCPCS) Level 1 codes;
- To update county Information Technology (IT) systems for CalAIM changes in medical necessity determinations;
- To incorporate managed care and other utilization data from the Department into county IT systems for care; and,
- To automate data reporting.

The Department will use these funds to provide targeted incentives and technical assistance for counties to build the key infrastructure components needed to implement payment reform – moving from cost-based reimbursement to Inter-Governmental Transfers (IGTs) – implementing level of care assessment tools to determine medical necessity, and integration of Specialty Mental Health and Drug Medi-Cal delivery systems, all of which will require sophisticated documentation and data reporting capabilities.

The BH-QIP would be a two-year county BH incentive program to prepare counties to implement CalAIM technology, data and billing changes, principally to establish the required building blocks of payment reform and medical necessity changes: accurate and detailed coding, accurate billing and payment, data collection, and performance measurement and

## BH QUALITY IMPROVEMENT PROGRAM

### REGULAR POLICY CHANGE NUMBER: 231

reporting. Similar to previous Department incentive payment programs, the initial payments would be allocated based on a formula balancing both equality and equity, and the Department would develop a framework for the incentive payments based on meeting planning, infrastructure, reporting, and outcomes milestones. Although the program will end by June 30, 2023, the Department anticipates incentive payments continuing into FY 2023-24.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. Assume all 56 counties apply for this funding (Sutter/Yuba and Placer/Sierra operate jointly).
2. Assume start-up payments in 2021-22 to provide for billing code conversion, technical assistance, and county IT infrastructure changes including incorporating managed care and other utilization data from DHCS into county IT systems.
3. Assume quarterly incentive payments will begin in January 2022.
4. The estimated payments in FY 2021-22 are:

FY 2021-22	TF	GF
<b>Start-Up Costs</b>	<b>\$14,000,000</b>	<b>\$14,000,000</b>
<b>Incentive Payments</b>	<b>\$7,750,000</b>	<b>\$7,750,000</b>
<b>Total</b>	<b>\$21,750,000</b>	<b>\$21,750,000</b>

#### Funding:

100% GF (4260-101-0001)

## PHARMACY RETROACTIVE ADJUSTMENTS

**REGULAR POLICY CHANGE NUMBER:** 232  
**IMPLEMENTATION DATE:** 2/2021  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2194

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$120,732,000	-\$74,078,000
<b>- STATE FUNDS</b>	-\$25,693,460	-\$33,332,590
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$120,732,000	-\$74,078,000
<b>STATE FUNDS</b>	-\$25,693,460	-\$33,332,590
<b>FEDERAL FUNDS</b>	-\$95,038,540	-\$40,745,410

**Purpose:**

This policy change estimates the retroactive adjustments from pharmacy providers.

**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), under the provisions of the Affordable Care Act, required States to modify the reimbursement methodology for Covered Outpatient Drugs and the professional dispensing fee. CMS approved SPA 17-002 authorizing the Department to implement a new pharmacy reimbursement methodology and professional dispensing fee, effective April 1, 2017. The new reimbursement methodology requires all outpatient drugs be billed at the Actual Acquisition Cost (AAC).

Providers continued to be billed using the old Average Wholesale Price reimbursement methodology until the AAC methodology was implemented on February 23, 2019. Retroactive adjustments for the 23-month period, from April 1, 2017, to February 23, 2019 via Erroneous Payment Correction (EPC) process were to be implemented in nine iterations. The first iteration of the EPC was for one month of claims (April 2017) and was installed on May 23, 2019.

A lawsuit, *California Pharmacists Association, et al. v. Kent, et al.*, was filed in U.S. District Court on June 5, 2019, seeking an injunction preventing the Department from implementing the retroactive EPCs. The Department agreed to the court's request to temporarily halt the EPCs. The Department plans to resume the EPCs in February 2021.

In addition, the Department developed a process to address the plaintiff's concerns. As a result, approximately 133 out of 5100 providers have requested and been approved by the Department for an Alternative Payment Agreement (APA) which will occur over a 48-month period. All EPCs for Non-APA providers are assumed to occur over an 8-month period.

## PHARMACY RETROACTIVE ADJUSTMENTS

### REGULAR POLICY CHANGE NUMBER: 232

#### Reason for Change:

The change from the prior estimate for FY 2020-21 is a decrease in savings due to delaying the resumption of the EPCs from an estimated start date of July 2020 to an estimated start date of February 2021.

The change in the current estimate, from FY 2020-21 to FY 2021-22 is due to:

- A decrease in TF savings due to including only 3 remaining months of EPCs for Non-APA providers in FY 2021-22, and
- An increase in General Funds (GF) savings due to estimating completing 12 months of EPCs for APA providers in FY 2021-22 and having returned the entire Federal Funds (FF) for APA providers in FY 2020-21.

#### Methodology:

1. Assume the retroactive adjustments for providers with a Department-approved APA and Non-APA providers will resume February 2021.
2. The total retroactive adjustments from APA providers and Non-APA providers will result in a net savings of \$206.8 million TF (\$71 million GF).

(Dollars in Thousands)

<b>Total Pharmacy Retroactive Savings</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Pharmacy Non-APA Retro Savings	(\$177,777)	(\$61,049)	(\$116,728)
Pharmacy APA Retro Savings	(\$29,023)	(\$9,967)	(\$19,056)
<b>Total</b>	<b>(\$206,800)</b>	<b>(\$71,016)</b>	<b>(\$135,784)</b>

3. Assume the retroactive adjustments for Non-APA providers, for the remaining 22-month period, will occur from February 2021 through September 2021.
4. APA providers have been approved for either a 24-month, 36-month, or 48-month payment plan. Assume total retroactive adjustments from APA providers will be completed over 48 months.
5. Assume in FY 2020-21, five months of the retroactive adjustments will occur for APA providers.

(Dollars in Thousands)

<b>Pharmacy APA Retro Savings</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>Total APA Savings - First 5 Months</b>	<b>(\$5,010)</b>	<b>(\$1,212)</b>	<b>(\$3,798)</b>

6. The Department, however, will be required to immediately return the total \$19 million FF for savings from APA providers with GF in FY 2020-21, resulting in a cost to the GF. As the APA repayments occur, these amounts will offset the GF costs.

**PHARMACY RETROACTIVE ADJUSTMENTS**  
REGULAR POLICY CHANGE NUMBER: 232

7. On a cash basis, the net fiscal impact in FY 2020-21 is estimated to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Pharmacy Non-APA Retro Savings	(\$115,722)	(\$39,739)	(\$75,983)
Pharmacy APA Retro Savings	(\$5,010)	(\$5,010)	\$0
Federal Funds Repayment	\$0	\$19,056	(\$19,056)
<b>Total</b>	<b>(\$120,732)</b>	<b>(\$25,693)</b>	<b>(\$95,039)</b>

8. On a cash basis the savings in FY 2021-22 is estimated to be:

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Pharmacy Non-APA Retro Savings	(\$62,055)	(\$21,310)	(\$40,745)
Pharmacy APA Retro Savings	(\$12,023)	(\$12,023)	\$0
<b>Total</b>	<b>(\$74,078)</b>	<b>(\$33,333)</b>	<b>(\$40,745)</b>

**Funding:**

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

## CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

**REGULAR POLICY CHANGE NUMBER:** 233  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2174

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$11,981,000
<b>- STATE FUNDS</b>	\$0	\$4,158,100
<b>PAYMENT LAG</b>	1.0000	0.9132
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$10,941,000
<b>STATE FUNDS</b>	\$0	\$3,797,180
<b>FEDERAL FUNDS</b>	\$0	\$7,143,870

**Purpose:**

This policy change estimates the cost of adding the continuous glucose monitoring (CGM) system as a Medi-Cal benefit for beneficiaries with Type 1 diabetes.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CGM systems take glucose measurements at regular intervals, 24 hours a day, and translate the readings into dynamic data, generating glucose direction and rate of change. Currently, CGM devices are a benefit for the California Children's Services (CCS) program and Genetically Handicapped Person Program (GHPP) for clients with an approved authorization request documenting medical necessity.

Most CGM systems are Federal Food and Drug Administration (FDA) approved for treatment decisions, to help individuals make changes to their diabetes care plan, and to make more informed therapy decisions than if they used finger stick glucoses alone. When compared with a standard blood glucose meter (SBGM), using a CGM can help to improve surveillance of glucose levels by giving feedback throughout the day while requiring fewer finger sticks. Those who gain the most benefit from using a CGM are those who use it daily to evaluate glucose trends and assist in therapy treatment decisions. Utilization of CGMs demonstrate improvement in diabetes management, fewer emergency rooms visits, significant decrease in hypoglycemic and diabetic ketoacidosis hospitalizations, and reduced diabetes-related health complications like stroke, kidney disease, amputations, and blindness. The vast majority of medical literature suggests much better glucose control and much fewer complications and hospitalizations occur when the patient uses a CGM.

Effective January 1, 2022, the Department will add CGMs as a covered Medi-Cal benefit for beneficiaries ages 21 and older with Type I diabetes. The Department will put in place policy and authorization controls to verify medical necessity is demonstrated. The Department will also



## CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

### REGULAR POLICY CHANGE NUMBER: 233

enter into rebate agreements with the various manufacturers for the CGM system and supplies. The rebates will offset the General Fund (GF) costs for CGMs.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. Assume the CGM system will be added as a Medi-Cal benefit for ages 21 and over beginning January 1, 2022.
2. Assume utilization controls would specify that poorly controlled diabetes need to be demonstrated to be eligible for CGMs.
3. Assume Medi-Cal beneficiaries, who will be prescribed CGM, will go through the following process in addition to their current level of treatment:
  - Two physician services –
    - First physician visit for CGM will involve sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.
    - Second physician visit would be a follow-up visit for reports interpretation, after the patient has gone through a minimum of 72 hours of CGM readings.
  - External CGM monitor (or receiver) – One-time cost every three years.
  - Bundled rate for CGM Sensors and Transmitters – Patients will receive monthly supplies. The CGM sensors are small sensors that would be located just underneath the skin to measure the glucose levels; the transmitter is a small device that fits onto the sensors and sends data to the CGM monitor.
4. Assume the Department will negotiate and secure rebates for the CGM systems with various manufacturers to offsets GF costs. Rebates would be eligible only in the Medi-Cal Fee-for-Service (FFS) setting.
5. Due to the decreased usage of medical supplies associated with self-monitoring of blood glucose (SMBG), it is estimated that an additional annual savings of approximately \$640 per beneficiary will be realized when beneficiaries transition from SMBG, to CGMs for their disease management.
6. Total net cost on an accrual basis, for FFS and managed care, is estimated to be:

<b>CGM System - FFS</b>	<b>First Year Cost</b>	<b>Second Year and Ongoing Cost</b>
CGM Office Visits	\$515,000	\$0
CGM - Accessories and Supplies	\$8,060,000	\$7,411,000
SMBG to CGM Transition Savings	(\$1,923,000)	(\$1,923,000)
Rebate Savings	(\$3,832,000)	(\$3,183,000)
<b>Total Fund</b>	<b>\$2,820,000</b>	<b>\$2,305,000</b>
<b>General Fund</b>	<b>\$1,009,000</b>	<b>\$825,000</b>

## CONTINUOUS GLUCOSE MONITORING SYSTEMS BENEFIT

### REGULAR POLICY CHANGE NUMBER: 233

<b>CGM System – Managed Care</b>	<b>First Year Cost</b>	<b>Second Year and Ongoing Cost</b>
CGM Office Visits	\$1,786,000	\$0
CGM - Accessories and Supplies	\$27,955,000	\$25,702,000
SMBG to CGM Transition Savings	(\$6,670,000)	(\$6,670,000)
Rebate Savings	\$0	\$0
<b>Total Fund</b>	<b>\$23,071,000</b>	<b>\$19,032,000</b>
<b>General Fund</b>	<b>\$7,945,000</b>	<b>\$6,554,000</b>

7. Assume in May 2022, the Department will begin invoicing all CGM manufacturers with whom it has executed rebate agreements for reimbursement on CGM devices utilized and billed for the first quarter of 2022 (January 1 - March 31, 2022). Assuming rebate collections will be received early June 2022, three months of rebate savings are estimated in FY 2021-22.
8. On a cash basis, six months of FFS costs and 5 months of managed care net costs are estimated in FY 2021-22, plus one quarter of rebate savings. The total estimated payments in FY 2021-22 is:

<b>FY 2021-22 - CGM System</b>	<b>FFS + Managed Care</b>	<b>FFS</b>	<b>Managed Care</b>
CGM Office Visits	\$1,002,000	\$258,000	\$744,000
CGM - Accessories and Supplies	\$15,678,000	\$4,030,000	\$11,648,000
SMBG to CGM Transition Savings	(\$3,741,000)	(\$962,000)	(\$2,779,000)
Rebate Savings	(\$958,000)	(\$958,000)	\$0
<b>Total Cost of CGM System</b>	<b>\$11,981,000</b>	<b>\$2,368,000</b>	<b>\$9,613,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Fee-for-Service	\$3,326,000	\$1,190,000	\$2,136,000
Managed Care	\$9,613,000	\$3,311,000	\$6,302,000
Rebates Savings	(\$958,000)	(\$343,000)	(\$615,000)
<b>Total</b>	<b>\$11,981,000</b>	<b>\$4,158,000</b>	<b>\$7,823,000</b>

#### Funding:

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$7,400,000	\$3,700,000	\$3,700,000
90% Title XIX ACA / 10% GF (4260-101-0001/0890)	\$4,581,000	\$458,000	\$4,123,000
<b>Total</b>	<b>\$11,981,000</b>	<b>\$4,158,000</b>	<b>\$7,823,000</b>

## CALAIM - MSSP CARVE-OUT OF CCI

**REGULAR POLICY CHANGE NUMBER:** 234  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Jerrold Anub  
**FISCAL REFERENCE NUMBER:** 2248

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$1,600,000
<b>- STATE FUNDS</b>	\$0	\$800,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$1,600,000
<b>STATE FUNDS</b>	\$0	\$800,000
<b>FEDERAL FUNDS</b>	\$0	\$800,000

**Purpose:**

This policy change estimates the Multipurpose Senior Services Program (MSSP) carve-out from the Coordinated Care Initiative (CCI) under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

CCI-Managed Care Payments  
 MSSP Supplemental Payments  
 Multipurpose Senior Services Program-CDA

**Background:**

Effective January 1, 2022, the Department proposes to implement the CalAIM initiative in order to move Medi-Cal to a more consistent and seamless system by reducing complexity, increasing flexibility, improving quality outcomes, and driving delivery system transformations through value-based initiatives, modernization of systems, and payment reform.

The MSSP benefit was proposed to be carved out from managed care under the CalAIM proposal, effective January 1, 2021. This proposed carve out was delayed due to the postponement of CalAIM and pending approved extension of the 1115 waiver, due to the COVID-19 public health emergency. Effective January 1, 2022, MSSP will operate as a waiver benefit in all CCI demonstration counties.

**Reason for Change:**

This is a new policy change.

**CALAIM - MSSP CARVE-OUT OF CCI**  
REGULAR POLICY CHANGE NUMBER: 234**Methodology:**

1. Costs are estimated to be:

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCI - Managed Care Payments	(\$7,996,000)	(\$3,998,000)	(\$3,998,000)
MSSP	\$9,596,000	\$4,798,000	\$4,798,000
<b>Total</b>	<b>\$1,600,000</b>	<b>\$800,000</b>	<b>\$800,000</b>

**Funding:**

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

## CALAIM - TRANSITIONING POPULATIONS

**REGULAR POLICY CHANGE NUMBER:** 235  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2201

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$401,597,000
<b>- STATE FUNDS</b>	\$0	\$174,759,600
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$401,597,000
<b>STATE FUNDS</b>	\$0	\$174,759,600
<b>FEDERAL FUNDS</b>	\$0	\$226,837,400

**Purpose:**

This policy change estimates the impact of transitioning populations to or from the Fee-for-Service (FFS) and Managed Care delivery systems resulting from the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

**Authority:**

CalAIM Initiative

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Currently there are differences across counties and plan model types on the benefits offered and the populations that are mandatorily required to enroll in managed care.

Effective January 1, 2022, the CalAIM initiative proposes to move Medi-Cal to a more consistent and seamless system by reducing complexity, increasing flexibility, and standardizing the benefits provided across all Plan Model types and counties, as well as require mandatory managed care enrollment for all populations, except those that have a limited scope of benefits or those enrolled in managed care for a limited time.

Transitions occurring January 1, 2022, include:

- Beneficiary populations transitioning to Mandatory FFS
  - Omnibus Budget Reconciliation Act
  - Share-of-Cost (SOC) in County organized health systems (COHS) and CCI
- Beneficiary populations transitioning to Mandatory Managed Care
  - Trafficking and Crime Victims Assistance Program, excluding SOC
  - Accelerated Enrollment
  - Child Health and Disability Prevention Infant Deeming
  - Pregnancy-related Medi-Cal (138-213% citizen/lawfully present)
  - American Indian/Alaskan Native
  - Beneficiaries with Other Healthcare Coverage

## CALAIM - TRANSITIONING POPULATIONS

### REGULAR POLICY CHANGE NUMBER: 235

- Beneficiaries in rural zip codes

All dual aid code groups, except SOC or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023. Individuals in long term care will also be mandatory in Medi-Cal managed care starting in 2023.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. Costs are assumed to be equal in both the FFS and managed care delivery systems.
2. The transition effective date is January 1, 2022. Costs below are representative of payment timing differences between delivery systems.

#### Funding:

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 100% FFP (4260-101-0890)	\$13,260	\$0	\$13,260
BCCTP Title XIX 65% FF / 35% GF (4260-101-0890/0001)	\$135	\$47	\$88
100% General Fund 4260-101-0001	\$335	\$335	\$0
50% Title XIX FF / 50% GF (4260-101-0890/0001)	\$337,316	\$168,658	\$168,658
90% Title XIX ACA / 10% GF (4260-101-0890/0001)	\$47,894	\$4,790	\$43,104
65% Title XXI FF / 35% GF (4260-113-0890/0001)	\$2,657	\$930	\$1,727
<b>Total</b>	<b>\$401,597</b>	<b>\$174,760</b>	<b>\$226,837</b>

## MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

**REGULAR POLICY CHANGE NUMBER:** 236  
**IMPLEMENTATION DATE:** 10/2021  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2249

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	-\$396,988,000
<b>- STATE FUNDS</b>	\$0	-\$132,833,250
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	-\$396,988,000
<b>STATE FUNDS</b>	\$0	-\$132,833,250
<b>FEDERAL FUNDS</b>	\$0	-\$264,154,750

**Purpose:**

This policy change estimates the savings for additional supplemental drug rebates as a result of transitioning the Medi-Cal pharmacy services from Managed Care (MC) to Fee-For Service (FFS) delivery system.

**Authority:**

Executive Order N-01-19

**Interdependent Policy Changes:**

Medi-Cal Rx-Managed Care Pharmacy Benefit to FFS

**Background:**

On January 7, 2019, the Governor issued Executive Order N-01-19, requiring that all Medi-Cal pharmacy services be transitioned from MC to FFS. The transition of pharmacy services from MC to FFS will be implemented on April 1, 2021. Transitioning pharmacy services from MC to FFS delivery system is referred to as Medi-Cal Rx.

State supplemental drug rebates for drugs provided through FFS are negotiated by the Department with drug manufactures to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change) and are budgeted in the State Supplemental Drug Rebates policy change. This policy change estimates the additional supplemental rebates that will be collected as a result of the MC population shift to Medi-Cal Rx. It is also assumed that due to Medi-Cal Rx, contracts with drug manufacturers for rebates will be renegotiated resulting in an increase in supplemental rebates for the existing FFS population.

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to the FFS delivery system. The PCs related to Medi-Cal Rx are:

Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from MAIC in FFS
- Medi-Cal Rx- Additional Supplemental Rebates
- Medical Supply Rebates

## MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES

### REGULAR POLICY CHANGE NUMBER: 236

- Non-Hospital 340B Clinic Supplemental Payments

#### Other Admin

- Medi-Cal Rx – Administrative Costs

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. The Department will begin collecting additional supplemental rebates for Medi-Cal Rx on October 1, 2021.
2. Assume additional supplemental rebates for Medi-Cal Rx will gradually increase to 12% of the annual pharmacy expenditures by FY 2023-24.
3. The estimated annual savings is \$946,515,000 TF.

(Dollars in Thousands)

<b>Annual</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Additional Supplemental Rebates-MC Carve-Out	(\$750,239)	(\$257,163)	(\$493,076)
Additional Supplemental Rebates- Existing FFS	(\$196,276)	(\$51,530)	(\$144,746)
<b>Total</b>	<b>(\$946,515)</b>	<b>(\$308,693)</b>	<b>(\$637,822)</b>

4. The estimated FY 2021-22 savings is \$396,988,000 TF.

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Additional Supplemental Rebates-MC Carve-Out	(\$356,551)	(\$122,217)	(\$234,443)
Additional Supplemental Rebates- Existing FFS	(\$40,437)	(\$10,616)	(\$29,821)
<b>Total</b>	<b>(\$396,988)</b>	<b>(132,833)</b>	<b>(\$264,155)</b>



**MEDI-CAL RX- ADDITIONAL SUPPLEMENTAL REBATES**  
REGULAR POLICY CHANGE NUMBER: 236**Funding:**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX/ 50% GF (4260-101-0001/0890)	(\$219,983)	(\$109,992)	(\$109,991)
90% Title XIX/ 10% GF (4260-101-0001/0890)	(\$156,440)	(\$15,644)	(\$140,796)
65% Title XIX/ 35% GF (4260-101-0001/0890)	(\$20,565)	(\$7,197)	(\$13,368)
<b>Total</b>	<b>(\$396,988)</b>	<b>(\$132,833)</b>	<b>(\$264,155)</b>

## ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

**REGULAR POLICY CHANGE NUMBER:** 237  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 2064

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**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:**

N/A

**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, FY 2015-16, FY 2016-17, and FY 2017-18. At this time, it is unknown whether the Centers for Medicare and Medicaid Services (CMS) will require the Department to extend the risk corridor to FY 2018-19.

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 the Department 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 the Department 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.

**Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease due to receiving MCP reported MLR data for the FY 2017-18 rating period. At this time, a net \$0 net recoupment is assumed to be collected from MCPs in FY 2020-21.

## ACA OPTIONAL EXPANSION MLR RISK CORRIDOR

### REGULAR POLICY CHANGE NUMBER: 237

There is no change from FY 2020-21 to FY 2021-22 in the current estimate. No risk corridor is in place at this time for FY 2018-19.

#### Methodology:

1. For each MLR period, the Department will determine which MCPs do not meet the minimum MLR threshold of 85% and which MCPs exceed the maximum MLR threshold of 95%. Any dollar amount below the 85% threshold will be recouped from the MCPs and any dollar amount over the 95% threshold will be paid to MCPs.
2. Any recoupments and repayments identified as a result of the final MLR calculations will be collected or paid out at the appropriate federal Medicaid assistance and corresponding State General Fund percentages for the MLR rating period.
3. FY 2017-18 MLR rating period recoupments and repayments are expected to occur in FY 2020-21. At this time, the Department estimates a net \$0 in recoupments and repayments from across all MCPs.
4. The ACA OE MLR risk corridor estimated recoupments are:

Fiscal Year	TF	GF	FF
FY 2020-21	\$0	\$0	\$0
FY 2021-22	\$0	\$0	\$0

#### Funding:

ACA 95% FFP / 5% GF (2017)

ACA 94% FFP / 6% GF (2018)

## CALAIM - ORGAN TRANSPLANT

**REGULAR POLICY CHANGE NUMBER:** 238  
**IMPLEMENTATION DATE:** 1/2022  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2199

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$4,656,000
<b>- STATE FUNDS</b>	\$0	\$1,355,150
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$4,656,000
<b>STATE FUNDS</b>	\$0	\$1,355,150
<b>FEDERAL FUNDS</b>	\$0	\$3,300,850

**Purpose:**

This policy change estimates the cost of carving-in organ transplant benefits from Medi-Cal Fee-for-Service (FFS) into Medi-Cal managed care plans (MCPs) as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

**Authority:**

California Advancing and Innovating Medi-Cal Initiative

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Currently in the Medi-Cal managed care program, organ transplants are a full benefit in County Operated Health Systems (COHS) counties. Non-COHS counties currently only cover kidney transplants.

Effective January 1, 2022, all organ transplant benefits will be standardized and carved into MCP covered benefits statewide for all Medi-Cal managed care members. This will reduce complexity and ensure continuity of care without burdening beneficiaries transitioning from one delivery system to another.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Effective January 1, 2022, all organ transplants for managed care beneficiaries in non-COHS, will be carved into MCPs.

**CALAIM - ORGAN TRANSPLANT**  
REGULAR POLICY CHANGE NUMBER: 238

2. On an ongoing basis, the net annual impact of the shift from FFS to managed care is expected to be budget neutral.

<b>ANNUAL</b>	<b>TF</b>	<b>GF</b>	<b>Title XIX</b>	<b>Title XXI</b>
CalAIM - Organ Transplant Fee-for-Service	(\$88,406,000)	(\$25,729,000)	(\$62,537,000)	(\$140,000)
CalAIM - Organ Transplant Managed Care	\$88,406,000	\$25,729,000	\$62,537,000	\$140,000
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

3. In FY 2021-22, however, a net fiscal impact of \$4.6 million TF is estimated due to the timing of the changes in the FFS and managed care payments.

<b>FY 2021-22 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>Title XIX</b>	<b>Title XXI</b>
CalAIM - Organ Transplant Fee-for-Service	(\$32,179,000)	(\$9,365,000)	(\$22,763,000)	(\$51,000)
CalAIM - Organ Transplant Managed Care	\$36,835,000	\$10,720,000	\$26,057,000	\$58,000
<b>Total</b>	<b>\$4,656,000</b>	<b>\$1,355,000</b>	<b>\$3,294,000</b>	<b>\$7,000</b>

**Funding:**

<b>FY 2021-22 (Lagged)</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$2,217,000	\$1,108,000	\$1,109,000
65% Title XXI / 35% GF (4260-113-0001/0890)	\$11,000	\$4,000	\$7,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$2,428,000	\$243,000	\$2,185,000
<b>Total</b>	<b>\$4,656,000</b>	<b>\$1,355,000</b>	<b>\$3,301,000</b>

## REMOTE PATIENT MONITORING

**REGULAR POLICY CHANGE NUMBER:** 239  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2251

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$100,196,000
<b>- STATE FUNDS</b>	\$0	\$35,928,000
<b>PAYMENT LAG</b>	1.0000	0.9460
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$94,785,400
<b>STATE FUNDS</b>	\$0	\$33,987,890
<b>FEDERAL FUNDS</b>	\$0	\$60,797,530

**Purpose:**

This policy change estimates the costs for expanded remote patient monitoring (RPM) as an allowable telehealth modality in fee-for-service (FFS) and managed care delivery systems.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

RPM treatment management services are provided when clinical staff use the results of remote physiological monitoring devices to manage a patient under specific treatment plans. Common physiological data collected with RPM devices include vital signs, weight, blood pressure, and heart rate.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume implementation date for RPM is July 1, 2021.
2. Assume RPM services will be for FFS and managed care beneficiaries, 21 years of age and older, with full scope Medi-Cal or pregnancy-only coverage.
3. Assume beneficiaries must have a primary diagnosis of an acute or chronic disease.
4. Paid claims data for FFS and managed care shows 2,352,209 unduplicated beneficiaries with one of the top five acute or chronic disease diagnoses, including asthma, chronic obstructive pulmonary disease, diabetes, cardiac disease (Atherosclerotic), and/or hypertension.

**REMOTE PATIENT MONITORING**  
REGULAR POLICY CHANGE NUMBER: 239

5. Assume 5 percent of those who received outpatient services could have utilized RPM in FY 2021-22.
- a. FY 2021-22 utilization at 2,352,209 x 5% = 117,610 beneficiaries
6. Total estimated costs for RPM, on an annual and cash basis, is as follows:

<b>ANNUAL</b>	<b>TF</b>	<b>GF</b>	<b>FF XIX</b>
Fee-for-Service	\$31,856,000	\$12,392,000	\$19,464,000
Managed Care	\$74,553,000	\$25,675,000	\$48,878,000
<b>Total</b>	<b>\$106,409,000</b>	<b>\$38,067,000</b>	<b>\$68,342,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF XIX</b>
Fee-for-Service	\$31,856,000	\$12,392,000	\$19,464,000
Managed Care	\$68,340,000	\$23,536,000	\$44,804,000
<b>Total</b>	<b>\$100,196,000</b>	<b>\$35,928,000</b>	<b>\$64,268,000</b>

**Funding:**

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF XIX</b>
50% Title XIX / 50% GF (4260-101-0001/0890)	\$64,771,000	\$32,385,000	\$32,386,000
90% ACA Title XIX FF / 10% GF (4260-101-0001/0890)	\$35,425,000	\$3,543,000	\$31,882,000
<b>Total</b>	<b>\$100,196,000</b>	<b>\$35,928,000</b>	<b>\$64,268,000</b>

## MHP COSTS FOR FFPSA - QUALIFIED INDIVIDUAL

**REGULAR POLICY CHANGE NUMBER:** 240  
**IMPLEMENTATION DATE:** 10/2021  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2252

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$21,356,000
<b>- STATE FUNDS</b>	\$0	\$10,678,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$21,356,000
<b>STATE FUNDS</b>	\$0	\$10,678,000
<b>FEDERAL FUNDS</b>	\$0	\$10,678,000

**Purpose:**

This policy change estimates the reimbursement to mental health plans (MHPs) to implement the new requirement for a Qualified Individual (QI) to provide specific pre-placement intensive case management prior to admission to a Short-Term Residential Treatment Facility.

**Authority:**

Families First Prevention Services Act (Public Law 115-123)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

MHPs are currently required to provide all Medi-Cal beneficiaries, including those in the Foster Care system, all medically necessary specialty mental health services (SMHS). Current law provides for an Interagency Placement Committee (IPC), representing Child Welfare, Probation and County Mental Health (at a minimum), to determine eligibility for Short-Term Residential Treatment Program (STRTP) placement and medical necessity for Medi-Cal SMHS. However, there is no specified criteria or process for making the determination. The process can be an administrative chart review, without direct contact with the child or family, and the only obligation of the MHP is to determine medical necessity for the mental health services provided within the facility (e.g., group therapy), not for the need for a residential level of care.

The Family First Prevention Services Act (FFPSA) requires the independently certified QI to perform detailed assessment, including reviewing past clinical and social service records, meeting the child and family and administering a detailed Child and Adolescent Needs (CANS) survey, and conducting a clinical assessment to determine if a treatment plan of home-based services would be more appropriate than residential care. The QI must work with the child and family teams (CFTs) and mental health providers, and if the STRTP is not medically necessary, must provide intensive care coordination (ICC) services to develop a more appropriate treatment plan. This is a much higher level of care coordination and care management than is currently provided, and is expected to require at least 10 hours per client.

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



## MHP COSTS FOR FFPSA - QUALIFIED INDIVIDUAL

### REGULAR POLICY CHANGE NUMBER: 240

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.

The specific requirements of this QI are beyond what is currently required for medical necessity determinations, and therefore would trigger Proposition 30.

#### Reason for Change:

This is a new policy change.

#### Methodology:

##### Standardized Assessments

1. Assume 5,592 children and youth will be placed in an STRTP in FY 2021-22.
2. Assume Standardized Assessment by a QI begin on October 1, 2021.
3. Assume a total of 4,194 ( $5,592 \times .75$ ) receive a standardized assessment by a QI in FY 2021-22. Each standardized assessment will take 10 total hours to complete.
4. Assume children and youth placed in an STRTP will receive, on average, 1.35 assessments per year.
5. Assume MHPs will spend, on average, \$283.20 per hour for a qualified individual to complete an assessment. The Department estimates MHPs will spend \$16,034,501 for a QI to complete standardized assessments in FY 2021-22.

Fiscal Year	STRTP Caseload (5,592*.75)	Assessment Hours	Assessments Per Year	Cost Per Hour (QI)	Assessment Cost
FY 2021-22	4,194	10	1.35	\$283.20	\$16,034,501

##### Child and Family Team (CFT)

1. Assume the children and youth placed in an STRTP will receive, on average, 2.24 CFT meetings during placement evaluation for an STRTP.
2. Assume the QI spends 2 hours providing a reimbursable SMHS in each CFT. Assume MHPs will spend, on average, \$283.20 per hour for a QI to participate in CFT meetings while children and youth are placed in an STRTP. The Department estimates MHPs will spend \$5,321,079 for QI participation in CFTs in FY 2021-22.

Fiscal Year	STRTP Caseload (5,592*.75)	CFT Hours	CFTs Per Year	Cost Per Hour (QI)	CFT Cost
FY 2021-22	4,194	2	2.24	\$283.20	\$5,321,079

**MHP COSTS FOR FFPSA - QUALIFIED INDIVIDUAL**  
**REGULAR POLICY CHANGE NUMBER: 240**Funding Summary

1. The FY 2021-22 estimate is:

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Standardized Assessments	\$16,035	\$8,018	\$8,017
CFTs	\$5,321	\$2,660	\$2,661
<b>Total</b>	<b>\$21,356</b>	<b>\$10,678</b>	<b>\$10,678</b>

**Funding:**

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

## MHP COSTS FOR FFPSA - AFTERCARE SERVICES

**REGULAR POLICY CHANGE NUMBER:** 241  
**IMPLEMENTATION DATE:** 10/2021  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2253

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$1,284,000
<b>- STATE FUNDS</b>	\$0	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$1,284,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$0	\$1,284,000

**Purpose:**

This policy change estimates the reimbursement to mental health plans to provide a standardized amount of mental health treatment to Medi-Cal beneficiaries for six months after being discharged from a Short-Term Residential Therapeutic Program (STRTP).

**Authority:**

Families First Prevention Services Act (Public Law 115-123)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Mental health plans (MHPs) are currently required to provide all Medi-Cal beneficiaries, including those in the Foster Care system, all medically necessary specialty mental health services (SMHS). On February 9, 2018, Congress enacted the Families First Prevention Services Act (FFPSA) that requires states to provide discharge planning and family-based after care support for at least 6 months after a child or youth is discharged from an STRTP. Discharge planning with a focus on family-based support for 6 months post-discharge is expected to result in an increase in utilization of medically necessary specialty mental health services during the 6 months after discharge.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. In FY 2018-19, there were 2,161 Medi-Cal beneficiaries discharged from an STRTP.
2. Assume the minimum amount of specialty mental health services (SMHS) provided to each Medi-Cal beneficiary in the 6 months after discharge from an STRTP is \$3,512 based on the median approved claims, per beneficiary, for In-Home Behavioral Services, Intensive Care Coordination, Therapeutic Behavioral Services, Targeted Case Management, and Mental Health Services provided for 6 months after discharge.

## MHP COSTS FOR FFP SA - AFTERCARE SERVICES

REGULAR POLICY CHANGE NUMBER: 241

3. The per-beneficiary approved claims for 1,080 Medi-Cal beneficiaries were below the median of \$3,512.
4. The total approved claims for those 1,080 beneficiaries below the median was \$1,225,019.
5. If the per beneficiary approved claims for those 1,080 beneficiaries was \$3,512 the total approved claims would have been \$3,792,960 (1,080 x \$3,512).
6. The Department would have approved an additional \$2,568,000 (rounded) in claims if mental health plans had spent a minimum of \$3,512 per beneficiary in the 6 months after discharge from an STRTP.
7. The FY 2021-22 estimate is:

(Dollars in Thousands)

FY 2021-22	TF	FF	CF
<b>Total</b>	\$2,568	<b>\$1,284</b>	\$1,284

**Funding:**

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

## PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM

**REGULAR POLICY CHANGE NUMBER:** 242  
**IMPLEMENTATION DATE:** 3/2021  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2254

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$57,000,000	\$76,000,000
<b>- STATE FUNDS</b>	\$24,966,000	\$35,644,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$57,000,000	\$76,000,000
<b>STATE FUNDS</b>	\$24,966,000	\$35,644,000
<b>FEDERAL FUNDS</b>	\$32,034,000	\$40,356,000

**Purpose:**

This policy change estimates payments to providers made through the Behavioral Health Integration (BHI) Incentive program intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

**Authority:**

FY 201920 Budget Bill  
 SB 78 (Chapter 38, Statutes of 2019)  
 AB 80 (Chapter 12, Statutes of 2020)  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Proposition 56 Funds Transfer

**Background:**

On November 8, 2016, California voters passed the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) to increase the excise tax rate on cigarettes and tobacco products. Under Proposition 56, a 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.

The Behavioral Healthcare Incentive (BHI) program will require MCPs to make value-based enhanced payments to eligible network providers for specific events tied to performance on 17 core measures across the BHI domain.

To address health disparities, this arrangement will also direct MCPs to make enhanced payments for events tied to beneficiaries diagnosed with a substance use disorder or serious mental illness, or who are homeless.

## **PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM**

### **REGULAR POLICY CHANGE NUMBER: 242**

The Behavioral Health Integration (BHI) Incentive program was intended to incentivize physical and behavioral health outcomes within the Medi-Cal Managed Care program and improve evidence-based medical and behavioral health integration practices.

Proposition 56 funding, along with federal funds, are used to make these payments. This policy change identifies the use of the General Fund (GF) for these Proposition 56 funded payments. See the Proposition 56 Funds Transfer policy change for the Proposition 56 offset to the GF.

While AB 80 suspends these Proposition 56 payments on July 1, 2021, the Department assumes the continuation of the Proposition 56 Behavioral Health Incentive Program payments.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change from the prior estimate, for FY 2020-21 is an increase due to updated BHI dollars.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the shifting of BHI program implementation date.

**PROP 56-BEHAVIORAL HEALTH INCENTIVE PROGRAM**  
REGULAR POLICY CHANGE NUMBER: 242

**Methodology:**

1. On a cash basis, the total directed payments are estimated to be \$57,000,000 in FY 2020-21 and \$76,000,000 in FY 2021-22.
2. The (6.2% Title XIX and/or 4.34% Title XXI) FFCRA increased FMAP is assumed for expenditures through December 31, 2021, in this policy change.

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% SF (4260-101-0890/0001)	\$57,000	\$28,500	\$28,500
FFCRA 6.2% Increased FFP	\$0	(\$3,534)	\$3,534
<b>Total</b>	<b>\$57,000</b>	<b>\$28,500</b>	<b>\$28,500</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX FF / 50% SF (4260-101-0890/0001)	\$76,000	\$38,000	\$38,000
FFCRA 6.2% Increased FFP	\$0	(\$2,356)	\$2,356
<b>Total</b>	<b>\$76,000</b>	<b>\$35,644</b>	<b>\$40,356</b>

## HOME HEALTH & PDHC RECOUPMENTS

**REGULAR POLICY CHANGE NUMBER:** 243  
**IMPLEMENTATION DATE:** 8/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2255

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$51,392,000	\$0
<b>- STATE FUNDS</b>	-\$25,030,160	\$0
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$51,392,000	\$0
<b>STATE FUNDS</b>	-\$25,030,160	\$0
<b>FEDERAL FUNDS</b>	-\$26,361,840	\$0

**Purpose:**

This policy change estimates the home health and pediatric day health care services (PDHC) recoupments resulting from an Erroneous Payment Correction (EPC) that was implemented for dates of service for the period from July 1, 2018 to December 31, 2018.

For the Proposition 56 impact of the EPC, please refer to the Prop 56 – Home Health Rate Increase and Prop 56 – Pediatric Day Health Care Rate Increase policy changes.

**Authority:**

SB 856 (Chapter 30, Statutes of 2018)  
SPA 18-0037

**Interdependent Policy Changes:**

Prop 56 – Home Health Rate Increase  
Prop 56 – Pediatric Day Health Care Rate Increase

**Background:**

The Department increased certain home health and PDHC services by 50%, effective for dates of service on and after July 1, 2018. The increased home health and PDHC payments are funded with revenue from the increased excise tax on cigarettes and electronic cigarettes that was authorized by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56).

The home health and PDHC rate increases were implemented on December 28, 2018. The EPC for the retroactive period from July 2018 to December 2018 occurred in April 2019. An additional EPC, for claims not captured in the original EPC, occurred in August 2020.

When the additional EPC was implemented in August 2020, recoupments against the base rate payments were necessary to determine the rate increase payments funded by Proposition 56 funds. The Proposition 56 impact of the EPC is budgeted in the Prop 56 – Home Health Rate Increase and Prop 56 – Pediatric Health Care Rate Increase policy changes.

**Reason for Change:**

This is a new policy change.



## HOME HEALTH & PDHC RECOUPMENTS

REGULAR POLICY CHANGE NUMBER: 243

**Methodology:**

1. The additional EPC, for the period July 1, 2018 to December 31, 2018, was implemented in August 2020.
2. Additional Proposition 56 payments were paid and base rate payments were recouped as a result of the additional EPC.
3. The base recoupments are estimated to be one-time adjustments in FY 2020-21.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Title XXI FF</b>	<b>Title XIX FF</b>	<b>ACA FF</b>
Home Health Recoupment	(\$48,485,000)	(\$23,614,000)	(\$1,824,000)	(\$22,699,000)	(\$348,000)
PDHC Recoupment	(\$2,907,000)	(\$1,416,000)	(\$109,000)	(\$1,361,000)	(\$21,000)
<b>Total</b>	<b>(\$51,392,000)</b>	<b>(\$25,030,000)</b>	<b>(\$1,933,000)</b>	<b>(\$24,060,000)</b>	<b>(\$369,000)</b>

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50% FF / 50% GF (4260-101-0001 / 0890)	(\$48,120,000)	(\$24,060,000)	(\$24,060,000)
94% Title XIX FF / 6% GF (4260-101-0001 / 0890)	(\$392,000)	(\$24,000)	(\$368,000)
88% Title XXI FF / 12% GF (4260-113-0001/0890)	(\$2,197,000)	(\$263,000)	(\$1,934,000)
100% GF (4260-101-0001)	(\$683,000)	(\$683,000)	\$0
<b>Total</b>	<b>(\$51,392,000)</b>	<b>(\$25,030,000)</b>	<b>(\$26,362,000)</b>

## STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC

**REGULAR POLICY CHANGE NUMBER:** 244  
**IMPLEMENTATION DATE:** 9/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2198

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	-\$3,169,000	-\$6,339,000
<b>- STATE FUNDS</b>	\$139,125,000	\$15,057,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	-\$3,169,000	-\$6,339,000
<b>STATE FUNDS</b>	\$139,125,000	\$15,057,000
<b>FEDERAL FUNDS</b>	-\$142,294,000	-\$21,396,000

**Purpose:**

This policy change estimates (1) the return of Federal Financial Participation (FFP) to the federal government for claiming for non-emergency or non-pregnancy related services for Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) provided to individuals without satisfactory immigrant status in full scope Medi-Cal coverage; and (2) the fiscal impact of prospective adjustments for this population.

For information on the state only claiming adjustments for the Medi-Cal Managed Care, Pharmacy, Dental, California Department of Developmental Services (CDDS) programs, and Immigration Status Change, please see the State Only Claiming Adjustments policy change. For information on the state only claiming adjustments for the Medi-Cal Targeted Case Management (TCM) program, please see the State Only Claiming Adjustments TCM policy change.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

State Only Claiming Adjustments  
 State Only Claiming Adjustments - TCM

**Background:**

California provides state only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and non-emergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department

## STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC

### REGULAR POLICY CHANGE NUMBER: 244

has estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

#### CMS Deferral

On July 23, 2020, CMS issued a deferral for the state only claiming issue, for the Federal Fiscal Year (FFY) 2020 Quarter 1. On October 5, 2020, CMS issued a deferral for FFY 2020 Quarter 2. The Department anticipates that these deferral payments will ultimately be reconciled against the Department's total estimated repayments owed to the federal government. See the CMS Deferred Claims policy change for details on CMS deferral payments.

#### **Reason for Change:**

The change for FY 2020-21, from the prior estimate, is due to the following changes:

- The policy change now includes separate displays for the FFP repayments and prospective adjustments.
- The Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) retroactive repayments from FY 2008-09 to FY 2019-20 have been updated with more recent data.
- A six-month lag has been added to account for SMHS and DMC prospective payments on a cash basis.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Completion of the retroactive federal repayments in FY 2020-21.

#### **Methodology:**

##### **Retroactive FFP Repayments**

1. Federal repayments for amounts in this policy change began in September 2020.
2. Federal repayments are estimated for Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) programs.
3. Estimates of FFP repayments for SMHS and DMC cover prior claims from FY 2008-09 to FY 2019-20 (July 2008 to June 2020). In FY 2020-21, for SMHS and DMC, both state and county portions of the federal repayments will be paid with State General Fund (GF).

**STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC**  
REGULAR POLICY CHANGE NUMBER: 244

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$126,756	\$0	(\$126,756)	\$0
Drug Medi-Cal	\$0	\$4,840	\$0	(\$4,840)	\$0
<b>Subtotal (In PC 244)</b>	<b>\$0</b>	<b>\$131,596</b>	<b>\$0</b>	<b>(\$131,596)</b>	<b>\$0</b>
Managed Care	\$0	\$92,383	\$0	(\$92,383)	\$0
Pharmacy Rebates	\$0	\$47,200	\$0	(\$47,200)	\$0
Dental FFS and Managed Care	\$0	\$114,352	\$0	(\$114,352)	\$0
CDDS	\$0	\$0	\$227,753	(\$227,753)	\$0
Immigration Status Change	\$0	(\$155,716)	\$0	\$155,716	\$0
<b>Subtotal (In PC 221)</b>	<b>\$0</b>	<b>\$98,219</b>	<b>\$227,753</b>	<b>(\$325,972)</b>	<b>\$0</b>
Targeted Case Management	\$0	\$42,652	\$0	(\$42,652)	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$42,652</b>	<b>\$0</b>	<b>(\$42,652)</b>	<b>\$0</b>
<b>Grand Total</b>	<b>\$0</b>	<b>\$272,467</b>	<b>\$227,753</b>	<b>(\$500,220)</b>	<b>\$0</b>

\*County Funds are not included in Total Funds

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0	\$0
<b>Subtotal (In PC 244)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Managed Care	\$0	\$0	\$0	\$0	\$0
Pharmacy Rebates	\$0	\$12,000	\$0	(\$12,000)	\$0
Dental FFS and Managed Care	\$0	\$0	\$0	\$0	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0	\$0	\$0
<b>Subtotal (In PC 221)</b>	<b>\$0</b>	<b>\$12,000</b>	<b>\$0</b>	<b>(\$12,000)</b>	<b>\$0</b>
Targeted Case Management	\$0	\$0	\$0	\$0	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Grand Total</b>	<b>\$0</b>	<b>\$12,000</b>	<b>\$0</b>	<b>(\$12,000)</b>	<b>\$0</b>

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC**  
REGULAR POLICY CHANGE NUMBER: 244

**Prospective Adjustments**

4. Prospective adjustments estimated for SMHS and DMC are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	(\$2,970)	\$6,863	\$0	(\$9,833)	\$2,970
Drug Medi-Cal	(\$199)	\$666	\$0	(\$865)	\$199
<b>Subtotal (In PC 244)</b>	<b>(\$3,169)</b>	<b>\$7,529</b>	<b>\$0</b>	<b>(\$10,698)</b>	<b>\$3,169</b>
Managed Care	\$0	\$59,100	\$0	(\$59,100)	\$0
Pharmacy Rebates	\$0	\$0	\$0	\$0	\$0
Pharmacy Claims	\$0	\$16,406	\$0	(\$16,406)	\$0
Dental FFS and Managed Care	\$0	\$19,327	\$0	(\$19,327)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,056)	\$0	\$127,056	\$0
Subtotal (In PC 221)	\$0	(\$32,223)	\$0	\$32,223	\$0
Targeted Case Management	\$0	\$1,979	\$0	(\$1,979)	\$0
Subtotal (In PC 245)	\$0	\$1,979	\$0	(\$1,979)	\$0
<b>Grand Total</b>	<b>(\$3,169)</b>	<b>(\$22,715)</b>	<b>\$0</b>	<b>\$19,546</b>	<b>\$3,169</b>

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC**  
REGULAR POLICY CHANGE NUMBER: 244

(Dollars in Thousands)

FY 2021-22	TF	GF	Reimbursement (SF)	FF	CF*
SMHS	(\$5,941)	\$13,726	\$0	(\$19,667)	\$5,941
Drug Medi-Cal	(\$398)	\$1,331	\$0	(\$1,729)	\$398
<b>Subtotal (In PC 244)</b>	<b>(\$6,339)</b>	<b>\$15,057</b>	<b>\$0</b>	<b>(\$21,396)</b>	<b>\$6,339</b>
Managed Care	\$0	\$151,582	\$0	(\$151,582)	\$0
Pharmacy Rebates	\$145,571	\$145,571	\$0	\$0	\$0
Pharmacy Claims	\$0	\$52,723	\$0	(\$52,723)	\$0
Dental FFS and Managed Care	\$0	\$25,770	\$0	(\$25,770)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,544)	\$0	\$127,544	\$0
Subtotal (In PC 221)	\$145,571	\$248,102	\$0	(\$102,531)	\$0
Targeted Case Management	\$0	\$3,958	\$0	(\$3,958)	\$0
Subtotal (In PC 245)	\$0	\$3,958	\$0	(\$3,958)	\$0
<b>Grand Total</b>	<b>\$139,232</b>	<b>\$267,117</b>	<b>\$0</b>	<b>(\$127,885)</b>	<b>\$6,339</b>

\*County Funds are not included in Total Funds

5. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
<b>SMHS and DMC (PC 244)</b>	<b>(\$3,169)</b>	<b>\$139,125</b>	<b>\$0</b>	<b>(\$142,294)</b>	<b>\$3,169</b>
MC, Pharmacy, Dental, CDDS, Immigration (PC 221)	\$0	\$65,996	\$227,753	(\$293,749)	\$0
TCM (PC 245)	\$0	\$44,631	\$0	(\$44,631)	\$0
FY 2020-21	(\$3,169)	\$249,752	\$227,753	(\$480,674)	\$3,169

\*County Funds are not included in Total Funds

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
<b>SMHS and DMC (PC 244)</b>	<b>(\$6,339)</b>	<b>\$15,057</b>	<b>\$0</b>	<b>(\$21,396)</b>	<b>\$6,339</b>
MC, Pharmacy, Dental, CDDS, Immigration (PC 221)	\$145,571	\$260,102	\$0	(\$114,531)	\$0
TCM (PC 245)	\$0	\$3,958	\$0	(\$3,958)	\$0
FY 2021-22	\$139,232	\$279,117	\$0	(\$139,885)	\$6,339

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS - SMHS and DMC**  
REGULAR POLICY CHANGE NUMBER: 244

**Funding:**

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

100% Title XXI GF (4260-113-0001)

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

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

## STATE ONLY CLAIMING ADJUSTMENTS - TCM

**REGULAR POLICY CHANGE NUMBER:** 245  
**IMPLEMENTATION DATE:** 12/2020  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 2256

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$0
<b>- STATE FUNDS</b>	\$44,631,000	\$3,958,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$44,631,000	\$3,958,000
<b>FEDERAL FUNDS</b>	-\$44,631,000	-\$3,958,000

**Purpose:**

This policy change estimates (1) the return of Federal Financial Participation (FFP) to the federal government for claiming Medi-Cal Targeted Case Management (TCM) services for individuals without satisfactory immigrant status in full scope Medi-Cal coverage; and (2) the fiscal impact of prospective adjustments for this population.

For information on the state only claiming adjustments for the Medi-Cal Managed Care, Pharmacy, Dental, California Department of Developmental Services (CDDS) programs, and Immigration Status Change, please see the State Only Claiming Adjustments policy change. For information on the state only claiming adjustments for the Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) programs, please see the State Only Claiming Adjustments – SMHS and DMC policy change.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

State Only Claiming Adjustments  
 State Only Claiming Adjustments – SMHS and DMC

**Background:**

California provides state only full scope Medi-Cal services to certain immigrant populations who meet all Medi-Cal eligibility requirements except for their citizenship status. For these covered populations, FFP is only available for emergency and pregnancy-related services, and non-emergency and non-pregnancy related services are paid using state only funds. Affected populations include qualified non-citizens subject to the five-year bar, individuals who are Permanent Residents or Permanently Residing Under Color of Law, and individuals under 26 years of age who otherwise meet all Medi-Cal eligibility criteria (such as income and state residency) but for their citizenship status.

The Department has identified claiming for ineligible covered benefits and is required to return the federal funding to the Centers for Medicare and Medicaid Services (CMS). The Department



## STATE ONLY CLAIMING ADJUSTMENTS - TCM

### REGULAR POLICY CHANGE NUMBER: 245

has estimated the FFP amounts subject to repayment that must be retroactively returned and updates to associated claiming methodologies for prospective use.

#### CMS Deferral

On July 23, 2020, CMS issued a deferral for the state only claiming issue, for the Federal Fiscal Year (FFY) 2020 Quarter 1. On October 5, 2020, CMS issued a deferral for FFY 2020 Quarter 2. The Department anticipates that these deferrals will ultimately be reconciled against the Department's total estimated repayments owed to the federal government. See the CMS Deferred Claims policy change for details on CMS deferral payments.

#### **Reason for Change:**

This is a new policy change.

#### **Methodology:**

##### **Retroactive FFP Repayments**

1. Federal repayments for amounts in this policy change are expected to begin in December 2020.
2. Estimates of FFP repayments for Targeted Case Management cover claims from July 2010 through December 2020.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$126,756	\$0	(\$126,756)	\$0
Drug Medi-Cal	\$0	\$4,840	\$0	(\$4,840)	\$0
Subtotal (In PC 244)	\$0	\$131,596	\$0	(\$131,596)	\$0
Managed Care	\$0	\$92,383	\$0	(\$92,383)	\$0
Pharmacy Rebates	\$0	\$47,200	\$0	(\$47,200)	\$0
Dental FFS and Managed Care	\$0	\$114,352	\$0	(\$114,352)	\$0
CDDS	\$0	\$0	\$227,753	(\$227,753)	\$0
Immigration Status Change	\$0	(\$155,716)	\$0	\$155,716	\$0
Subtotal (In PC 221)	\$0	\$98,219	\$227,753	(\$325,972)	\$0
Targeted Case Management	\$0	\$42,652	\$0	(\$42,652)	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$42,652</b>	<b>\$0</b>	<b>(\$42,652)</b>	<b>\$0</b>
Grand Total	\$0	\$272,467	\$227,753	(\$500,220)	\$0

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS - TCM**  
REGULAR POLICY CHANGE NUMBER: 245

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	\$0	\$0	\$0	\$0	\$0
Drug Medi-Cal	\$0	\$0	\$0	\$0	\$0
Subtotal (In PC 244)	\$0	\$0	\$0	\$0	\$0
Managed Care	\$0	\$0	\$0	\$0	\$0
Pharmacy Rebates	\$0	\$12,000	\$0	(\$12,000)	\$0
Dental FFS and Managed Care	\$0	\$0	\$0	\$0	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	\$0	\$0	\$0	\$0
Subtotal (In PC 221)	\$0	\$12,000	\$0	(\$12,000)	\$0
Targeted Case Management	\$0	\$0	\$0	\$0	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Grand Total	\$0	\$12,000	\$0	(\$12,000)	\$0

\*County Funds are not included in Total Funds

**Prospective Adjustments**

3. Prospective adjustments estimates for TCM are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement (SF)</b>	<b>FF</b>	<b>CF*</b>
SMHS	(\$2,970)	\$6,863	\$0	(\$9,833)	\$2,970
Drug Medi-Cal	(\$199)	\$666	\$0	(\$865)	\$199
Subtotal (In PC 244)	(\$3,169)	\$7,529	\$0	(\$10,698)	\$3,169
Managed Care	\$0	\$59,100	\$0	(\$59,100)	\$0
Pharmacy Rebates	\$0	\$0	\$0	\$0	\$0
Pharmacy Claims	\$0	\$16,406	\$0	(\$16,406)	\$0
Dental FFS and Managed Care	\$0	\$19,327	\$0	(\$19,327)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,056)	\$0	\$127,056	\$0
Subtotal (In PC 221)	\$0	(\$32,223)	\$0	\$32,223	\$0
Targeted Case Management	\$0	\$1,979	\$0	(\$1,979)	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$1,979</b>	<b>\$0</b>	<b>(\$1,979)</b>	<b>\$0</b>
Grand Total	(\$3,169)	(\$22,715)	\$0	\$19,546	\$3,169

**STATE ONLY CLAIMING ADJUSTMENTS - TCM**  
REGULAR POLICY CHANGE NUMBER: 245

\*County Funds are not included in Total Funds

(Dollars in Thousands)

FY 2021-22	TF	GF	Reimbursement (SF)	FF	CF*
SMHS	(\$5,941)	\$13,726	\$0	(\$19,667)	\$5,941
Drug Medi-Cal	(\$398)	\$1,331	\$0	(\$1,729)	\$398
Subtotal (In PC 244)	(\$6,339)	\$15,057	\$0	(\$21,396)	\$6,339
Managed Care	\$0	\$151,582	\$0	(\$151,582)	\$0
Pharmacy Rebates	\$145,571	\$145,571	\$0	\$0	\$0
Pharmacy Claims	\$0	\$52,723	\$0	(\$52,723)	\$0
Dental FFS and Managed Care	\$0	\$25,770	\$0	(\$25,770)	\$0
CDDS	\$0	\$0	\$0	\$0	\$0
Immigration Status Change	\$0	(\$127,544)	\$0	\$127,544	\$0
Subtotal (In PC 221)	\$145,571	\$248,102	\$0	(\$102,531)	\$0
Targeted Case Management	\$0	\$3,958	\$0	(\$3,958)	\$0
<b>Subtotal (In PC 245)</b>	<b>\$0</b>	<b>\$3,958</b>	<b>\$0</b>	<b>(\$3,958)</b>	<b>\$0</b>
Grand Total	\$139,232	\$267,117	\$0	(\$127,885)	\$6,339

\*County Funds are not included in Total Funds

4. Total federal repayments and prospective adjustments are estimated to be:

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
SMHS and DMC (PC 244)	(\$3,169)	\$139,125	\$0	(\$142,294)	\$3,169
MC, Pharmacy, Dental, CDDS, Immigration (PC 221)	\$0	\$65,996	\$227,753	(\$293,749)	\$0
<b>TCM (PC 245)</b>	<b>\$0</b>	<b>\$44,631</b>	<b>\$0</b>	<b>(\$44,631)</b>	<b>\$0</b>
FY 2020-21	(\$3,169)	\$249,752	\$227,753	(\$480,674)	\$3,169

\*County Funds are not included in Total Funds

(Dollars In Thousands)	TF	GF	Reimbursement (SF)	FF	CF*
SMHS and DMC (PC 244)	(\$6,339)	\$15,057	\$0	(\$21,396)	\$6,339
MC, Pharmacy, Dental, CDDS, Immigration (PC 221)	\$145,571	\$260,102	\$0	(\$114,531)	\$0
<b>TCM (PC 245)</b>	<b>\$0</b>	<b>\$3,958</b>	<b>\$0</b>	<b>(\$3,958)</b>	<b>\$0</b>
FY 2021-22	\$139,232	\$279,117	\$0	(\$139,885)	\$6,339

\*County Funds are not included in Total Funds

**STATE ONLY CLAIMING ADJUSTMENTS - TCM**  
REGULAR POLICY CHANGE NUMBER: 245

**Funding:**

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

100% Title XIX Federal Funds (4260-101-0890)

## COVID-19 INCREASED FMAP EXTENSION - DHCS

**REGULAR POLICY CHANGE NUMBER:** 246  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Jerrold Anub  
**FISCAL REFERENCE NUMBER:** 2257

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$513,836,000
<b>- STATE FUNDS</b>	\$0	-\$1,583,411,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$513,836,000
<b>STATE FUNDS</b>	\$0	-\$1,583,411,000
<b>FEDERAL FUNDS</b>	\$0	\$2,097,247,000

**Purpose:**

This policy change estimates the impact on benefits expenditures of an assumed extension of the availability of increased federal medical assistance percentage (FMAP) from July 2021 through December 2021. For the estimated impact of assuming an extension of the availability of increased FMAP from July 2021 through December 2021 on administrative expenditures, see the COVID-19 Increased FMAP Extension - Other Admin policy change. For the estimated impact of increased FMAP from January 2020 through June 2021, see the COVID-19 Increased FMAP - DHCS and COVID-19 Increased FMAP – Other Admin policy changes.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

## COVID-19 INCREASED FMAP EXTENSION - DHCS

### REGULAR POLICY CHANGE NUMBER: 246

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. The increased FMAP of 6.2% is applicable on regular Medicaid 50% FMAP expenditures.
2. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures.
3. The COVID-19 Increased FMAP Extension policy change assumes a 6-month extension of the COVID-19 Increased FMAP policy change and is assumed to continue through December 31, 2021.
4. The following estimates reflect a cash basis:

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>Special Fund</b>	<b>FF</b>
FFCRA 6.20% Increased FFP	\$628,806	(\$1,369,992)	\$0	\$1,998,798
FFCRA 4.34% Increased FFP	\$565	(\$63,420)	\$0	\$63,985
HQA Revenue Fund 3158 COVID-19	(\$34,594)	\$0	(\$34,594)	\$0
COVID-19 FF T-19 HQAF 6.2%	\$33,120	\$0	\$0	\$33,120
COVID-19 FF T-21 HQAF 4.34%	\$1,474	\$0	\$0	\$1,474
Reimbursement GF	(\$3,824)	\$0	(\$3,824)	\$0
WPC Special Fund	(\$26,210)	\$0	(\$26,210)	\$0
BCCTP FFCRA Fund	\$0	\$130	\$0	(\$130)
Medi-Cal Drug Rebate Fund	(\$85,501)	\$0	(\$85,501)	\$0
<b>Total</b>	<b>\$513,836</b>	<b>(\$1,433,282)</b>	<b>(\$150,129)</b>	<b>\$2,097,247</b>

#### Funding:

FFCRA 6.20% Increased FFP (4260-101-0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 6.20% GF (4260-101-0001)  
 FFCRA 4.34% GF (4260-113-0001)  
 Hospital Quality Assurance Revenue Fund (4260-611-3158)  
 FFCRA 6.2% Increased FFP (4260-611-0890)  
 FFCRA 4.34% Increased FFP (4260-611-0890)  
 Whole Person Care Pilot Special Fund (4260-601-8107)  
 100% Reimbursement (4260-601-0995)  
 FFCRA BCCTP 4.34% Increase FFP (4260-101-0890)  
 FFCRA BCCTP 4.34% GF (4260-101-0001)  
 Medi-Cal Drug Rebate Fund (4260-601-3331)

## COVID-19 VACCINE ADMINISTRATION

**REGULAR POLICY CHANGE NUMBER:** 247  
**IMPLEMENTATION DATE:** 1/2021  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2259

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$31,650,000	\$315,744,000
<b>- STATE FUNDS</b>	\$10,761,000	\$107,353,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$31,650,000	\$315,744,000
<b>STATE FUNDS</b>	\$10,761,000	\$107,353,000
<b>FEDERAL FUNDS</b>	\$20,889,000	\$208,391,000

**Purpose:**

This policy change estimates the cost of reimbursing providers for administering the COVID-19 vaccine to Medi-Cal beneficiaries.

**Authority:**

Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Centers for Medicare and Medicaid Services (CMS) expects the initial supply of COVID-19 vaccines will be federally purchased. Medicaid programs must provide reimbursement to providers for the administration of the vaccine. The provider reimbursement of the vaccine administration includes costs involved in administering the vaccine including the additional resources involved with required public health reporting, conducting outreach, and patient education. The Medi-Cal cost of the administration of the COVID-19 vaccine will be shared between the state and federal government.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume the COVID-19 vaccine will begin to be administered by January 2021 for adults, and a pediatric COVID-19 vaccine to be administered by July 2021.
2. The reimbursement rate for the COVID-19 vaccine administration is \$28.39 to administer single-dose vaccines and \$45.33 for vaccines requiring a series of two or more doses, based on Medicare rates.
3. Assume 50% of beneficiaries will receive a single dose of the vaccine, and 50% will receive a double dose of the vaccine.

**COVID-19 VACCINE ADMINISTRATION**  
REGULAR POLICY CHANGE NUMBER: 247

4. The estimated cost for the COVID-19 vaccine administration for FY 2020-21 and FY 2021-22 is:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
COVID-19 Vaccine Administration	\$31,650	\$10,761	\$20,889
<b>Total</b>	<b>\$31,650</b>	<b>\$10,761</b>	<b>\$20,889</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
COVID-19 Vaccine Administration	\$315,744	\$107,353	\$208,391
<b>Total</b>	<b>\$315,744</b>	<b>\$107,353</b>	<b>\$208,391</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
100% Title XIX GF (4260-101-0001)	\$10,761	\$10,761	\$0
100% Title XIX FF (4260-101-0890)	\$14,076	\$0	\$14,076
ACA 100% FFP (4260-101-0890)	\$6,813	\$0	\$6,813
<b>Total</b>	<b>\$31,650</b>	<b>\$10,761</b>	<b>\$20,889</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
100% Title XIX GF (4260-101-0001)	\$96,287	\$96,287	\$0
100% Title XIX FF (4260-101-0890)	\$125,946	\$0	\$125,946
ACA 100% FFP (4260-101-0890)	\$60,964	\$0	\$60,964
100% Title XXI GF (4260-113-0001)	\$11,066	\$11,066	\$0
100% Title XXI FFP (4260-113-0890)	\$21,481	\$0	\$21,481
<b>Total</b>	<b>\$315,744</b>	<b>\$107,353</b>	<b>\$208,391</b>



## INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SRVS.

**REGULAR POLICY CHANGE NUMBER:** 248  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Jerrold Anub  
**FISCAL REFERENCE NUMBER:** 2260

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$388,986,000
<b>- STATE FUNDS</b>	\$0	\$194,493,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$388,986,000
<b>STATE FUNDS</b>	\$0	\$194,493,000
<b>FEDERAL FUNDS</b>	\$0	\$194,493,000

**Purpose:**

This policy change estimates expenditures related to implementing an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Schools are a critical point of access for preventive and early intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. The consequences of not addressing child and adolescent mental health conditions often extend to adulthood. Early identification and treatment through school-based or school-linked services can reduce emergency room visits, crisis situations, inpatient stays and placement in high-cost special education settings and/or out of home placement. Schools often lack on-campus behavioral health resources and find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school-based mental health professionals.

In order to build infrastructure, partnerships, and capacity statewide, DHCS will implement incentive payments to qualifying Medi-Cal managed care plans for a variety of interventions for a maximum period of three calendar years commencing with the January 1, 2022, rating period.

**Reason for Change:**

This is a new Policy Change.

**INCREASE ACCESS TO STUDENT BEHAVIORAL HEALTH SRVS.**  
**REGULAR POLICY CHANGE NUMBER: 248**

**Methodology:**

1. Assume expenditures of \$388,986,000 TF (\$194,493,000 GF) in FY 2021-22. These funds will be available until June 30, 2024.

**Funding:**

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

## BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE

**REGULAR POLICY CHANGE NUMBER:** 249  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2262

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	\$0	\$750,000,000
<b>- STATE FUNDS</b>	\$0	\$750,000,000
<b>PAYMENT LAG</b>	1.0000	1.0000
<b>% REFLECTED IN BASE</b>	0.00 %	0.00 %
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	\$0	\$750,000,000
<b>STATE FUNDS</b>	\$0	\$750,000,000
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the funding available to provide competitive grants to counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days by appropriately utilizing community-based models of care. The Department proposes to invest in the addition of at least 5,000 beds, units, or rooms to expand behavioral health continuum infrastructure capacity. These resources would improve the comprehensive continuum of services by enabling facilities to provide short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation opportunities of persons with behavioral health disorders, in the least restrictive and least costly setting. Counties would be required to provide a match of local funds.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume \$750 million General Fund (GF) will be available for counties to expand resources beginning FY 2021-22. These funds will be available until June 30, 2024.

**BEHAVIORAL HEALTH CONTINUUM INFRASTRUCTURE**  
REGULAR POLICY CHANGE NUMBER: 249

2. Funding would be made available to counties via a competitive application process.

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Behavioral Health Continuum Infrastructure Funds	\$750,000	\$750,000	\$0
<b>Total</b>	<b>\$750,000</b>	<b>\$750,000</b>	<b>\$0</b>

**Funding:**

100% GF (4260-101-0001)

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**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2020-21**

<b>NO.</b>	<b>POLICY CHANGE TITLE</b>	<b>TOTAL FUNDS</b>	<b>FEDERAL FUNDS</b>	<b>GENERAL FUNDS</b>	<b>OTHER STATE FUNDS</b>
	<b><u>OTHER</u></b>				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,150,566,000	\$1,075,283,000	\$1,075,283,000	\$0
2	SAWS	\$110,718,000	\$110,718,000	\$0	\$0
3	CaWORKS APPLICATIONS	\$67,498,000	\$33,749,000	\$33,749,000	\$0
4	CASE MANAGEMENT FOR OTLICP	\$43,498,000	\$21,749,000	\$21,749,000	\$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$40,547,000	\$35,691,500	\$4,855,500	\$0
6	ENHANCED FEDERAL FUNDING	\$0	\$521,754,500	(\$521,754,500)	\$0
7	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$2,412,827,000</b>	<b>\$1,802,945,000</b>	<b>\$609,882,000</b>	<b>\$0</b>
	<b>GRAND TOTAL</b>	<b>\$2,412,827,000</b>	<b>\$1,802,945,000</b>	<b>\$609,882,000</b>	<b>\$0</b>

**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE COST BREAKDOWN  
FISCAL YEAR 2020-21**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	<b><u>OTHER</u></b>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,150,566,000	\$0	\$2,150,566,000	\$1,075,283,000
2	SAWS	\$110,718,000	\$0	\$0	\$0	\$110,718,000	\$0
3	CalWORKS APPLICATIONS	\$0	\$0	\$67,498,000	\$0	\$67,498,000	\$33,749,000
4	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$43,498,000	\$43,498,000	\$21,749,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$40,547,000	\$40,547,000	\$4,855,500
6	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$521,754,500)
7	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	<b>OTHER SUBTOTAL</b>	<b>\$110,718,000</b>	<b>\$0</b>	<b>\$2,218,064,000</b>	<b>\$84,045,000</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>
	<b>GRAND TOTAL</b>	<b>\$110,718,000</b>	<b>\$0</b>	<b>\$2,218,064,000</b>	<b>\$84,045,000</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>

**SUMMARY OF COUNTY ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2021-22**

<b>NO.</b>	<b>POLICY CHANGE TITLE</b>	<b>TOTAL FUNDS</b>	<b>FEDERAL FUNDS</b>	<b>GENERAL FUNDS</b>	<b>OTHER STATE FUNDS</b>
	<b><u>OTHER</u></b>				
1	COUNTY ADMINISTRATION ALLOCATION	\$2,215,943,000	\$1,107,971,500	\$1,107,971,500	\$0
2	SAWS	\$67,310,000	\$67,310,000	\$0	\$0
3	CaWORKS APPLICATIONS	\$67,498,000	\$33,749,000	\$33,749,000	\$0
4	CASE MANAGEMENT FOR OTLICP	\$43,560,000	\$21,780,000	\$21,780,000	\$0
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$40,547,000	\$35,691,500	\$4,855,500	\$0
6	ENHANCED FEDERAL FUNDING	\$0	\$518,160,500	(\$518,160,500)	\$0
7	SAVE	\$0	\$4,000,000	(\$4,000,000)	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$2,434,858,000</b>	<b>\$1,788,662,500</b>	<b>\$646,195,500</b>	<b>\$0</b>
	<b>GRAND TOTAL</b>	<b>\$2,434,858,000</b>	<b>\$1,788,662,500</b>	<b>\$646,195,500</b>	<b>\$0</b>



**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE COST BREAKDOWN  
FISCAL YEAR 2021-22**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGES	GENERAL FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	<b><u>OTHER</u></b>						
1	COUNTY ADMINISTRATION ALLOCATION	\$0	\$0	\$2,215,943,000	\$0	\$2,215,943,000	\$1,107,971,500
2	SAWS	\$67,310,000	\$0	\$0	\$0	\$67,310,000	\$0
3	CalWORKS APPLICATIONS	\$0	\$0	\$67,498,000	\$0	\$67,498,000	\$33,749,000
4	CASE MANAGEMENT FOR OTLICP	\$0	\$0	\$0	\$43,560,000	\$43,560,000	\$21,780,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$40,547,000	\$40,547,000	\$4,855,500
6	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	(\$518,160,500)
7	SAVE	\$0	\$0	\$0	\$0	\$0	(\$4,000,000)
	<b>OTHER SUBTOTAL</b>	<b>\$67,310,000</b>	<b>\$0</b>	<b>\$2,283,441,000</b>	<b>\$84,107,000</b>	<b>\$2,434,858,000</b>	<b>\$646,195,500</b>
	<b>GRAND TOTAL</b>	<b>\$67,310,000</b>	<b>\$0</b>	<b>\$2,283,441,000</b>	<b>\$84,107,000</b>	<b>\$2,434,858,000</b>	<b>\$646,195,500</b>

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>OTHER</b>						
1	1	COUNTY ADMINISTRATION ALLOCATION	\$2,150,566,000	\$1,075,283,000	\$2,150,566,000	\$1,075,283,000	\$0	\$0
2	2	SAWS	\$120,600,000	\$0	\$110,718,000	\$0	(\$9,882,000)	\$0
3	3	CalWORKS APPLICATIONS	\$56,119,000	\$28,059,500	\$67,498,000	\$33,749,000	\$11,379,000	\$5,689,500
4	4	CASE MANAGEMENT FOR OTLICP	\$43,498,000	\$21,749,000	\$43,498,000	\$21,749,000	\$0	\$0
5	5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$43,275,000	\$4,761,000	\$40,547,000	\$4,855,500	(\$2,728,000)	\$94,500
6	6	ENHANCED FEDERAL FUNDING	\$0	(\$517,726,000)	\$0	(\$521,754,500)	\$0	(\$4,028,500)
8	7	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
		<b>OTHER SUBTOTAL</b>	<b>\$2,414,058,000</b>	<b>\$608,126,500</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>	<b>(\$1,231,000)</b>	<b>\$1,755,500</b>
		<b>COUNTY ADMINISTRATION GRAND TOTAL</b>	<b>\$2,414,058,000</b>	<b>\$608,126,500</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>	<b>(\$1,231,000)</b>	<b>\$1,755,500</b>

**COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b>OTHER</b>						
1	COUNTY ADMINISTRATION ALLOCATION	\$2,150,566,000	\$1,075,283,000	\$2,215,943,000	\$1,107,971,500	\$65,377,000	\$32,688,500
2	SAWS	\$110,718,000	\$0	\$67,310,000	\$0	(\$43,408,000)	\$0
3	CalWORKS APPLICATIONS	\$67,498,000	\$33,749,000	\$67,498,000	\$33,749,000	\$0	\$0
4	CASE MANAGEMENT FOR OTLICP	\$43,498,000	\$21,749,000	\$43,560,000	\$21,780,000	\$62,000	\$31,000
5	LOS ANGELES COUNTY HOSPITAL INTAKES	\$40,547,000	\$4,855,500	\$40,547,000	\$4,855,500	\$0	\$0
6	ENHANCED FEDERAL FUNDING	\$0	(\$521,754,500)	\$0	(\$518,160,500)	\$0	\$3,594,000
7	SAVE	\$0	(\$4,000,000)	\$0	(\$4,000,000)	\$0	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>	<b>\$2,434,858,000</b>	<b>\$646,195,500</b>	<b>\$22,031,000</b>	<b>\$36,313,500</b>
	<b>COUNTY ADMINISTRATION GRAND TOTAL</b>	<b>\$2,412,827,000</b>	<b>\$609,882,000</b>	<b>\$2,434,858,000</b>	<b>\$646,195,500</b>	<b>\$22,031,000</b>	<b>\$36,313,500</b>

**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE INDEX**

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b><u>OTHER</u></b>
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	SAVE

## COUNTY ADMINISTRATION ALLOCATION

**COUNTY ADMIN. POLICY CHANGE NUMBER:** 1  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1704

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$2,150,566,000	\$0	\$2,215,943,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	<b>\$0</b>	<b>\$2,150,566,000</b>	<b>\$0</b>	<b>\$2,215,943,000</b>
STATE FUNDS	\$0	\$1,075,283,000	\$0	\$1,107,971,500
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$2,150,566,000	\$0	\$2,215,943,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	<b>\$0</b>	<b>\$2,150,566,000</b>	<b>\$0</b>	<b>\$2,215,943,000</b>
STATE FUNDS	\$0	\$1,075,283,000	\$0	\$1,107,971,500

**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.

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 Consumer 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. 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.

## COUNTY ADMINISTRATION ALLOCATION

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the Department increasing the total allocation by 3.04% for the projected California CPI, resulting in a \$65M increase.

**Methodology:**

1. The total rounded estimated FY 2020-21 and FY 2021-22 county administration costs are:

(Dollars in Thousands)

Total Allocation	TF	GF	FF
FY 2020-21	\$2,150,566	\$1,075,283	\$1,075,283
FY 2021-22	\$2,215,943	\$1,107,972	\$1,107,971

\* Totals may differ due to rounding

**Funding:**

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

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:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 214

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
<b>PROCEDURAL - TOT.</b>	\$110,718,000	\$0	\$67,310,000	\$0
<b>CASELOAD - TOT.</b>	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$110,718,000	\$0	\$67,310,000	\$0
<b>STATE FUNDS</b>	\$0	\$0	\$0	\$0
<b>% IN BASE</b>				
<b>PROCEDURAL</b>	0.00 %	0.00 %	0.00 %	0.00 %
<b>CASELOAD</b>	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
<b>PROCEDURAL - TOT.</b>	\$110,718,000	\$0	\$67,310,000	\$0
<b>CASELOAD - TOT.</b>	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$110,718,000	\$0	\$67,310,000	\$0
<b>STATE FUNDS</b>	\$0	\$0	\$0	\$0

**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 interfaces.

## SAWS

### COUNTY ADMIN. POLICY CHANGE NUMBER: 2

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.

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 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 change from the prior estimate, for FY 2020-21, is a decrease due to updated expenditure data provided by CDSS. The change from FY 2020-21 to 2021-22, in the current estimate, is a decrease due to updated expenditure data provided by CDSS.

#### Methodology:

- The following estimate was provided by CDSS on a cash basis:

(Dollars in Thousands)

Line Item	FY 2020-21	FY 2021-22
Statewide Project Management	\$2,372	\$2,372
SB 1341 Medi-Cal/SAWS	\$3,049	\$6,082
WCDS-CalWIN	\$40,219	\$40,001
CalACES	\$62,722	\$18,856
Shared Application Forms Revisions	\$2,356	\$0
<b>Total</b>	<b>\$110,718</b>	<b>\$67,310</b>

\*Totals may differ due to rounding.

- Assume an estimated annual cost of \$110,718,000 TF in FY 2020-21 and \$67,310,000 TF in FY 2021-22.

#### Funding:

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

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



## CalWORKS APPLICATIONS

**COUNTY ADMIN. POLICY CHANGE NUMBER:** 3  
**IMPLEMENTATION DATE:** 7/1998  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 217

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$67,498,000	\$0	\$67,498,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$67,498,000	\$0	\$67,498,000
STATE FUNDS	\$0	\$33,749,000	\$0	\$33,749,000
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$67,498,000	\$0	\$67,498,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$67,498,000	\$0	\$67,498,000
STATE FUNDS	\$0	\$33,749,000	\$0	\$33,749,000

**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 has shared 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 for FY 2020-21, from the previous estimate, is an increase due to updated expenditure data provided by CDSS. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**CaIWORKS APPLICATIONS**  
**COUNTY ADMIN. POLICY CHANGE NUMBER: 3**

**Methodology:**

- The estimated costs for FY 2020-21 and FY 2021-22 are provided on a cash basis by CDSS:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$67,498</b>	<b>\$33,749</b>	<b>\$33,749</b>
<b>FY 2021-22</b>	<b>\$67,498</b>	<b>\$33,749</b>	<b>\$33,749</b>

\*Totals may differ due to rounding.

**Funding:**

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

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:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1598

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$43,498,000	\$0	\$43,560,000
<b>TOTAL FUNDS</b>	\$0	\$43,498,000	\$0	\$43,560,000
STATE FUNDS	\$0	\$21,749,000	\$0	\$21,780,000
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$43,498,000	\$0	\$43,560,000
<b>TOTAL FUNDS</b>	\$0	\$43,498,000	\$0	\$43,560,000
STATE FUNDS	\$0	\$21,749,000	\$0	\$21,780,000

**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:**

There is no change from the previous estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase due to higher estimated eligible trends.

**Methodology:**

1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at \$4.00 Per Member Per Month.
2. The estimated average monthly OTLICP eligibles for FY 2020-21 is 906,218 and 907,490 for FY 2021-22.

**CASE MANAGEMENT FOR OTLICP**  
**COUNTY ADMIN. POLICY CHANGE NUMBER: 4**

3. The estimated costs are:

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$43,498</b>	<b>\$21,749</b>	<b>\$21,749</b>
<b>FY 2021-22</b>	<b>\$43,560</b>	<b>\$21,780</b>	<b>\$21,780</b>

**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:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 213

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$40,547,000	\$0	\$40,547,000
<b>TOTAL FUNDS</b>	\$0	\$40,547,000	\$0	\$40,547,000
STATE FUNDS	\$0	\$4,855,500	\$0	\$4,855,500
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$40,547,000	\$0	\$40,547,000
<b>TOTAL FUNDS</b>	\$0	\$40,547,000	\$0	\$40,547,000
STATE FUNDS	\$0	\$4,855,500	\$0	\$4,855,500

**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 (W&I) 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. W&I 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:**

The change from the prior estimate, for FY 2020-21, is a slight decrease due to the final reconciliation being lower than the placeholder amounts for FY 2018-19.

There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

## LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

**Methodology:**

1. The reimbursement rate is \$268 for both current year and budget year. Assume in FY 2020-21 and FY 2021-22, PFSWs will continue processing a base caseload of 2,215 per month.

FY 2020-21: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,561,500 GF)

FY 2021-22: 2,215 x \$268 x 12 = \$7,123,000 TF (\$3,561,500 GF)

2. The Department completed the FY 2018-19 reconciliation in FY 2020-21. The FY 2019 -20 reconciliation amounts are placeholders.

(Dollars in Thousands)

Line Item	FY 2020-21			FY 2021-22		
	TF	GF	FF	TF	GF	FF
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2018-19 Recon.	\$18,006	\$1,294	\$16,712			
FY 2018-19 Pass.	\$15,418	\$0	\$15,418			
FY 2019-20 Recon.				\$18,006	\$1,294	\$16,712
FY 2019-20 Pass.				\$15,418	\$0	\$15,418
<b>Total</b>	<b>\$40,547</b>	<b>\$4,855</b>	<b>\$35,692</b>	<b>\$40,547</b>	<b>\$4,855</b>	<b>\$35,692</b>

**Funding:**

(Dollars in Thousands)

FY 2020-21	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	\$32,130	\$0	\$32,130
100% GF	4260-101-0001	\$1,294	\$1,294	\$0
<b>Total</b>		<b>\$40,547</b>	<b>\$4,855</b>	<b>\$35,692</b>

FY 2021-22	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	\$32,130	\$0	\$32,130
100% GF	4260-101-0001	\$1,294	\$1,294	\$0
<b>Total</b>		<b>\$40,547</b>	<b>\$4,855</b>	<b>\$35,692</b>

**ENHANCED FEDERAL FUNDING**

**COUNTY ADMIN. POLICY CHANGE NUMBER:** 6  
**IMPLEMENTATION DATE:** 1/2015  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1835

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$0	\$0	\$0
STATE FUNDS	-\$521,754,500	\$0	-\$518,160,500	\$0
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$0	\$0	\$0
STATE FUNDS	-\$521,754,500	\$0	-\$518,160,500	\$0

**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.

There are various conditions required of a MMIS to secure the enhanced funding. There are also minimum critical success factors for accepting the new applications, making modified adjusted gross income determinations and coordination with Covered California. The Department submitted an Advanced Planning Document (APD) to secure CMS approval in January 2014, and received approval on September 29, 2014. The Department conducts an

## ENHANCED FEDERAL FUNDING

### COUNTY ADMIN. POLICY CHANGE NUMBER: 6

annual APD review and submits an update to CMS. CMS approved the APD for FFY 2020 on September 30, 2019.

#### Reason for Change:

The change from the prior estimate, for FY 2020-21, is an increase in General Fund (GF) savings due to receiving more quarters of actual, audited, and updated claimed expenditure data from the California Department of Social Services (CDSS), which is used to identify and claim enhanced federal funding.

The change from FY 2020-21 to 2021-22, in the current estimate, is a decrease in GF savings due to updated estimated claim funding projections that utilize the expenditure trends from 3 quarters of prior claim actuals for FY 2019-20 and 1 quarter of current claim actuals for FY 2020-21.

#### Methodology:

1. The effective date for the Department's APD is September 30, 2019.
2. The Department utilizes actual, audited, and claimed expenditure data provided by CDSS to identify and claim Enhanced FFP and to estimate FFP for future quarters.
3. Beginning December 2018, the Department will receive reports from CDSS identifying actual expenditure costs eligible for enhanced funding.
4. In FY 2020-21, the Department will claim payments for FY 2019-20 quarters 3 and 4 and FY 2020-21 quarters 1 and 2. In FY 2021-22, the Department will claim payments for FY 2020-21 quarters 3 and 4 and FY 2021-22 quarters 1 and 2.
5. The savings are estimated to be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX at 50% FFP	(\$2,087,000)	(\$1,044,000)	(\$1,044,000)
Title XIX at 75% FFP	\$2,087,000	\$522,000	\$1,565,000
<b>Total Difference</b>	<b>\$0</b>	<b>(\$522,000)</b>	<b>\$522,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX at 50% FFP	(\$2,073,000)	(\$1,036,000)	(\$1,036,000)
Title XIX at 75% FFP	\$2,073,000	\$518,000	\$1,554,000
<b>Total Difference</b>	<b>\$0</b>	<b>(\$518,000)</b>	<b>\$518,000</b>

\*Totals may differ due to rounding.

#### Funding:

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

75% Title XIX FF/ 25% GF (4260-101-0890/0001)



**SAVE**

**COUNTY ADMIN. POLICY CHANGE NUMBER:** 7  
**IMPLEMENTATION DATE:** 10/1988  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 215

	FY 2020-21		FY 2021-22	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
<b>TOTAL FUNDS</b>	\$0	\$0	\$0	\$0
STATE FUNDS	-\$4,000,000	\$0	-\$4,000,000	\$0

**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 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 2020-21. There is no change, in the current estimate, from FY 2020-21 to FY 2021-22.

**Methodology:**

1. A reconciliation is completed 18 months after the end of each fiscal year to adjust funding received by counties from 50% FFP to 100% FFP.

**SAVE**  
**COUNTY ADMIN. POLICY CHANGE NUMBER: 7**

2. The Medi-Cal accrual costs for SAVE reported over the last three years by the counties were:

<b>Fiscal Year</b>	<b>Actual</b>	<b>Fiscal Year</b>	<b>Estimated</b>
FY 2016-17	\$8,037,456	FY 2019-20	\$8,000,000
FY 2017-18	\$7,747,115	FY 2020-21	\$8,000,000
FY 2018-19	\$8,130,592	FY 2021-22	\$8,000,000

3. Based on claims through June 2019, federal funds will be:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX /50% GF 4260-101-0890/0001	(\$8,000)	(\$4,000)	(\$4,000)
100 % Title XIX FFP 4260-101-0890	\$8,000	\$0	\$8,000
<b>Net Impact</b>	<b>\$0</b>	<b>(\$4,000)</b>	<b>\$4,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX /50% GF 4260-101-0890/0001	(\$8,000)	(\$4,000)	(\$4,000)
100% Title XIX FFP 4260-101-0890	\$8,000	\$0	\$8,000
<b>Net Impact</b>	<b>\$0</b>	<b>(\$4,000)</b>	<b>\$4,000</b>

**Funding:**

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

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

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**OTHER ADMINISTRATION**

*The Other Administration section provides a detailed overview of estimated expenditures required to administer the Medi-Cal program for both current and budget years. This section includes both Local Assistance Administrative (other than County Administration) costs and Fiscal Intermediary (FI) costs associated with processing of claims.*

**FUNDING SUMMARY OF ALL LOCAL ASSISTANCE ADMINISTRATION COSTS BY FUND TYPE (INCLUDES COUNTY ADMINISTRATION COSTS) ..... COVER PAGE**

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## November 2020 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.

<b><u>FY 2020-2021 Estimate:</u></b>	<b><u>Total Funds</u></b>	<b><u>Federal Funds</u></b>	<b><u>General Funds</u></b>	<b><u>Other State Funds</u></b>
<b>OTHER ADMINISTRATION</b>				
County Administration	\$2,299,444,000	\$1,897,119,000	\$392,628,000	\$9,697,000
Fiscal Intermediary	\$384,968,000	\$260,491,000	\$124,477,000	\$0
<b>Total Other Administration Tab</b>	<b>\$2,684,412,000</b>	<b>\$2,157,610,000</b>	<b>\$517,105,000</b>	<b>\$9,697,000</b>

**Management Summary:**

<b>COUNTY ADMINISTRATION</b>	<b>\$4,712,272,000</b>	<b>\$3,700,064,000</b>	<b>\$1,002,510,000</b>	<b>\$9,697,000</b>
Shown in Other Administration Tab	\$2,299,444,000	\$1,897,119,000	\$392,628,000	\$9,697,000
Shown in County Administration Tab	\$2,412,828,000	\$1,802,945,000	\$609,882,000	\$0
<b>FISCAL INTERMEDIARY</b>	<b>\$384,968,000</b>	<b>\$260,491,000</b>	<b>\$124,477,000</b>	<b>\$0</b>
Shown in Other Administration Tab	\$384,968,000	\$260,491,000	\$124,477,000	\$0

<b><u>FY 2021-2022 Estimate:</u></b>	<b><u>Total Funds</u></b>	<b><u>Federal Funds</u></b>	<b><u>General Funds</u></b>	<b><u>Other State Funds</u></b>
<b>OTHER ADMINISTRATION</b>				
County Administration	\$2,126,894,000	\$2,134,080,000	(\$12,454,000)	\$5,268,000
Fiscal Intermediary	\$463,753,000	\$319,600,000	\$144,153,000	\$0
<b>Total Other Administration Tab</b>	<b>\$2,590,647,000</b>	<b>\$2,453,680,000</b>	<b>\$131,699,000</b>	<b>\$5,268,000</b>

**Management Summary:**

<b>COUNTY ADMINISTRATION</b>	<b>\$4,561,754,000</b>	<b>\$3,922,743,000</b>	<b>\$633,742,000</b>	<b>\$5,268,000</b>
Shown in Other Administration Tab	\$2,126,894,000	\$2,134,080,000	(\$12,454,000)	\$5,268,000
Shown in County Administration Tab	\$2,434,860,000	\$1,788,663,000	\$646,196,000	\$0
<b>FISCAL INTERMEDIARY</b>	<b>\$463,753,000</b>	<b>\$319,600,000</b>	<b>\$144,153,000</b>	<b>\$0</b>
Shown in Other Administration Tab	\$463,753,000	\$319,600,000	\$144,153,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2020-21**

<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>
	<b><u>DHCS-OTHER</u></b>				
1	CCS CASE MANAGEMENT	\$172,475,000	\$113,941,720	\$58,533,280	\$0
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$180,524,000	\$180,524,000	\$0	\$0
3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$139,218,000	\$139,283,000	(\$65,000)	\$0
4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$130,567,000	\$130,567,000	\$0	\$0
5	SMH MAA	\$51,376,000	\$51,376,000	\$0	\$0
6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$40,057,000	\$36,030,000	\$4,027,000	\$0
7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$39,781,000	\$29,399,420	\$10,381,580	\$0
8	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$26,862,000	\$15,031,000	\$11,831,000	\$0
9	ARRA HITECH INCENTIVE PROGRAM	\$38,843,000	\$38,171,000	\$0	\$672,000
10	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$35,633,000	\$35,633,000	\$0	\$0
11	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$35,349,000	\$22,349,020	\$12,999,980	\$0
12	CHDP COUNTY ALLOCATION	\$33,962,000	\$22,005,000	\$11,957,000	\$0
13	SMHS COUNTY UR & QA ADMIN	\$53,136,000	\$52,173,000	\$963,000	\$0
14	HEALTH ENROLLMENT NAVIGATORS	\$28,638,000	\$14,319,000	\$14,319,000	\$0
15	POSTAGE & PRINTING	\$27,600,000	\$13,671,500	\$13,928,500	\$0
16	DRUG MEDI-CAL COUNTY UR & QA ADMIN	\$22,977,000	\$22,977,000	\$0	\$0
17	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$20,836,000	\$19,815,000	\$1,021,000	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$19,706,000	\$9,853,000	\$9,434,500	\$418,500
19	MANAGED CARE REGULATIONS - MH PARITY	\$19,155,000	\$16,418,000	\$2,737,000	\$0
20	HCBA WAIVER ADMINISTRATIVE COST	\$13,947,000	\$6,973,500	\$6,973,500	\$0
21	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,606,500	\$0
22	MITA	\$11,002,000	\$9,574,440	\$1,427,560	\$0
23	PAVE SYSTEM	\$10,238,000	\$14,721,770	(\$4,483,770)	\$0
24	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
25	CAPMAN	\$8,324,000	\$6,155,930	\$2,168,070	\$0
26	MEDI-CAL RECOVERY CONTRACTS	\$7,785,000	\$5,838,750	\$1,946,250	\$0
27	PASRR	\$7,441,000	\$5,580,750	\$1,860,250	\$0
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$6,139,000	\$4,354,250	\$1,784,750	\$0
29	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$3,065,500	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2020-21**

<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>
<b><u>DHCS-OTHER</u></b>					
30	PERFORMANCE OUTCOMES SYSTEM	\$4,379,000	\$2,479,500	\$1,899,500	\$0
31	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,960,000	\$1,980,000	\$1,980,000	\$0
32	PACES	\$2,725,000	\$2,317,880	\$407,120	\$0
33	MEDCOMPASS SOLUTION	\$2,401,000	\$2,419,070	(\$18,070)	\$0
34	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,066,000	\$1,033,000	\$1,033,000	\$0
36	T-MSIS	\$1,585,000	\$1,338,060	\$246,940	\$0
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
38	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$981,000	\$696,000	\$285,000	\$0
39	CALIFORNIA HEALTH INTERVIEW SURVEY	\$977,000	\$977,000	\$0	\$0
40	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$375,000	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$731,000	\$365,500	\$365,500	\$0
42	LTSS ACTUARIAL STUDY	\$423,000	\$0	\$423,000	\$0
43	CCT OUTREACH - ADMINISTRATIVE COSTS	\$360,000	\$360,000	\$0	\$0
45	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	\$1,824,000	(\$1,824,000)	\$0
46	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	(\$182,984,000)	\$182,984,000	\$0
47	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	(\$9,113,000)	(\$9,113,000)	\$0	\$0
	<b>DHCS-OTHER SUBTOTAL</b>	<b>\$1,224,652,000</b>	<b>\$856,714,840</b>	<b>\$366,846,660</b>	<b>\$1,090,500</b>
<b><u>DHCS-MEDICAL FI</u></b>					
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$52,284,000	\$39,008,370	\$13,275,630	\$0
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$45,377,000	\$32,862,760	\$12,514,240	\$0
50	MEDICAL FI BO & IT CHANGE ORDERS	\$37,656,000	\$28,093,880	\$9,562,120	\$0
51	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$33,989,000	\$25,363,220	\$8,625,780	\$0
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$23,272,000	\$16,505,780	\$6,766,220	\$0
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$15,899,000	\$11,280,680	\$4,618,320	\$0
54	MEDICAL FI BUSINESS OPERATIONS	\$15,289,000	\$11,407,370	\$3,881,630	\$0
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,776,000	\$8,040,270	\$2,735,730	\$0
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,468,000	\$1,703,720	\$764,280	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2020-21**

<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>
<b><u>DHCS-MEDICAL FI</u></b>					
57	CMS DEFERRED CLAIMS - FI	\$0	(\$920,000)	\$920,000	\$0
	<b>DHCS-MEDICAL FI SUBTOTAL</b>	<b>\$237,010,000</b>	<b>\$173,346,060</b>	<b>\$63,663,940</b>	<b>\$0</b>
<b><u>DHCS-HEALTH CARE OPT</u></b>					
58	HCO OPERATIONS 2017 CONTRACT	\$40,500,000	\$20,611,940	\$19,888,060	\$0
59	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,646,000	\$10,507,470	\$10,138,530	\$0
60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$14,171,000	\$7,212,200	\$6,958,800	\$0
	<b>DHCS-HEALTH CARE OPT SUBTOTAL</b>	<b>\$75,317,000</b>	<b>\$38,331,620</b>	<b>\$36,985,380</b>	<b>\$0</b>
<b><u>DHCS-DENTAL FI</u></b>					
61	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$34,722,000	\$21,854,250	\$12,867,750	\$0
62	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,897,000	\$15,002,500	\$5,894,500	\$0
	<b>DHCS-DENTAL FI SUBTOTAL</b>	<b>\$55,619,000</b>	<b>\$36,856,750</b>	<b>\$18,762,250</b>	<b>\$0</b>
<b><u>OTHER DEPARTMENTS</u></b>					
64	PERSONAL CARE SERVICES	\$406,386,000	\$406,386,000	\$0	\$0
65	HEALTH-RELATED ACTIVITIES - CDSS	\$298,645,000	\$298,645,000	\$0	\$0
66	CALHEERS DEVELOPMENT	\$129,262,000	\$98,850,560	\$30,411,440	\$0
67	CDDS ADMINISTRATIVE COSTS	\$80,796,000	\$80,796,000	\$0	\$0
68	MATERNAL AND CHILD HEALTH	\$51,251,000	\$51,251,000	\$0	\$0
69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$41,379,000	\$0	\$0
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,378,000	\$28,378,000	\$0	\$0
71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$30,057,000	\$21,450,500	\$0	\$8,606,500
72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,771,000	\$5,771,000	\$0	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$8,346,000	\$8,346,000	\$0	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$3,293,000	\$3,293,000	\$0	\$0
75	VITAL RECORDS	\$1,404,000	\$1,390,000	\$14,000	\$0
76	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
77	KIT FOR NEW PARENTS	\$1,536,000	\$1,536,000	\$0	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2020-21**

<b>NO.</b>	<b>POLICY CHANGE TITLE</b>	<b>TOTAL FUNDS</b>	<b>FEDERAL FUNDS</b>	<b>GENERAL FUNDS</b>	<b>OTHER STATE FUNDS</b>
<b><u>OTHER DEPARTMENTS</u></b>					
78	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,036,000	\$1,036,000	\$0	\$0
79	CHHS AGENCY HIPAA FUNDING	\$1,004,000	\$1,004,000	\$0	\$0
80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$1,050,000	\$1,050,000	\$0	\$0
81	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0
82	CDPH I&E PROGRAM AND EVALUATION	\$277,000	\$277,000	\$0	\$0
83	PIA EYEWEAR COURIER SERVICE	\$653,000	\$326,500	\$326,500	\$0
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$1,091,814,000</b>	<b>\$1,052,360,560</b>	<b>\$30,846,940</b>	<b>\$8,606,500</b>
	<b>GRAND TOTAL</b>	<b>\$2,684,412,000</b>	<b>\$2,157,609,820</b>	<b>\$517,105,180</b>	<b>\$9,697,000</b>



**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2021-22**

<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>
	<b><u>DHCS-OTHER</u></b>				
1	CCS CASE MANAGEMENT	\$175,865,000	\$115,367,350	\$60,497,650	\$0
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$188,941,000	\$188,941,000	\$0	\$0
3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$143,285,000	\$143,285,000	\$0	\$0
4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$118,970,000	\$118,970,000	\$0	\$0
5	SMH MAA	\$57,757,000	\$57,757,000	\$0	\$0
6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$11,343,000	\$10,190,000	\$1,153,000	\$0
7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$27,411,000	\$20,184,000	\$7,227,000	\$0
8	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$84,311,000	\$68,893,150	\$15,417,850	\$0
9	ARRA HITECH INCENTIVE PROGRAM	\$12,930,000	\$12,930,000	\$0	\$0
11	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$39,902,000	\$20,245,150	\$19,656,850	\$0
12	CHDP COUNTY ALLOCATION	\$33,962,000	\$22,005,000	\$11,957,000	\$0
13	SMHS COUNTY UR & QA ADMIN	\$35,030,000	\$34,066,000	\$964,000	\$0
14	HEALTH ENROLLMENT NAVIGATORS	\$30,744,000	\$15,372,000	\$15,372,000	\$0
15	POSTAGE & PRINTING	\$27,600,000	\$13,671,500	\$13,928,500	\$0
16	DRUG MEDI-CAL COUNTY UR & QA ADMIN	\$10,695,000	\$10,695,000	\$0	\$0
17	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$21,470,000	\$20,443,000	\$1,027,000	\$0
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$21,104,000	\$10,552,000	\$10,291,000	\$261,000
19	MANAGED CARE REGULATIONS - MH PARITY	\$19,155,000	\$16,418,000	\$2,737,000	\$0
20	HCBA WAIVER ADMINISTRATIVE COST	\$15,670,000	\$7,835,000	\$7,835,000	\$0
21	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$5,606,500	\$0
22	MITA	\$11,405,000	\$9,912,750	\$1,492,250	\$0
23	PAVE SYSTEM	\$11,234,000	\$8,280,250	\$2,953,750	\$0
24	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$4,990,000	\$0
25	CAPMAN	\$8,904,000	\$6,709,800	\$2,194,200	\$0
26	MEDI-CAL RECOVERY CONTRACTS	\$9,177,000	\$6,882,750	\$2,294,250	\$0
27	PASRR	\$6,056,000	\$4,542,000	\$1,514,000	\$0
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$6,139,000	\$4,354,250	\$1,784,750	\$0
29	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$3,065,500	\$0
30	PERFORMANCE OUTCOMES SYSTEM	\$3,270,000	\$1,851,500	\$1,418,500	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2021-22**

<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>
<b><u>DHCS-OTHER</u></b>					
31	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,960,000	\$1,980,000	\$1,980,000	\$0
32	PACES	\$2,850,000	\$2,420,300	\$429,700	\$0
33	MEDCOMPASS SOLUTION	\$2,736,000	\$2,031,550	\$704,450	\$0
34	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$1,162,500	\$0
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$1,920,000	\$960,000	\$960,000	\$0
36	T-MSIS	\$3,349,000	\$2,876,350	\$472,650	\$0
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$1,086,300	\$120,700	\$0
38	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$981,000	\$696,000	\$285,000	\$0
39	CALIFORNIA HEALTH INTERVIEW SURVEY	\$1,100,000	\$1,100,000	\$0	\$0
40	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$375,000	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$400,000	\$0
43	CCT OUTREACH - ADMINISTRATIVE COSTS	\$360,000	\$360,000	\$0	\$0
44	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$4,407,000	\$2,938,000	\$1,469,000	\$0
45	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	\$365,000	(\$365,000)	\$0
46	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$216,398,000	(\$216,398,000)	\$0
84	MEDI-CAL NONMEDICAL TRANSPORTATION	\$1,704,000	\$1,227,000	\$477,000	\$0
86	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	\$1,556,000	(\$1,556,000)	\$0
	<b>DHCS-OTHER SUBTOTAL</b>	<b>\$1,188,103,000</b>	<b>\$1,201,947,450</b>	<b>(\$14,105,450)</b>	<b>\$261,000</b>
<b><u>DHCS-MEDICAL FI</u></b>					
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$45,517,000	\$33,553,300	\$11,963,700	\$0
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$43,739,000	\$31,250,650	\$12,488,350	\$0
50	MEDICAL FI BO & IT CHANGE ORDERS	\$33,028,000	\$24,345,550	\$8,682,450	\$0
51	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$29,588,000	\$21,810,850	\$7,777,150	\$0
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$19,400,000	\$13,574,700	\$5,825,300	\$0
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$13,509,000	\$9,465,450	\$4,043,550	\$0
54	MEDICAL FI BUSINESS OPERATIONS	\$12,947,000	\$9,543,700	\$3,403,300	\$0
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,309,000	\$7,599,100	\$2,709,900	\$0
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,468,000	\$1,681,950	\$786,050	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2021-22**

<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>
	<b>DHCS-MEDICAL FI SUBTOTAL</b>	<b>\$210,505,000</b>	<b>\$152,825,250</b>	<b>\$57,679,750</b>	<b>\$0</b>
	<b><u>DHCS-HEALTH CARE OPT</u></b>				
58	HCO OPERATIONS 2017 CONTRACT	\$40,836,000	\$20,724,300	\$20,111,700	\$0
59	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,646,000	\$10,477,800	\$10,168,200	\$0
60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$14,720,000	\$7,470,400	\$7,249,600	\$0
	<b>DHCS-HEALTH CARE OPT SUBTOTAL</b>	<b>\$76,202,000</b>	<b>\$38,672,500</b>	<b>\$37,529,500</b>	<b>\$0</b>
	<b><u>DHCS-DENTAL FI</u></b>				
61	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$47,467,000	\$30,558,500	\$16,908,500	\$0
62	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,942,000	\$15,805,000	\$6,137,000	\$0
	<b>DHCS-DENTAL FI SUBTOTAL</b>	<b>\$69,409,000</b>	<b>\$46,363,500</b>	<b>\$23,045,500</b>	<b>\$0</b>
	<b><u>OTHER DEPARTMENTS</u></b>				
64	PERSONAL CARE SERVICES	\$404,661,000	\$404,661,000	\$0	\$0
65	HEALTH-RELATED ACTIVITIES - CDSS	\$300,852,000	\$300,852,000	\$0	\$0
66	CALHEERS DEVELOPMENT	\$116,227,000	\$89,187,660	\$27,039,340	\$0
67	CDDS ADMINISTRATIVE COSTS	\$66,507,000	\$66,507,000	\$0	\$0
68	MATERNAL AND CHILD HEALTH	\$47,668,000	\$47,668,000	\$0	\$0
69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$41,379,000	\$0	\$0
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,378,000	\$28,378,000	\$0	\$0
71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$18,296,000	\$13,289,000	\$0	\$5,007,000
72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,700,000	\$4,700,000	\$0	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$4,200,000	\$4,200,000	\$0	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$2,400,000	\$0	\$0
75	VITAL RECORDS	\$890,000	\$882,000	\$8,000	\$0
76	VETERANS BENEFITS	\$1,100,000	\$1,100,000	\$0	\$0
77	KIT FOR NEW PARENTS	\$912,000	\$912,000	\$0	\$0
78	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,036,000	\$1,036,000	\$0	\$0
79	CHHS AGENCY HIPAA FUNDING	\$1,022,000	\$1,022,000	\$0	\$0
80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$5,009,000	\$5,009,000	\$0	\$0
81	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$95,000	\$0

**SUMMARY OF OTHER ADMINISTRATION POLICY CHANGES  
FISCAL YEAR 2021-22**

<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>
<b><u>OTHER DEPARTMENTS</u></b>					
82	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$187,000	\$0	\$0
83	PIA EYEWEAR COURIER SERVICE	\$814,000	\$407,000	\$407,000	\$0
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$1,046,428,000</b>	<b>\$1,013,871,660</b>	<b>\$27,549,340</b>	<b>\$5,007,000</b>
	<b>GRAND TOTAL</b>	<b>\$2,590,647,000</b>	<b>\$2,453,680,360</b>	<b>\$131,698,640</b>	<b>\$5,268,000</b>

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>DHCS-OTHER</u></b>						
2	1	CCS CASE MANAGEMENT	\$172,410,000	\$58,668,880	\$172,475,000	\$58,533,280	\$65,000	(\$135,600)
3	2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$170,067,000	\$0	\$180,524,000	\$0	\$10,457,000	\$0
1	3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$141,765,000	\$0	\$139,218,000	(\$65,000)	(\$2,547,000)	(\$65,000)
5	4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$113,838,000	\$0	\$130,567,000	\$0	\$16,729,000	\$0
13	5	SMH MAA	\$49,860,000	\$0	\$51,376,000	\$0	\$1,516,000	\$0
21	6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$42,620,000	\$4,262,000	\$40,057,000	\$4,027,000	(\$2,563,000)	(\$235,000)
23	7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$22,943,000	\$5,745,900	\$39,781,000	\$10,381,580	\$16,838,000	\$4,635,680
48	8	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$39,230,000	\$19,119,000	\$26,862,000	\$11,831,000	(\$12,368,000)	(\$7,288,000)
8	9	ARRA HITECH INCENTIVE PROGRAM	\$37,058,000	\$0	\$38,843,000	\$0	\$1,785,000	\$0
6	10	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$32,100,000	\$0	\$35,633,000	\$0	\$3,533,000	\$0
9	11	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$35,910,000	\$13,388,300	\$35,349,000	\$12,999,980	(\$561,000)	(\$388,320)
10	12	CHDP COUNTY ALLOCATION	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
11	13	SMHS COUNTY UR & QA ADMIN	\$32,288,000	\$953,000	\$53,136,000	\$963,000	\$20,848,000	\$10,000
12	14	HEALTH ENROLLMENT NAVIGATORS	\$54,426,000	\$27,213,000	\$28,638,000	\$14,319,000	(\$25,788,000)	(\$12,894,000)
14	15	POSTAGE & PRINTING	\$29,793,000	\$15,025,000	\$27,600,000	\$13,928,500	(\$2,193,000)	(\$1,096,500)
32	16	DRUG MEDI-CAL COUNTY UR & QA ADMIN	\$3,365,000	\$0	\$22,977,000	\$0	\$19,612,000	\$0
7	17	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$23,426,000	\$894,000	\$20,836,000	\$1,021,000	(\$2,590,000)	\$127,000
18	18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$17,190,000	\$8,332,000	\$19,706,000	\$9,434,500	\$2,516,000	\$1,102,500
16	19	MANAGED CARE REGULATIONS - MH PARITY	\$19,367,000	\$2,767,000	\$19,155,000	\$2,737,000	(\$212,000)	(\$30,000)
27	20	HCBA WAIVER ADMINISTRATIVE COST	\$12,316,000	\$6,158,000	\$13,947,000	\$6,973,500	\$1,631,000	\$815,500
25	21	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$11,213,000	\$5,606,500	\$0	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b>DHCS-OTHER</b>						
24	22	MITA	\$11,326,000	\$1,471,340	\$11,002,000	\$1,427,560	(\$324,000)	(\$43,780)
17	23	PAVE SYSTEM	\$10,353,000	(\$4,476,750)	\$10,238,000	(\$4,483,770)	(\$115,000)	(\$7,020)
28	24	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
31	25	CAPMAN	\$8,324,000	\$2,166,540	\$8,324,000	\$2,168,070	\$0	\$1,530
22	26	MEDI-CAL RECOVERY CONTRACTS	\$6,837,000	\$1,709,250	\$7,785,000	\$1,946,250	\$948,000	\$237,000
26	27	PASRR	\$10,555,000	\$2,638,750	\$7,441,000	\$1,860,250	(\$3,114,000)	(\$778,500)
30	28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$6,139,000	\$1,784,750	\$6,139,000	\$1,784,750	\$0	\$0
29	29	NEWBORN HEARING SCREENING PROGRAM	\$7,580,000	\$3,790,000	\$6,131,000	\$3,065,500	(\$1,449,000)	(\$724,500)
19	30	PERFORMANCE OUTCOMES SYSTEM	\$4,401,000	\$2,137,250	\$4,379,000	\$1,899,500	(\$22,000)	(\$237,750)
44	31	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,960,000	\$1,980,000	\$3,960,000	\$1,980,000	\$0	\$0
33	32	PACES	\$3,760,000	\$467,700	\$2,725,000	\$407,120	(\$1,035,000)	(\$60,580)
34	33	MEDCOMPASS SOLUTION	\$3,037,000	(\$63,000)	\$2,401,000	(\$18,070)	(\$636,000)	\$44,930
35	34	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
37	35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,210,000	\$1,105,000	\$2,066,000	\$1,033,000	(\$144,000)	(\$72,000)
46	36	T-MSIS	\$2,334,000	\$283,500	\$1,585,000	\$246,940	(\$749,000)	(\$36,560)
38	37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0
15	38	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$981,000	\$285,000	\$981,000	\$285,000	\$0	\$0
42	39	CALIFORNIA HEALTH INTERVIEW SURVEY	\$977,000	\$0	\$977,000	\$0	\$0	\$0
43	40	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
40	41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$800,000	\$400,000	\$731,000	\$365,500	(\$69,000)	(\$34,500)
39	42	LTSS ACTUARIAL STUDY	\$547,000	\$547,000	\$423,000	\$423,000	(\$124,000)	(\$124,000)
47	43	CCT OUTREACH - ADMINISTRATIVE COSTS	\$360,000	\$0	\$360,000	\$0	\$0	\$0
102	45	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$2,000,000)	\$0	(\$1,824,000)	\$0	\$176,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>DHCS-OTHER</u></b>						
66	46	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$80,000,000	\$0	\$182,984,000	\$0	\$102,984,000
--	47	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	\$0	\$0	(\$9,113,000)	\$0	(\$9,113,000)	\$0
20	--	SURS AND MARS SYSTEM REPROCUREMENT	\$14,351,000	(\$1,722,250)	\$0	\$0	(\$14,351,000)	\$1,722,250
41	--	MEDICARE BENEFICIARY IDENTIFIER	\$128,000	\$16,360	\$0	\$0	(\$128,000)	(\$16,360)
103	--	RECONCILIATION	(\$13,942,000)	(\$9,374,000)	\$0	\$0	\$13,942,000	\$9,374,000
		<b>DHCS-OTHER SUBTOTAL</b>	<b>\$1,194,427,000</b>	<b>\$269,884,220</b>	<b>\$1,224,652,000</b>	<b>\$366,846,660</b>	<b>\$30,225,000</b>	<b>\$96,962,440</b>
		<b><u>DHCS-MEDICAL FI</u></b>						
50	48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$46,503,000	\$11,625,750	\$52,284,000	\$13,275,630	\$5,781,000	\$1,649,880
52	49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$38,460,000	\$11,716,050	\$45,377,000	\$12,514,240	\$6,917,000	\$798,180
51	50	MEDICAL FI BO & IT CHANGE ORDERS	\$24,668,000	\$10,587,000	\$37,656,000	\$9,562,120	\$12,988,000	(\$1,024,880)
53	51	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$30,627,000	\$8,698,500	\$33,989,000	\$8,625,780	\$3,362,000	(\$72,720)
56	52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$21,744,000	\$6,390,000	\$23,272,000	\$6,766,220	\$1,528,000	\$376,220
57	53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$16,322,000	\$4,737,500	\$15,899,000	\$4,618,320	(\$423,000)	(\$119,180)
58	54	MEDICAL FI BUSINESS OPERATIONS	\$13,737,000	\$4,180,000	\$15,289,000	\$3,881,630	\$1,552,000	(\$298,370)
60	55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$11,407,000	\$2,851,750	\$10,776,000	\$2,735,730	(\$631,000)	(\$116,020)
64	56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,468,000	\$768,500	\$2,468,000	\$764,280	\$0	(\$4,220)
--	57	CMS DEFERRED CLAIMS - FI	\$0	\$0	\$0	\$920,000	\$0	\$920,000
		<b>DHCS-MEDICAL FI SUBTOTAL</b>	<b>\$205,936,000</b>	<b>\$61,555,050</b>	<b>\$237,010,000</b>	<b>\$63,663,940</b>	<b>\$31,074,000</b>	<b>\$2,108,900</b>

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>DHCS-HEALTH CARE OPT</u></b>								
67	58	HCO OPERATIONS 2017 CONTRACT	\$40,500,000	\$19,888,060	\$40,500,000	\$19,888,060	\$0	\$0
68	59	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,646,000	\$10,138,530	\$20,646,000	\$10,138,530	\$0	\$0
69	60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$14,171,000	\$6,958,800	\$14,171,000	\$6,958,800	\$0	\$0
<b>DHCS-HEALTH CARE OPT SUBTOTAL</b>			<b>\$75,317,000</b>	<b>\$36,985,380</b>	<b>\$75,317,000</b>	<b>\$36,985,380</b>	<b>\$0</b>	<b>\$0</b>
<b><u>DHCS-DENTAL FI</u></b>								
70	61	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$46,692,000	\$18,388,750	\$34,722,000	\$12,867,750	(\$11,970,000)	(\$5,521,000)
71	62	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$21,744,000	\$6,161,500	\$20,897,000	\$5,894,500	(\$847,000)	(\$267,000)
<b>DHCS-DENTAL FI SUBTOTAL</b>			<b>\$68,436,000</b>	<b>\$24,550,250</b>	<b>\$55,619,000</b>	<b>\$18,762,250</b>	<b>(\$12,817,000)</b>	<b>(\$5,788,000)</b>
<b><u>OTHER DEPARTMENTS</u></b>								
76	64	PERSONAL CARE SERVICES	\$392,044,000	\$0	\$406,386,000	\$0	\$14,342,000	\$0
75	65	HEALTH-RELATED ACTIVITIES - CDSS	\$341,958,000	\$0	\$298,645,000	\$0	(\$43,313,000)	\$0
77	66	CALHEERS DEVELOPMENT	\$131,197,000	\$31,037,290	\$129,262,000	\$30,411,440	(\$1,935,000)	(\$625,840)
79	67	CDDS ADMINISTRATIVE COSTS	\$70,757,000	\$0	\$80,796,000	\$0	\$10,039,000	\$0
78	68	MATERNAL AND CHILD HEALTH	\$64,269,000	\$0	\$51,251,000	\$0	(\$13,018,000)	\$0
80	69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$0	\$41,379,000	\$0	\$0	\$0
81	70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,236,000	\$0	\$28,378,000	\$0	\$142,000	\$0
82	71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$21,435,000	\$0	\$30,057,000	\$0	\$8,622,000	\$0
84	72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$4,712,000	\$0	\$5,771,000	\$0	\$1,059,000	\$0
83	73	CLPP CASE MANAGEMENT SERVICES	\$4,200,000	\$0	\$8,346,000	\$0	\$4,146,000	\$0
85	74	CALIFORNIA SMOKERS' HELPLINE	\$2,400,000	\$0	\$3,293,000	\$0	\$893,000	\$0
87	75	VITAL RECORDS	\$890,000	\$8,000	\$1,404,000	\$14,000	\$514,000	\$6,000



**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
NOVEMBER 2020 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2020-21**

MAY NO.	NOV. NO.	POLICY CHANGE TITLE	2020-21 APPROPRIATION		NOV. 2020 EST. FOR 2020-21		DIFFERENCE	
			TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
		<b><u>OTHER DEPARTMENTS</u></b>						
88	76	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
86	77	KIT FOR NEW PARENTS	\$1,061,000	\$0	\$1,536,000	\$0	\$475,000	\$0
89	78	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,036,000	\$0	\$1,036,000	\$0	\$0	\$0
90	79	CHHS AGENCY HIPAA FUNDING	\$1,004,000	\$0	\$1,004,000	\$0	\$0	\$0
--	80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$0	\$0	\$1,050,000	\$0	\$1,050,000	\$0
92	81	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
91	82	CDPH I&E PROGRAM AND EVALUATION	\$187,000	\$0	\$277,000	\$0	\$90,000	\$0
93	83	PIA EYEWEAR COURIER SERVICE	\$941,000	\$470,500	\$653,000	\$326,500	(\$288,000)	(\$144,000)
		<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$1,108,996,000</b>	<b>\$31,610,790</b>	<b>\$1,091,814,000</b>	<b>\$30,846,940</b>	<b>(\$17,182,000)</b>	<b>(\$763,840)</b>
		<b>OTHER ADMINISTRATION TOTAL</b>	<b>\$2,653,112,000</b>	<b>\$424,585,700</b>	<b>\$2,684,412,000</b>	<b>\$517,105,180</b>	<b>\$31,300,000</b>	<b>\$92,519,480</b>
		<b>GRAND TOTAL COUNTY AND OTHER ADMINISTRATION</b>	<b>\$5,067,170,000</b>	<b>\$1,032,712,200</b>	<b>\$5,097,239,000</b>	<b>\$1,126,987,180</b>	<b>\$30,069,000</b>	<b>\$94,274,980</b>

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b><u>DHCS-OTHER</u></b>						
1	CCS CASE MANAGEMENT	\$172,475,000	\$58,533,280	\$175,865,000	\$60,497,650	\$3,390,000	\$1,964,360
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$180,524,000	\$0	\$188,941,000	\$0	\$8,417,000	\$0
3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$139,218,000	(\$65,000)	\$143,285,000	\$0	\$4,067,000	\$65,000
4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$130,567,000	\$0	\$118,970,000	\$0	(\$11,597,000)	\$0
5	SMH MAA	\$51,376,000	\$0	\$57,757,000	\$0	\$6,381,000	\$0
6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY	\$40,057,000	\$4,027,000	\$11,343,000	\$1,153,000	(\$28,714,000)	(\$2,874,000)
7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM	\$39,781,000	\$10,381,580	\$27,411,000	\$7,227,000	(\$12,370,000)	(\$3,154,580)
8	MEDI-CAL RX - ADMINISTRATIVE COSTS	\$26,862,000	\$11,831,000	\$84,311,000	\$15,417,850	\$57,449,000	\$3,586,850
9	ARRA HITECH INCENTIVE PROGRAM	\$38,843,000	\$0	\$12,930,000	\$0	(\$25,913,000)	\$0
10	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$35,633,000	\$0	\$0	\$0	(\$35,633,000)	\$0
11	OTLCP, MCAP, SPECIAL POPULATIONS ADMIN COSTS	\$35,349,000	\$12,999,980	\$39,902,000	\$19,656,850	\$4,553,000	\$6,656,870
12	CHDP COUNTY ALLOCATION	\$33,962,000	\$11,957,000	\$33,962,000	\$11,957,000	\$0	\$0
13	SMHS COUNTY UR & QA ADMIN	\$53,136,000	\$963,000	\$35,030,000	\$964,000	(\$18,106,000)	\$1,000
14	HEALTH ENROLLMENT NAVIGATORS	\$28,638,000	\$14,319,000	\$30,744,000	\$15,372,000	\$2,106,000	\$1,053,000
15	POSTAGE & PRINTING	\$27,600,000	\$13,928,500	\$27,600,000	\$13,928,500	\$0	\$0
16	DRUG MEDI-CAL COUNTY UR & QA ADMIN	\$22,977,000	\$0	\$10,695,000	\$0	(\$12,282,000)	\$0
17	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$20,836,000	\$1,021,000	\$21,470,000	\$1,027,000	\$634,000	\$6,000
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT	\$19,706,000	\$9,434,500	\$21,104,000	\$10,291,000	\$1,398,000	\$856,500
19	MANAGED CARE REGULATIONS - MH PARITY	\$19,155,000	\$2,737,000	\$19,155,000	\$2,737,000	\$0	\$0
20	HCBA WAIVER ADMINISTRATIVE COST	\$13,947,000	\$6,973,500	\$15,670,000	\$7,835,000	\$1,723,000	\$861,500
21	CCI-ADMINISTRATIVE COSTS	\$11,213,000	\$5,606,500	\$11,213,000	\$5,606,500	\$0	\$0
22	MITA	\$11,002,000	\$1,427,560	\$11,405,000	\$1,492,250	\$403,000	\$64,680
23	PAVE SYSTEM	\$10,238,000	(\$4,483,770)	\$11,234,000	\$2,953,750	\$996,000	\$7,437,520

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
	<b><u>DHCS-OTHER</u></b>						
24	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
25	CAPMAN	\$8,324,000	\$2,168,070	\$8,904,000	\$2,194,200	\$580,000	\$26,130
26	MEDI-CAL RECOVERY CONTRACTS	\$7,785,000	\$1,946,250	\$9,177,000	\$2,294,250	\$1,392,000	\$348,000
27	PASRR	\$7,441,000	\$1,860,250	\$6,056,000	\$1,514,000	(\$1,385,000)	(\$346,250)
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$6,139,000	\$1,784,750	\$6,139,000	\$1,784,750	\$0	\$0
29	NEWBORN HEARING SCREENING PROGRAM	\$6,131,000	\$3,065,500	\$6,131,000	\$3,065,500	\$0	\$0
30	PERFORMANCE OUTCOMES SYSTEM	\$4,379,000	\$1,899,500	\$3,270,000	\$1,418,500	(\$1,109,000)	(\$481,000)
31	ELECTRONIC ASSET VERIFICATION PROGRAM	\$3,960,000	\$1,980,000	\$3,960,000	\$1,980,000	\$0	\$0
32	PACES	\$2,725,000	\$407,120	\$2,850,000	\$429,700	\$125,000	\$22,580
33	MEDCOMPASS SOLUTION	\$2,401,000	(\$18,070)	\$2,736,000	\$704,450	\$335,000	\$722,520
34	SDMC SYSTEM M&O SUPPORT	\$2,325,000	\$1,162,500	\$2,325,000	\$1,162,500	\$0	\$0
35	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,066,000	\$1,033,000	\$1,920,000	\$960,000	(\$146,000)	(\$73,000)
36	T-MSIS	\$1,585,000	\$246,940	\$3,349,000	\$472,650	\$1,764,000	\$225,720
37	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$120,700	\$1,207,000	\$120,700	\$0	\$0
38	MANAGED CARE REGULATIONS - MENTAL HEALTH	\$981,000	\$285,000	\$981,000	\$285,000	\$0	\$0
39	CALIFORNIA HEALTH INTERVIEW SURVEY	\$977,000	\$0	\$1,100,000	\$0	\$123,000	\$0
40	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
41	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$731,000	\$365,500	\$800,000	\$400,000	\$69,000	\$34,500
42	LTSS ACTUARIAL STUDY	\$423,000	\$423,000	\$0	\$0	(\$423,000)	(\$423,000)
43	CCT OUTREACH - ADMINISTRATIVE COSTS	\$360,000	\$0	\$360,000	\$0	\$0	\$0
44	DRUG MEDI-CAL PARITY RULE ADMINISTRATION	\$0	\$0	\$4,407,000	\$1,469,000	\$4,407,000	\$1,469,000
45	COVID-19 INCREASED FMAP - OTHER ADMIN	\$0	(\$1,824,000)	\$0	(\$365,000)	\$0	\$1,459,000
46	CMS DEFERRED CLAIMS - OTHER ADMIN	\$0	\$182,984,000	\$0	(\$216,398,000)	\$0	(\$399,382,000)
47	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS	(\$9,113,000)	\$0	\$0	\$0	\$9,113,000	\$0
84	MEDI-CAL NONMEDICAL TRANSPORTATION	\$0	\$0	\$1,704,000	\$477,000	\$1,704,000	\$477,000

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>DHCS-OTHER</u></b>							
86	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN	\$0	\$0	\$0	(\$1,556,000)	\$0	(\$1,556,000)
	<b>DHCS-OTHER SUBTOTAL</b>	<b>\$1,224,652,000</b>	<b>\$366,846,660</b>	<b>\$1,188,103,000</b>	<b>(\$14,105,450)</b>	<b>(\$36,549,000)</b>	<b>(\$380,952,100)</b>
<b><u>DHCS-MEDICAL FI</u></b>							
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES	\$52,284,000	\$13,275,630	\$45,517,000	\$11,963,700	(\$6,767,000)	(\$1,311,930)
49	MEDICAL FI BO & IT COST REIMBURSEMENT	\$45,377,000	\$12,514,240	\$43,739,000	\$12,488,350	(\$1,638,000)	(\$25,880)
50	MEDICAL FI BO & IT CHANGE ORDERS	\$37,656,000	\$9,562,120	\$33,028,000	\$8,682,450	(\$4,628,000)	(\$879,660)
51	MEDICAL FI IT INFRASTRUCTURE SERVICES	\$33,989,000	\$8,625,780	\$29,588,000	\$7,777,150	(\$4,401,000)	(\$848,630)
52	MEDICAL FI BO OTHER ESTIMATED COSTS	\$23,272,000	\$6,766,220	\$19,400,000	\$5,825,300	(\$3,872,000)	(\$940,920)
53	MEDICAL FI BO TELEPHONE SERVICE CENTER	\$15,899,000	\$4,618,320	\$13,509,000	\$4,043,550	(\$2,390,000)	(\$574,780)
54	MEDICAL FI BUSINESS OPERATIONS	\$15,289,000	\$3,881,630	\$12,947,000	\$3,403,300	(\$2,342,000)	(\$478,330)
55	MEDICAL FI BO HOURLY REIMBURSEMENT	\$10,776,000	\$2,735,730	\$10,309,000	\$2,709,900	(\$467,000)	(\$25,830)
56	MEDICAL FI BO MISCELLANEOUS EXPENSES	\$2,468,000	\$764,280	\$2,468,000	\$786,050	\$0	\$21,770
57	CMS DEFERRED CLAIMS - FI	\$0	\$920,000	\$0	\$0	\$0	(\$920,000)
	<b>DHCS-MEDICAL FI SUBTOTAL</b>	<b>\$237,010,000</b>	<b>\$63,663,940</b>	<b>\$210,505,000</b>	<b>\$57,679,750</b>	<b>(\$26,505,000)</b>	<b>(\$5,984,200)</b>
<b><u>DHCS-HEALTH CARE OPT</u></b>							
58	HCO OPERATIONS 2017 CONTRACT	\$40,500,000	\$19,888,060	\$40,836,000	\$20,111,700	\$336,000	\$223,640
59	HCO COST REIMBURSEMENT 2017 CONTRACT	\$20,646,000	\$10,138,530	\$20,646,000	\$10,168,200	\$0	\$29,670
60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT	\$14,171,000	\$6,958,800	\$14,720,000	\$7,249,600	\$549,000	\$290,800
	<b>DHCS-HEALTH CARE OPT SUBTOTAL</b>	<b>\$75,317,000</b>	<b>\$36,985,380</b>	<b>\$76,202,000</b>	<b>\$37,529,500</b>	<b>\$885,000</b>	<b>\$544,120</b>
<b><u>DHCS-DENTAL FI</u></b>							
61	DENTAL ASO ADMINISTRATION 2016 CONTRACT	\$34,722,000	\$12,867,750	\$47,467,000	\$16,908,500	\$12,745,000	\$4,040,750

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>DHCS-DENTAL FI</u></b>							
62	DENTAL FI ADMINISTRATION 2016 CONTRACT	\$20,897,000	\$5,894,500	\$21,942,000	\$6,137,000	\$1,045,000	\$242,500
	<b>DHCS-DENTAL FI SUBTOTAL</b>	<b>\$55,619,000</b>	<b>\$18,762,250</b>	<b>\$69,409,000</b>	<b>\$23,045,500</b>	<b>\$13,790,000</b>	<b>\$4,283,250</b>
<b><u>OTHER DEPARTMENTS</u></b>							
64	PERSONAL CARE SERVICES	\$406,386,000	\$0	\$404,661,000	\$0	(\$1,725,000)	\$0
65	HEALTH-RELATED ACTIVITIES - CDSS	\$298,645,000	\$0	\$300,852,000	\$0	\$2,207,000	\$0
66	CALHEERS DEVELOPMENT	\$129,262,000	\$30,411,440	\$116,227,000	\$27,039,340	(\$13,035,000)	(\$3,372,100)
67	CDDS ADMINISTRATIVE COSTS	\$80,796,000	\$0	\$66,507,000	\$0	(\$14,289,000)	\$0
68	MATERNAL AND CHILD HEALTH	\$51,251,000	\$0	\$47,668,000	\$0	(\$3,583,000)	\$0
69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN	\$41,379,000	\$0	\$41,379,000	\$0	\$0	\$0
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$28,378,000	\$0	\$28,378,000	\$0	\$0	\$0
71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$30,057,000	\$0	\$18,296,000	\$0	(\$11,761,000)	\$0
72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$5,771,000	\$0	\$4,700,000	\$0	(\$1,071,000)	\$0
73	CLPP CASE MANAGEMENT SERVICES	\$8,346,000	\$0	\$4,200,000	\$0	(\$4,146,000)	\$0
74	CALIFORNIA SMOKERS' HELPLINE	\$3,293,000	\$0	\$2,400,000	\$0	(\$893,000)	\$0
75	VITAL RECORDS	\$1,404,000	\$14,000	\$890,000	\$8,000	(\$514,000)	(\$6,000)
76	VETERANS BENEFITS	\$1,100,000	\$0	\$1,100,000	\$0	\$0	\$0
77	KIT FOR NEW PARENTS	\$1,536,000	\$0	\$912,000	\$0	(\$624,000)	\$0
78	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$1,036,000	\$0	\$1,036,000	\$0	\$0	\$0
79	CHHS AGENCY HIPAA FUNDING	\$1,004,000	\$0	\$1,022,000	\$0	\$18,000	\$0

**COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2020-21 AND 2021-22**

NO.	POLICY CHANGE TITLE	NOV. 2020 EST. FOR 2020-21		NOV. 2020 EST. FOR 2021-22		DIFFERENCE	
		TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS	TOTAL FUNDS	GENERAL FUNDS
<b><u>OTHER DEPARTMENTS</u></b>							
80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG	\$1,050,000	\$0	\$5,009,000	\$0	\$3,959,000	\$0
81	MERIT SYSTEM SERVICES FOR COUNTIES	\$190,000	\$95,000	\$190,000	\$95,000	\$0	\$0
82	CDPH I&E PROGRAM AND EVALUATION	\$277,000	\$0	\$187,000	\$0	(\$90,000)	\$0
83	PIA EYEWEAR COURIER SERVICE	\$653,000	\$326,500	\$814,000	\$407,000	\$161,000	\$80,500
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$1,091,814,000</b>	<b>\$30,846,940</b>	<b>\$1,046,428,000</b>	<b>\$27,549,340</b>	<b>(\$45,386,000)</b>	<b>(\$3,297,600)</b>
	<b>OTHER ADMINISTRATION TOTAL</b>	<b>\$2,684,412,000</b>	<b>\$517,105,180</b>	<b>\$2,590,647,000</b>	<b>\$131,698,640</b>	<b>(\$93,765,000)</b>	<b>(\$385,406,540)</b>
	<b>GRAND TOTAL COUNTY AND OTHER ADMINISTRATION</b>	<b>\$5,097,239,000</b>	<b>\$1,126,987,180</b>	<b>\$5,025,505,000</b>	<b>\$777,894,140</b>	<b>(\$71,734,000)</b>	<b>(\$349,093,040)</b>

## MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<b><u>DHCS-OTHER</u></b>
1	CCS CASE MANAGEMENT
2	COUNTY SPECIALTY MENTAL HEALTH ADMIN
3	SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES
4	COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES
5	SMH MAA
6	HEALTH INFORMATION EXCHANGE INTEROPERABILITY
7	MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM
8	MEDI-CAL RX - ADMINISTRATIVE COSTS
9	ARRA HITECH INCENTIVE PROGRAM
10	INTERIM AND FINAL COST SETTLEMENTS-SMHS
11	OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS
12	CHDP COUNTY ALLOCATION
13	SMHS COUNTY UR & QA ADMIN
14	HEALTH ENROLLMENT NAVIGATORS
15	POSTAGE & PRINTING
16	DRUG MEDI-CAL COUNTY UR & QA ADMIN
17	DRUG MEDI-CAL COUNTY ADMINISTRATION
18	ACTUARIAL COSTS FOR RATE DEVELOPMENT
19	MANAGED CARE REGULATIONS - MH PARITY
20	HCBA WAIVER ADMINISTRATIVE COST
21	CCI-ADMINISTRATIVE COSTS
22	MITA
23	PAVE SYSTEM
24	LITIGATION RELATED SERVICES
25	CAPMAN
26	MEDI-CAL RECOVERY CONTRACTS
27	PASRR
28	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
29	NEWBORN HEARING SCREENING PROGRAM
30	PERFORMANCE OUTCOMES SYSTEM
31	ELECTRONIC ASSET VERIFICATION PROGRAM
32	PACES
33	MEDCOMPASS SOLUTION
34	SDMC SYSTEM M&O SUPPORT
35	SSA COSTS FOR HEALTH COVERAGE INFO.
36	T-MSIS
37	FAMILY PACT PROGRAM ADMIN.
38	MANAGED CARE REGULATIONS - MENTAL HEALTH

## MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	<b><u>DHCS-OTHER</u></b>
39	CALIFORNIA HEALTH INTERVIEW SURVEY
40	ENCRYPTION OF PHI DATA
41	MMA - DSH ANNUAL INDEPENDENT AUDIT
42	LTSS ACTUARIAL STUDY
43	CCT OUTREACH - ADMINISTRATIVE COSTS
44	DRUG MEDI-CAL PARITY RULE ADMINISTRATION
45	COVID-19 INCREASED FMAP - OTHER ADMIN
46	CMS DEFERRED CLAIMS - OTHER ADMIN
47	MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS
84	MEDI-CAL NONMEDICAL TRANSPORTATION
86	COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN
	<b><u>DHCS-MEDICAL FI</u></b>
48	MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES
49	MEDICAL FI BO & IT COST REIMBURSEMENT
50	MEDICAL FI BO & IT CHANGE ORDERS
51	MEDICAL FI IT INFRASTRUCTURE SERVICES
52	MEDICAL FI BO OTHER ESTIMATED COSTS
53	MEDICAL FI BO TELEPHONE SERVICE CENTER
54	MEDICAL FI BUSINESS OPERATIONS
55	MEDICAL FI BO HOURLY REIMBURSEMENT
56	MEDICAL FI BO MISCELLANEOUS EXPENSES
57	CMS DEFERRED CLAIMS - FI
	<b><u>DHCS-HEALTH CARE OPT</u></b>
58	HCO OPERATIONS 2017 CONTRACT
59	HCO COST REIMBURSEMENT 2017 CONTRACT
60	HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT
	<b><u>DHCS-DENTAL FI</u></b>
61	DENTAL ASO ADMINISTRATION 2016 CONTRACT
62	DENTAL FI ADMINISTRATION 2016 CONTRACT
	<b><u>OTHER DEPARTMENTS</u></b>
64	PERSONAL CARE SERVICES
65	HEALTH-RELATED ACTIVITIES - CDSS
66	CALHEERS DEVELOPMENT
67	CDDS ADMINISTRATIVE COSTS



**MEDI-CAL OTHER ADMINISTRATION  
POLICY CHANGE INDEX**

<b><u>POLICY CHANGE NUMBER</u></b>	<b><u>POLICY CHANGE TITLE</u></b>
	<b><u>OTHER DEPARTMENTS</u></b>
68	MATERNAL AND CHILD HEALTH
69	HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
71	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
72	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
73	CLPP CASE MANAGEMENT SERVICES
74	CALIFORNIA SMOKERS' HELPLINE
75	VITAL RECORDS
76	VETERANS BENEFITS
77	KIT FOR NEW PARENTS
78	MEDI-CAL INPATIENT SERVICES FOR INMATES
79	CHHS AGENCY HIPAA FUNDING
80	FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG
81	MERIT SYSTEM SERVICES FOR COUNTIES
82	CDPH I&E PROGRAM AND EVALUATION
83	PIA EYEWEAR COURIER SERVICE

## CCS CASE MANAGEMENT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 1  
**IMPLEMENTATION DATE:** 7/1999  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 230

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$172,475,000	\$175,865,000
<b>STATE FUNDS</b>	\$58,533,280	\$60,497,650
<b>FEDERAL FUNDS</b>	\$113,941,720	\$115,367,350

**Purpose:**

This policy change estimates the California Children's Services (CCS) case management cost.

**Authority:**

Health & Safety Code, sections 123800-123995

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**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, 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.

Starting July 1, 2018, the Department began transitioning some of the case management administrative functions from the county to the County Organized Health Systems (COHS) health plans under the Whole Child Model. The WCM transition was completed on July 1, 2019.

**Reason for Change:**

The change from the prior estimate, FY 2020-21, is a slight increase due to greater updated CMS Net costs for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to updated estimated invoiced expenditure data and caseload amounts for FY 2020-21.

**Methodology:**

1. The county administrative estimate for the budget year is updated every May based on additional data collected.
2. For FY 2020-21, the CCS case management costs are based on budgeted county expenditures of \$164,999,000.

For FY 2021-22, caseload is expected to increase 0.06% from FY 2020-21.

$$\$164,999,000 \times (1 + 0.06\%) = \$165,098,000$$

**CCS CASE MANAGEMENT**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 1**

3. Assume administrative costs of \$1,057,000 in both FY 2020-21 and FY 2021-22 for the Medi-Cal expansion of undocumented children which are funded at 100% GF.
4. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be \$2,605,000 in FY 2020-21 and \$2,784,000 in FY 2020-21.
5. Medi-Cal Optional Targeted Low Income Children Program (OTLICP) costs are separate from other Medi-Cal costs. Total Medi-Cal OTLICP costs listed below do not include county share of cost:

	FY 2020-21	FY 2021-22
County Administration:	\$31,977,000	\$31,966,000
County share of cost:	(\$2,564,000)	(\$2,809,000)
Total Medi-Cal OTLICP:	\$29,413,000	\$29,187,000

6. County data processing costs associated with CMS Net for OTLICP are estimated to be \$377,000 in FY 2020-21 and \$404,000 FY 2021-22.
7. 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 \$25,239,000 in FY 2020-21 and \$22,040,000 in FY 2021-22.
8. 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. The cost to CCS case management is \$360,000 in FY 2020-21 and \$221,000 in FY 2021-22.
9. Enhanced, Title XIX (75% FFP), funding is available for Skilled Professional Medical Personnel (SPMP) for the Medi-Cal and OTLICP populations in FY 2020-21 and FY 2021-22.

**CCS CASE MANAGEMENT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 1

FY 2020-21				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$29,413,000	\$6,568,000	\$22,845,000	\$2,564,000
CMS Net	\$377,000	\$121,000	\$256,000	\$0
<b>Subtotal</b>	<b>\$29,790,000</b>	<b>\$6,689,000</b>	<b>\$23,101,000</b>	<b>\$2,564,000</b>
CCS Medi-Cal				
CCS Case Management	\$164,999,000	\$61,842,000	\$103,157,000	\$0
Medi-Cal Expansion	\$1,057,000	\$1,057,000	\$0	\$0
CMS Net	\$2,228,000	\$1,114,000	\$1,114,000	\$0
<b>Subtotal</b>	<b>\$168,284,000</b>	<b>\$64,013,000</b>	<b>\$104,271,000</b>	<b>\$0</b>
Rady Children's Hospital	(\$360,000)	(\$180,000)	(\$180,000)	\$0
WCM Implementation	(\$25,239,000)	(\$11,988,000)	(\$13,251,000)	\$0
<b>Total</b>	<b>\$172,475,000</b>	<b>\$58,534,000</b>	<b>\$113,941,000</b>	<b>\$2,564,000</b>

FY 2021-22				
CCS Medi-Cal/OTLICP	TF*	GF	FF	CF**
CCS Case Management	\$29,187,000	\$6,795,000	\$22,392,000	\$2,809,000
CMS Net	\$404,000	\$142,000	\$263,000	\$0
<b>Subtotal</b>	<b>\$29,591,000</b>	<b>\$6,937,000</b>	<b>\$22,655,000</b>	<b>\$2,809,000</b>
CCS Medi-Cal				
CCS Case Management	\$165,098,000	\$61,982,000	\$103,116,000	\$0
Medi-Cal Expansion	\$1,057,000	\$1,057,000	\$0	\$0
CMS Net	\$2,380,000	\$1,190,000	\$1,190,000	\$0
<b>Subtotal</b>	<b>\$168,535,000</b>	<b>\$64,229,000</b>	<b>\$104,306,000</b>	<b>\$0</b>
Rady Children's Hospital	(\$221,000)	(\$110,000)	(\$111,000)	\$0
WCM Implementation	(\$22,040,000)	(\$10,557,000)	(\$11,483,000)	\$0
<b>Total</b>	<b>\$175,865,000</b>	<b>\$60,499,000</b>	<b>\$115,367,000</b>	<b>\$2,809,000</b>

\* Totals may differ due to rounding

\*\* County Funds are not included in the Total Fund

**CCS CASE MANAGEMENT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 1

**Funding:**

<b>FY 2020-21</b>	<b>TF*</b>	<b>GF</b>	<b>FF</b>	<b>CF**</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$62,531,000	\$31,265,000	\$31,265,000	\$0
75% Title XIX / 25% GF (4260-101-0890/0001)	\$98,645,000	\$24,661,000	\$73,984,000	\$0
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	(\$789,000)	(\$185,000)	(\$604,000)	\$0
76.5% Title XXI / 11.75% GF / 11.75% CF (4260-113- 0890/0001)	\$3,522,000	\$469,000	\$3,053,000	\$469,000
65% Title XXI / 35% GF (4260-113-0890/0001)	(\$2,368,000)	(\$829,000)	(\$1,539,000)	\$0
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0890/0001)	\$9,877,000	\$2,095,000	\$7,782,000	\$2,095,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000	\$0	\$0
<b>Total</b>	<b>\$172,475,000</b>	<b>\$58,534,000</b>	<b>\$113,941,000</b>	<b>\$2,564,000</b>

<b>FY 2021-22</b>	<b>TF*</b>	<b>GF</b>	<b>FF</b>	<b>CF**</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$66,034,000	\$33,017,000	\$33,017,000	\$0
75% Title XIX / 25% GF (4260-101-0890/0001)	\$98,212,000	\$24,553,000	\$73,659,000	\$0
65% Title XXI / 35% GF (4260-113-0890/0001)	(\$2,681,000)	(\$938,000)	(\$1,743,000)	
65% Title XXI / 17.5% GF / 17.5% CF (4260-113-0890/0001)	\$13,243,000	\$2,809,000	\$10,434,000	\$2,809,000
100% GF (4260-101-0001)	\$1,057,000	\$1,057,000	\$0	\$0
<b>Total</b>	<b>\$175,865,000</b>	<b>\$60,499,000</b>	<b>\$115,367,000</b>	<b>\$2,809,000</b>

\* Totals may differ due to rounding

\*\* County Funds are not included in the Total Fund

\*\*\* COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

\*\*\*\*COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

## COUNTY SPECIALTY MENTAL HEALTH ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 2  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1721

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$180,524,000	\$188,941,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$180,524,000	\$188,941,000

**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.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to:

- Updated base year expenditures, and
- Updated payment lag factors resulting in an increase in estimated payments in the year services occur based on claims payment data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to updated payment lags, and applying a 6.13% growth factor, based on the compounded annual growth rate from FY 2014-15 through FY 2018-19.

**Methodology:**

1. Mental Health administration costs are based on historical claims payment data. Based on historical claims received, assume 21% of each fiscal year claims will be paid in the year the services occur, 67% is paid in the following year, and 12% in the third year. The costs on an accrual and cash basis are:

**COUNTY SPECIALTY MENTAL HEALTH ADMIN**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 2**

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2020-21	FY 2021-22
MC	\$298,700	\$35,226	\$0
CHIP	\$25,329	\$2,987	\$0
FY 2018-19	\$324,029	\$38,213	\$0
MC	\$317,023	\$212,474	\$37,387
CHIP	\$26,883	\$18,017	\$3,170
FY 2019-20	\$343,906	\$230,492	\$40,558
MC	\$336,470	\$71,281	\$225,508
CHIP	\$28,532	\$6,045	\$19,123
FY 2020-21	\$365,002	\$77,326	\$244,631
MC	\$357,110	\$0	\$75,654
CHIP	\$30,282	\$0	\$6,415
FY 2021-22	\$387,392	\$0	\$82,069
<b>Total</b>		\$346,031	\$367,257

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, 2020, enhanced CHIP funding will decrease from 76.5% to 65%.

(Dollars in Thousands)

Claim Type	FY 2020-21			FY 2021-22		
	TF	FF	CF	TF	FF	CF
MC	\$318,982	\$159,491	\$159,491	\$338,549	\$169,275	\$169,274
CHIP	\$27,049	\$21,033	\$6,016	\$28,708	\$19,666	\$9,042
<b>Total</b>	\$346,031	<b>\$180,524</b>	\$165,507	\$367,257	<b>\$188,941</b>	\$178,316

**Funding:**

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

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

## SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 3  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 235

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$139,218,000	\$143,285,000
<b>STATE FUNDS</b>	-\$65,000	\$0
<b>FEDERAL FUNDS</b>	\$139,283,000	\$143,285,000

**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) for costs incurred through performing Medicaid administrative activities.

**Authority:**

AB 2377 (Chapter 147, Statutes of 1994)  
 AB 2780 (Chapter 310, Statutes of 1998)  
 Welfare and Institutions (W&I) Code 14132.47

**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 certified public expenditures incurred through performing Medicaid administrative activities. 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. The remaining backcasting recoupments will be returned to the General Fund (GF) in FY 2020-21.



## SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 3

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is a net decrease due to:

- Actuals were used for FY 2018-19 Q2 invoices, with the exception of FY 2018-19 Q2 for Glenn LEC, which was projected using FY 2017-18 Q2, plus the Employment Cost Index (ECI) growth factor. This resulted in lower totals for FY 2018-19 Q2 than previously estimated.
- Increased ECI growth factor based on two additional quarters of ECI data, and
- Inclusion of Glenn LEC remaining backcast recoupments to pay back GF.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to:

- Applying the ECI growth factor to determine FY 2019-20 Q2 to Q4 projections, and
- Completing the backcasting recoupments in FY 2020-21 with no GF payback in FY 2021-22.

### Methodology:

The FY 2020-21 estimate includes:

1. The FY 2018-19 Q2 estimate is based on actual invoice claims received for all the LECs/LGAs, except for the portion representing Glenn LEC, as the Glenn LEC invoice claim totals are still pending. The portion of the FY 2018-19 Q2 estimate representing Glenn LEC reflects estimates based on actual invoice claims for Glenn LEC received from FY 2017-18 Q2, plus an Employment Cost Index (ECI) adjustment factor of 2.87% per year.
2. The FY 2018-19 Q3 and Q4 estimates are based on FY 2017-18 Q3 and Q4 actual invoices received plus the ECI adjustment factor of 2.87%.
3. The FY 2019-20 Q1 estimate is based on an average of the FY 2018-19 Q2-Q4 estimates (per the SMAA Manual).
4. The total estimate for the Backcasting Recoupments is the amount SMAA will recoup from the claiming units under Glenn LEC to pay back the General Fund, as these LEAs' Proposition 98 funds did not cover the full amounts due to the Department.

The FY 2021-22 estimate includes:

1. The FY 2019-20 Q2-Q4 estimates are based on FY 2018-19 Q2-Q4 estimated invoice claims for FY 2018-19 Q2-Q4, plus an ECI adjustment factor of 2.87%.
2. The FY 2020-21 Q1 estimate is based on an average of the FY 2019-20 Q2-Q4 estimates (per the SMAA Manual).

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FY 2018-19 Q2-Q4	\$104,462,000	\$0	\$104,462,000
FY 2019-20 Q1	\$34,821,000	\$0	\$34,821,000
Remaining Backcasting Recoupments	(\$65,000)	(\$65,000)	\$0
<b>Total</b>	<b>\$139,218,000</b>	<b>(\$65,000)</b>	<b>\$139,283,000</b>

**SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES**  
OTHER ADMIN. POLICY CHANGE NUMBER: 3

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
FY 2019-20 Q2-Q4	\$107,464,000	\$107,464,000
FY 2020-21 Q1	\$35,821,000	\$35,821,000
<b>Total</b>	<b>\$143,285,000</b>	<b>\$143,285,000</b>

**Funding:**

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

100% GF (4260-101-0001)

## COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 4  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1963

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$130,567,000	\$118,970,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$130,567,000	\$118,970,000

**Purpose:**

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs) including Native American Indian tribes for Medicaid administrative activities.

**Authority:**

Welfare & Institutions Code (WIC) 14132.47

**Interdependent Policy Changes:**

Not Applicable

**Background:**

WIC 14132.47 authorizes the State to administer the County-based Medi-Cal Administrative Activities (CMAA) and Tribal Medi-Cal Administrative Activities (TMAA) claiming processes. CMAA and TMAA are voluntary programs that allow LGAs to receive federal reimbursement for allowable administrative activities upon entering into a contract with the Department. The Department submits claims on behalf of the LGAs, which includes counties and chartered cities, and Native American Indian tribes and tribal organizations to obtain FFP for certified public expenditures incurred through performing CMAA and TMAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a net increase due to the following:

For CMAA, the:

- FY 2018-19 Q1 claims were shifted to be paid in FY 2020-21 instead of FY 2019-20, resulting in an increase in the FY 2020-21 estimate.
- The FY 2019-20 Q1 estimate has decreased based on updated actual claims data.

For TMAA:

- The estimate for FY 2018-19 decreased because FY 2018-19 Q2-Q3 were paid earlier in FY 2019-20. In addition, the FY 2018-19 Q4 estimate has decreased based on FY 2018-19 actual claims data.
- Two additional FY 2019-20 quarters are now estimated to be paid in FY 2020-21, resulting in increased costs. However, the FY 2019-20 quarterly estimate has decreased based on updated actual claims data.

## COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 4

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a net decrease due to:

- Fewer quarters of CMAA payments are expected in FY 2021-22 than in FY 2020-21. The CMAA FY 2020-21 payments include FY 2018-19 Q1 claims resulting in payments made for five quarters, while CMAA FY 2021-22 only includes payments for four quarters.
- An increase in CMAA and TMAA quarterly payments estimated in FY 2020-21 based on an 8% growth factor.

### Methodology:

#### County Medi-Cal Administrative Activities

1. The CMAA FY 2020-21 estimate includes the remaining FY 2018-19 Q1-Q4 claims and FY 2019-20 Q1 claims.
  - Estimated costs for FY 2018-19 are annualized projections based on actual claims data from FY 2017-18 Q1-Q4 and FY 2018-19 Q1 , plus an 8% growth factor, based on CMAA claims from FY 2014-15 through FY 2018-19.
  - The estimated base payments for FY 2019-20 claims assumes an 8% growth factor from FY 2018-19, based on growth in CMAA claims from FY 2014-15 through FY 2018-19.

CMAA FY 2020-21 Estimated Payments	
FY 2018-19 Q1- Q4	\$101,033,000
FY 2019-20 Q1	\$29,024,000
Total	\$130,057,000

3. The CMAA FY 2021-22 estimate includes FY 2019-20 Q2-Q4 claims and FY 2020-21 Q1 claims. The estimated base payments for FY 2020-21 claims assume an 8% growth factor, based on CMAA growth in claims from FY 2014-15 through FY 2018-19.

CMAA FY 2021-22 Estimated Payments	
FY 2019-20 Q2 - Q4	\$87,073,000
FY 2020-21 Q1	\$31,346,000
Total	\$118,419,000

#### Tribal Medi-Cal Administrative Activities

1. The TMAA FY 2020-21 estimate includes the remaining FY 2018-19 Q4 claims and FY 2019-20 Q1-Q3 claims.
  - FY 2018-19 Q4 claims are estimated to be \$120,000 TF. This estimate was based on FY 2018-19 Q1-Q3 actuals, which decreased from prior years due to fewer non-medical transportation (NMT) TMAA claims.

## COUNTY & TRIBAL MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 4

- The estimated base payments for FY 2019-20 claims assume an 8% growth factor, based on growth in TMAA claims from FY 2014-15 through FY 2018-19.

TMAA FY 2020-21 Estimated Payments	
FY 2018-19 Q4	\$120,000
FY 2019-20 Q1-Q3	\$390,000
<b>Total</b>	<b>\$510,000</b>

- The TMAA FY 2021-22 estimate includes the remaining FY 2019-20 Q4 and FY 2020-21 Q1-Q3 claims. The estimated base payments for FY 2020-21 claims assume an 8% growth factor based on growth in TMAA claims from FY 2014-15 through FY 2018-19.

TMAA FY 2021-22 Estimated Payments	
FY 2019-20 Q4	\$130,000
FY 2020-21 Q1-Q3	\$421,000
<b>Total</b>	<b>\$551,000</b>

- Total CMAA and TMAA reimbursements for FY 2020-21 and FY 2021-22 on a cash basis are:

FY 2020-21	TF	FF
County MAA	\$130,057,000	\$130,057,000
Tribal MAA	\$510,000	\$510,000
<b>Total</b>	<b>\$130,567,000</b>	<b>\$130,567,000</b>

FY 2021-22	TF	FF
County MAA	\$118,419,000	\$118,419,000
Tribal MAA	\$551,000	\$551,000
<b>Total</b>	<b>\$118,970,000</b>	<b>\$118,970,000</b>

**Funding:**

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

## SMH MAA

**OTHER ADMIN. POLICY CHANGE NUMBER:** 5  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1722

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$51,376,000	\$57,757,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$51,376,000	\$57,757,000

**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 2020-21, is a net increase due to:

- Increased actual FY 2018-19 expenditures, and higher estimated FY 2019-20 and FY 2020-21 expenditures;
- Updating the growth factor;
- Updating the payment lags to assume 98.39% of claims will be paid in the following year services occur, based on actual FY 2017-18 claims data; and
- Updating the assumed percentage of skilled professional medical personnel (SPMP) and other personnel, based on actual FY 2019-20 claims.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the addition of claims to be paid in FY 2021-22 based on projected costs.

**Methodology:**

1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year.
2. Assume total SMH MAA claims increases by 12.35% each fiscal year starting in FY 2019-20.

**SMH MAA**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 5**

3. For FY 2019-20, the Department projects to receive \$98,246,000 TF in SMH MAA claims on an accrual basis.

(Dollars in Thousands)

<b>Fiscal Years</b>	<b>Expenditures</b>	<b>Growth</b>	<b>Increase</b>
2019-20	\$98,246	12.35%	\$12,137
2020-21	\$110,383	12.35%	\$13,636
2021-22	\$124,019		

4. Based on historical claims received, assume 1.67% of FY 2019-20 claims will be paid in the year services occur and 98.33% are paid in the following year. Assume for 1.61% of FY 2020-21 and FY 2021-22 claims will be paid in the year services occur and 98.39% are paid in the following year.

(Dollars in Thousands)

<b>Fiscal Years</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
2019-20	\$98,246	\$96,610	\$0
2020-21	\$110,383	\$1,774	\$108,609
2021-22	\$124,019	\$0	\$1,993
<b>Total</b>	<b>\$332,648</b>	<b>\$98,384</b>	<b>\$110,602</b>

5. 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 2019-20, assume 8.88% of costs are eligible for 75% reimbursement and the remaining 91.12% are eligible for 50% reimbursement. SMH MAA total expenditures are shared between federal funds (FF) and county funds (CF).

(Dollars in Thousands)

<b>Expenditures</b>	<b>FY 2020-21</b>			<b>FY 2021-22</b>		
	<b>TF</b>	<b>FF</b>	<b>CF</b>	<b>TF</b>	<b>FF</b>	<b>CF</b>
SPMP (75/25)	\$8,736	\$6,552	\$2,184	\$9,821	\$7,366	\$2,455
Other (50/50)	\$89,648	\$44,824	\$44,824	\$100,781	\$50,391	\$50,390
<b>Total</b>	<b>\$98,384</b>	<b>\$51,376</b>	<b>\$47,008</b>	<b>\$110,602</b>	<b>\$57,757</b>	<b>\$52,845</b>

**Funding:**

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

## HEALTH INFORMATION EXCHANGE INTEROPERABILITY

**OTHER ADMIN. POLICY CHANGE NUMBER:** 6  
**IMPLEMENTATION DATE:** 6/2020  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2159

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$40,057,000	\$11,343,000
<b>STATE FUNDS</b>	\$4,027,000	\$1,153,000
<b>FEDERAL FUNDS</b>	\$36,030,000	\$10,190,000

**Purpose:**

This policy change estimates the cost to administer the California Health Information Exchanges (HIE) Onboarding Program (Cal-HOP) as part of the Medi-Cal Promoting Interoperability Program. The policy change also estimates the cost to deploy and operate the DHCS HIE platform for Clinical Data Exchange (CDE).

**Authority:**

ARRA of 2009  
 21st Century Cures Act of 2016  
 Title 42 of the Code of Federal Regulations, Section 431.60  
 Title 42 of the Code of Federal Regulations, Section 457.730  
 Title 22 of the California Code of Regulations, Section 51476

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On February 29, 2016, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to draw down enhanced federal funding to implement activities to promote HIE and encourage the adoption of certified Electronic Health Record (EHR). The Cal-HOP program will support Health Information Organizations (HIO) onboarding and technical assistance as well as establish interfaces between HIOs and Controlled Substance Utilization Review and Evaluation System.

In addition, in December 2019 the Department began using a Software-as-a-Service (SaaS) HIE solution to retrieve clinical information about Medi-Cal members directly from HIOs and enterprise health systems. The data is accepted, validated, and organized by the SaaS solution. This effort supports Medi-Cal operational requirements in the business area of utilization management. Over time, the solution will be expanded to take advantage of the increased connectivity through Cal-HOP to support additional Medi-Cal business areas. The DHCS HIE solution also supports compliance with recently published and emerging federal requirements for health information interoperability.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an overall increase for the policy change. The increase for the Cal-HOP portion is due to a delay in implementation which caused more costs to be paid in FY 2020-21. The increase for the CDE project is due to the delayed start of some contracts and one-time costs related to operating the program being paid in FY 2020-21.



## HEALTH INFORMATION EXCHANGE INTEROPERABILITY

### OTHER ADMIN. POLICY CHANGE NUMBER: 6

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an overall decrease for the policy change. The decrease for the Cal-HOP portion is due to the program concluding in the first quarter of the FY 2021-22. The decrease for the CDE project is due to the conclusion of change management activities and one-time costs being paid in FY 2020-21.

#### Methodology:

1. Estimated expenditures for the Cal-HOP program are \$39,260,714 TF (\$3,926,071 GF) in FY 2020-21, and \$10,639,286 TF (\$1,063,929 GF) in FY 2021-22.
2. Estimated expenditures for the CDE project are \$750,175 TF (\$95,272 GF) in FY 2020-21 and \$703,600 TF (\$89,360 GF) in FY 2021-22.

#### CDE Cost Estimates for FY 2020-21

Source of Cost	TF	FF	GF
NextGen Health Data Hub Software-as-a-Service	\$220,000	\$192,058	\$27,942
HIE Subject-Matter Expert (SME)	\$222,750	\$194,469	\$28,281
Change Management SME	\$164,000	\$143,176	\$20,824
NextGen Health Data Hub System Administration	\$164,000	\$143,176	\$20,824
NextGen Health Data Hub Training	\$25,000	\$21,825	\$3,175
<b>Total</b>	<b>\$795,750</b>	<b>\$694,684</b>	<b>\$101,066</b>

#### CDE Cost Estimates for FY 2021-22

Source of Cost	TF	FF	GF
NextGen Health Data Hub Software-as-a-Service	\$132,600	\$115,764	\$16,836
HIE Subject-Matter Expert (SME)	\$243,000	\$212,148	\$30,852
Change Management SME	\$82,000	\$71,588	\$10,412
NextGen Health Data Hub System Administration	\$246,000	\$214,764	\$31,236
<b>Total</b>	<b>\$703,600</b>	<b>\$614,240</b>	<b>\$89,360</b>

FY 2020-21	TF	FF	GF
Cal-HOP	\$39,261,000	\$35,335,000	\$3,926,000
Clinical Data Exchange	\$796,000	\$695,000	\$101,000
<b>Total*</b>	<b>\$40,057,000</b>	<b>\$36,030,000</b>	<b>\$4,027,000</b>

\*Note: some slight variations due to rounding

FY 2021-22	TF	FF	GF
Cal-HOP	\$10,639,000	\$9,575,000	\$1,064,000
Clinical Data Exchange	\$704,000	\$615,000	\$89,000
<b>Total</b>	<b>\$11,343,000</b>	<b>\$10,190,000</b>	<b>\$1,153,000</b>

#### Funding:

100% State GF (4260-101-0001)

100% Title XIX (4260-101-0890)

## MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 7  
**IMPLEMENTATION DATE:** 7/2002  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 252

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$39,781,000	\$27,411,000
<b>STATE FUNDS</b>	\$10,381,580	\$7,227,000
<b>FEDERAL FUNDS</b>	\$29,399,420	\$20,184,000

**Purpose:**

The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS), the Surveillance and Utilization Review Subsystem (SURS) and the Management Administration Reporting Subsystem (MARS).

**Authority:**

Contract #14-90129  
Centers for Medicaid Services (CMS) Transformed Medicaid Statistical Information System (T-MSIS) Requirements

**Interdependent Policy Changes:**

COVID Increased FMAP – Other Admin  
COVID-19 Increased FMAP Extension –DHCS-Other Admin

**Background:**

The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. SURS and MARS are a subset of MIS/DSS. 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 MIS/DSS system and subsystems are used by more than 20 different areas within the Department (i.e. Audits & Investigations, Managed Care Operations, Pharmacy Benefits, Provider Enrollment, Integrated Systems of Care, Third Party Liability and Recovery, and Accounting), several other State departments, such as the California Department of Public Health and the Department of Justice, and other approved entities. The Department uses the system in various ways, including:

- CMS Reporting;
- The Managed Care Quality and Monitoring 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.

## MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM

### OTHER ADMIN. POLICY CHANGE NUMBER: 7

Ongoing maintenance and operation (M&O) 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.

Effective July 2016, the contract with Optum includes design, development, and implementation (DD&I) and ongoing M&O of SURS and MARS. The system replacement for SURS was implemented on April 3, 2017. CMS requires that projects be funded at 50% / 50% Federal Medical Assistance Percentage (FMAP) for projects that have been implemented but have not received CMS certification. The Department received the certification approval letter from CMS in August 2020. Once CMS certification is received, the appropriate FMAP for M&O invoices will be applied retroactively.

The existing MIS/DSS, SURS and MARS contract with Optum will expire June 2023. This contract will be amended in FY 2020-21 (contract Amendment 4) to address mandatory, mission-critical state and federal requirements which impact the volume and complexity of data to be stored in the warehouse. The increased volume and complexity of data is due to accommodating larger operational data loads, primarily to satisfy T-MSIS requirements that CMS now mandates the Department to provide including utilization and claims data, beneficiary and provider enrollment data, enhanced information about beneficiary eligibility and service utilization.

The Department is currently working on an Operational Annual Planning Document Update (OAPDU) to seek enhanced funding from CMS for contract Amendment 4. The Department submitted the OAPDU to CMS for approval during the first quarter of State Fiscal Year 2020-21.

#### **Reason for Change:**

MIS/DSS and SURS and MARS Combined Changes for FY 2020-21 from the prior estimate: The change from the prior estimate for FY 2020-21 is an increase due to MIS/DSS, SURS and MARS combining into one PC. Increased Total includes system and Amendment 4 costs for all systems. Total also includes costs to procure consulting services to procure a new MIS/DSS contract as the current contract will expire June 2023. DDI cost associated with CMS certification activities of the SURS and MARS systems shifted from FY 2019-20 to FY 2020-21.

MIS/DSS changes for FY 2020-21 from the prior estimate:

The change from the prior estimate for FY 2020-21 is an increase due to Amendment 4 costs that affect the remaining contract years (CY7, CY8 and CY9) and includes increased consulting services costs to procure a new MIS/DSS contract as the current contract will expire June 2023.

SURS and MARS changes for FY 2020-21 from the prior estimate:

The change from the prior estimate for FY 2020-21 is an increase due to Amendment 4 costs that affect the remaining contract years (CY7, CY8 and CY9). Totals include increased DDI costs associated with CMS certification activities of the SURS and MARS systems moved from FY 2019-20 to FY 2020-21.

MIS/DSS and SURS and MARS Combined Changes from FY 2020-21 to FY 2021-22:

The change from FY 2020-21 to FY 2021-22 is due to a decrease in volume and data loads. The hardware/software refresh originally scheduled for FY 2021-22 was performed earlier in FY 2020-21, thereby reducing hardware/software costs for FY 2021-22.

## MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM

### OTHER ADMIN. POLICY CHANGE NUMBER: 7

MIS/DSS changes from FY 2020-21 to FY 2021-22:

The change from FY 2020-21 to FY 2021-22 is a decrease due to an decrease for Amendment 4 costs that affect the remaining contract years (CY7, CY8, and CY9) and includes a decrease in consulting services costs to procure a new MIS/DSS contract as the current contract will expire June 2023.

SURS and MARS changes from FY 2020-21 to FY 2021-22:

The change from FY 2020-21 to FY 2021-22 is a decrease due to Amendment 4 costs that affect the remaining contract years (CY7, CY8, and CY9).

#### Methodology:

1. MIS/DSS total contract Amendment 4 costs began on September 1, 2020, and will end on June 30, 2023, which is the date the original contract expires. The estimated total Amendment costs through June 30, 2023, are \$14,119,000 (\$9,645,000 for FY 2020-21, \$785,000 for FY 2021-22, and \$3,689,000 for FY 2022-23).
2. SURS and MARS contract Amendment 4 began on September 1, 2020, and will end on June 30, 2023, which is the date the original contract expires. The estimated total Amendment costs through June 30, 2023, are \$10,905,000 (\$6,349,000 for FY 2020-21, \$2,202,000 for FY 2021-22, and \$2,354,000 for FY 2022-23). DDI cost associated with CMS certification activities of the SURS and MARS systems moved from FY 2019-20 to FY 2020-21 due to delays in certification timelines. DDI costs for FY 2020-21 are as follows: MARS \$1,419,000 and SURS \$838,000.
3. The estimated breakdown of the SURS costs are:

SURS	FY 2020-21	FY 2021-22
DD&I Costs	\$838,000	\$0
Operational Costs	\$11,458,000	\$7,581,000
<b>Total</b>	<b>\$12,296,000</b>	<b>\$7,581,000</b>

Totals may differ due to rounding

4. The estimated breakdown of the MARS costs are:

MARS	FY 2020-21	FY 2021-22
DD&I Costs	\$1,419,000	\$0
Operational Costs	\$3,117,000	\$3,010,000
<b>Total</b>	<b>\$4,536,000</b>	<b>\$3,010,000</b>

Totals may differ due to rounding

**MIS/DSS SYSTEM AND SURS & MARS SUBSYSTEM**  
OTHER ADMIN. POLICY CHANGE NUMBER: 7

5. The estimated breakdown of MIS/DSS costs are:

MIS/DSS	FY 2020-21	FY 2021-22
DD&I Costs	\$1,104,000	\$1,104,000
Operational Costs	\$21,844,000	\$15,716,000
Total	\$22,948,000	\$16,820,000

Totals may differ due to rounding

6. The estimated total costs for SURS, MARS and MIS/DSS are:

SURS, MARS and MIS/DSS	TF	GF	FF
DD&I Costs	\$3,361,000	\$415,000	\$2,946,000
Operational Costs	\$36,420,000	\$9,966,000	\$26,454,000
Total FY 2020-21	\$39,781,000	\$10,381,000	\$29,400,000

Totals may differ due to rounding

SURS, MARS and MIS/DSS	TF	GF	FF
DD&I Costs	\$1,104,000	\$140,000	\$964,000
Operational Costs	\$26,307,000	\$7,087,000	\$19,220,000
Total FY 2021-22	\$27,411,000	\$7,227,000	\$20,184,000

Totals may differ due to rounding

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0890/0001)

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

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

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

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP–DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## MEDI-CAL RX - ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 8  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 2167

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$26,862,000	\$84,311,000
<b>STATE FUNDS</b>	\$11,831,000	\$15,417,850
<b>FEDERAL FUNDS</b>	\$15,031,000	\$68,893,150

**Purpose:**

This policy change estimates the net impact from the cost of the new administrative services vendor contract and impact on the current Fee-For-Service (FFS) pharmacy claims administrator for Medi-Cal Rx.

**Authority:**

Executive Order N-01-19

**Interdependent Policy Changes:**

Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS

**Background:**

Executive Order N-01-19 requires the Department to transition Medi-Cal pharmacy services into a FFS benefit. This effort is known as Medi-Cal Rx and will be implemented on April 1, 2021. To facilitate and support the carve-out and ongoing management of the Medi-Cal pharmacy benefit, the Department will procure an external vendor to provide various administrative services for Medi-Cal Rx.

The Medi-Cal Rx vendor will modernize existing pharmacy support systems and will include, but not be limited to services related to claims administration and utilization management, pharmacy drug rebate administration, and provider and beneficiary support. The Department estimates a cost savings for the administrative services that would have been provided under the existing vendor contract for the FFS pharmacy claims administrator. Administrative costs also include contractor services and supports related to takeover of operations from the current Medi-Cal Fiscal Intermediary and managed care plans.

Effective July 1, 2020, a contractor will provide consulting and project management services to support work efforts related to Medi-Cal Rx.

The Department will be seeking necessary federal approvals for enhanced federal funding for specified periods, and standard federal funding for these administrative services, as outlined below:

Vendor

FY 2020-21:

- Operation costs funded at 50% FF / 50% GF

## MEDI-CAL RX - ADMINISTRATIVE COSTS

### OTHER ADMIN. POLICY CHANGE NUMBER: 8

FY 2021-22 and ongoing:

- Ongoing operations costs funded at 75% FF / 25% GF

#### Consulting

- July 2020 through August 2021 funded at 90% FF / 10% GF

This policy change (PC) is part of the carve-out effort transitioning MC pharmacy services to FFS delivery system. The PCs related to Medi-Cal Rx are:

#### Regular

- Medi-Cal Rx – Managed Care Pharmacy Benefit to FFS
- Medi-Cal Rx – Additional Savings from Maximum Allowable Ingredient Cost (MAIC) in FFS
- Medi-Cal Rx – Additional Supplemental Rebates
- Medical Supply Rebates
- Non-Hospital 340B Clinic Supplemental Payments

#### Other Admin

- Medi-Cal Rx – Administrative Costs

#### **Reason for Change:**

There change from the prior estimate for FY 2020-21 is a net decrease in costs due to:

- Decreased new pharmacy-related administrative costs due to the delayed Medi-Cal Rx implementation from January 1, 2021, to April 1, 2021,
- A delay in the FFS related administrative savings from FY 2020-21 to FY 2021-22,
- Decreased contractor costs, and
- Increased vendor cost reimbursements in FY 2020-21.

The change from FY 2020-21 to FY 2021-22 in the current estimate is a net increase in cost due to:

- Estimating a full year of pharmacy-related administrative cost in FY 2021-22.
- Estimating savings for FFS related administrative savings starting in FY 2021-22, and
- Lower contractor costs due to the end of the contract.

#### **Methodology:**

1. Assume the FFS related administrative cost is an annual savings of \$8,000,000 TF.
2. Assume the new pharmacy-related administrative cost are \$88,684,000 TF annually.

(Dollars in Thousands)

<b>Annual</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS Related Administrative Cost Savings	(\$8,000)	(\$2,000)	(\$6,000)
New Pharmacy Related Administrative Costs	\$88,684	\$22,171	\$66,513
<b>Net Administrative Costs</b>	<b>\$80,684</b>	<b>\$20,171</b>	<b>\$60,513</b>

3. Contractor costs are included, effective July 1, 2020 through August 30, 2021.

**MEDI-CAL RX - ADMINISTRATIVE COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 8

4. The estimated cost for FY 2020-21 and FY 2021-22 is:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
New Pharmacy Related Administrative Costs	\$26,862	\$11,831	\$15,031
<b>Total</b>	<b>\$26,862</b>	<b>\$11,831</b>	<b>\$15,031</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS Related Administrative Cost Savings	(\$4,000)	(\$1,000)	(\$3,000)
New Pharmacy Related Administrative Costs	\$88,311	\$16,418	\$71,893
<b>Total</b>	<b>\$84,311</b>	<b>\$15,418</b>	<b>\$68,893</b>

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
90% Title XIX / 10% GF (4260-101-0001/0890)	\$4,000	\$400	\$3,600
50% Title XIX / 50% GF (4260-101-0001/0890)	\$22,862	\$11,431	\$11,431
<b>Total</b>	<b>\$26,862</b>	<b>\$11,831</b>	<b>\$15,031</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FI 75% Title XIX / 25% GF (4260-101-0001/0890)	(\$4,000)	(\$1,000)	(\$3,000)
FI 75% Title XIX/ 25% GF (4260-101-0001/0890)	\$109,885	\$27,471	\$82,414
90% Title XIX / 10% GF (4260-101-0001/0890)	\$666	\$67	\$599
50% Title XIX / 50% GF (4260-101-0001/0890)	(\$22,240)	(\$11,120)	(\$11,120)
<b>Total</b>	<b>\$84,311</b>	<b>\$15,418</b>	<b>\$68,893</b>



## ARRA HITECH INCENTIVE PROGRAM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 9  
**IMPLEMENTATION DATE:** 7/2010  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1370

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$38,843,000	\$12,930,000
<b>STATE FUNDS</b>	\$672,000	\$0
<b>FEDERAL FUNDS</b>	\$38,171,000	\$12,930,000

**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

**Interdependent Policy Changes:**

ARRA HITECH Provider Payments

**Background:**

The HITECH Act, a component of ARRA, authorizes federal funds for the Promoting Interoperability Program, 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 to the Health Care Services Plans Fines and Penalties Fund for HITECH projects.

The Department annually submits an Implementation Advance Planning Document Update (IAPD-U) to the Centers for Medicare and Medicaid Services (CMS) for approval of continued funding. CMS approved the Department's IAPD-U for FFY 2020 on October 8, 2019. The current IAPD-U will expire September 30, 2020.

CMS requires the Department to conduct a detailed landscape assessment of the state of health information technology in California. This assessment will be completed at the end of the program and will serve as a bookend to the assessment that was completed in 2010, when the program began.

CMS requires the Department to assess the current usage of and barriers to electronic health record (EHR) adoption and administration of the Promoting Interoperability 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

## ARRA HITECH INCENTIVE PROGRAM

### OTHER ADMIN. POLICY CHANGE NUMBER: 9

Project Book that identifies a series of projects to facilitate the ongoing development and evaluation of the program.

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 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 Promoting Interoperability Program Surveys, required to refine the initial landscape assessment of EHR use, and to document activities. The Department does not plan to conduct the surveys in FY 2019-20, but may implement in 2020-21.
- California Promoting Interoperability Program Summit, held annually each state fiscal year.
- The State Health Information Guidance (SHIG) document explains when it is appropriate to exchange mental health and substance use disorder information between behavioral health providers and other providers involved in providing and coordinating patient care. The Department will work with the CA Office of Health Information Integrity to expand the SHIG to address additional use cases in order to facilitate the exchange of health and behavioral health information.
- The Department of Justice (DOJ) Controlled Substance Utilization Review and Evaluation System (CURES) project seeks to support the connectivity of Health Information Exchanges (HIE) and providers to the state Prescription Drug Monitoring Program. DOJ will be responsible for establishing a method of system integration whereby approved health care practitioners and pharmacists may use a qualified health information technology system to access information in the CURES database.

#### Reasons for Change:

The change in FY 2020-21, from the prior estimate, is an increase due to:

- An increase in HITEMS due to pending invoices from CDPH.
- An increase in Provider Technical Assistance due to anticipated invoice increase related to the closeout deadlines of the program.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to the expiration of several programs and contracts. Costs for CTAP will end April 2021. CAIR, CalREDIE, HITEMS, and SHIG will all conclude September 30, 2021.

#### Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

**ARRA HITECH INCENTIVE PROGRAM**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 9**

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. A subsequent three month extension of CTAP due to COVID-19 challenges was approved by CMS and will continue the program until September 30, 2020, with project reallocated to FY 2020-21, and anticipated delayed invoices being paid into FY 2020-21.
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.
6. DOJ/CURES project costs are eligible for Title XIX 90% FF.
7. SHIG/Cal-OHII project costs are eligible for Title XIX 90% FF.
8. The medical Fiscal Intermediary (FI) projects are eligible for ARRA HITECH funding under the FI contract.

<b>FY 2020-21</b>	<b>TF</b>	<b>Reimburs.</b>	<b>SF</b>	<b>FF</b>
CAIR Onboarding (90% FF/10% GF)	\$2,635,000	\$0	\$0	\$2,635,000
CalREDIE eCR (90% FF/10% GF)	\$1,635,000	\$0	\$0	\$1,635,000
HITEMS (90% FF/10% GF)	\$25,193,000	\$0	\$0	\$25,193,000
Provider Technical Assist. (90% FF/10% SF)	\$6,454,000	\$0	\$646,000	\$5,809,000
California HIT/HIE Summit (90% FF/10% GF)	\$264,000	\$26,000	\$0	\$237,000
DOJ / CURES (90% FF/10% GF)	\$789,000	\$0	\$0	\$789,000
SHIG / Cal-OHII (90% FF/10% GF)	\$1,873,000	\$0	\$0	\$1,873,000
<b>Total FY 2020-21</b>	<b>\$38,843,000</b>	<b>\$26,000</b>	<b>\$646,000</b>	<b>\$38,171,000</b>

**ARRA HITECH INCENTIVE PROGRAM**  
OTHER ADMIN. POLICY CHANGE NUMBER: 9

<b>FY 2021-22</b>	<b>TF</b>	<b>Reimburs.</b>	<b>SF</b>	<b>FF</b>
CAIR Onboarding (90% FF/10% GF)	\$925,000	\$0	\$0	\$925,000
CalREDIE eCR (90% FF/10% GF)	\$613,000	\$0	\$0	\$613,000
HITEMS (90% FF/10% GF)	\$10,475,000	\$0	\$0	\$10,475,000
Provider Technical Assist. (90% FF/10% SF)	\$0	\$0	\$0	\$0
California HIT/HIE Summit (90% FF/10% GF)	\$0	\$0	\$0	\$0
DOJ / CURES (90% FF/10% GF)	\$448,000	\$0	\$0	\$448,000
SHIG / Cal-OHII (90% FF/10% GF)	\$468,000	\$0	\$0	\$468,000
<b>Total FY 2021-22</b>	<b>\$12,930,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$12,930,000</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% Reimbursement (4260-601-0995)

100% Health Care Services Plans Fines and Penalties Fund (4260-602-3311)

## INTERIM AND FINAL COST SETTLEMENTS-SMHS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 10  
**IMPLEMENTATION DATE:** 7/2016  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1757

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$35,633,000	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$35,633,000	\$0

**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 2020-21, is a net increase due to:

- Updating county interim settlements for FY 2011-12, FY 2012-13, and FY 2013-14 due to including additional completed interim settlements;
- Adding interim settlements payments for FY 2014-15; and
- Updating audit cost settlements for FY 2008-09, FY 2010-11 and FY 2011-12 based on including additional final settlements.

The change in the current estimate for FY 2020-21 to FY 2021-22 is due to no settlements scheduled for FY 2021-22 at this time.

**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: 10

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 2020-21 for interim settlements and audit settlements are shown below:

(Dollars in Thousands)

<b>Interim Settlements</b>	<b>Total FF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>
FY 2011-12	(\$464)	(\$469)	\$5
FY 2012-13	\$4,977	\$4,954	\$23
FY 2013-14	\$30,812	\$30,811	\$1
FY 2014-15	\$6,789	\$6,789	\$0
<b>Subtotal</b>	<b>\$42,114</b>	<b>\$42,085</b>	<b>\$29</b>

(Dollars in Thousands)

<b>Audit Settlements</b>	<b>Total FF</b>	<b>Title XIX FF</b>	<b>Title XXI FF</b>
FY 2008-09	\$54	\$50	\$4
FY 2010-11	\$458	\$457	\$1
FY 2011-12	(\$6,993)	(\$7,077)	\$84
<b>Subtotal</b>	<b>(\$6,481)</b>	<b>(\$6,570)</b>	<b>\$89</b>
<b>Total FY 2020-21</b>	<b>\$35,633</b>	<b>\$35,515</b>	<b>\$118</b>

**Funding:**

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

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

## OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 11  
**IMPLEMENTATION DATE:** 1/2013  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1748

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$35,349,000	\$39,902,000
<b>STATE FUNDS</b>	\$12,999,980	\$19,656,850
<b>FEDERAL FUNDS</b>	\$22,349,020	\$20,245,150

**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:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**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, through 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.

Effective 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 application availability in the community, Maximus forwards any HFP applications it receives to the appropriate CWDs for a determination without the benefit of screening for accelerated enrollment.

## **OTLIPC, MCAP, SPECIAL POPULATIONS ADMIN COSTS**

### **OTHER ADMIN. POLICY CHANGE NUMBER: 11**

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.

Effective October 1, 2019, the Department transitioned the administrative functions for the County Children Health Initiative Program (CCHIP) to the state's administrative vendor, MAXIMUS. These administrative functions include case management and premium collection for CCHIP. The additional costs for the increased scope of work is budgeted through the current MAXIMUS contract through this policy change.

The Governor's Proposed Budget (2020-2021) proposes to create a state program to assist families with the cost of hearing aids and related services for children without health insurance coverage for hearing aids in households with incomes up to 600 percent of the federal poverty level. The Department is anticipating on leveraging administrative vendor services through the existing vendor to administer this program.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is a decrease due to an expected decrease in overall contract costs. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to the addition of the Hearing Aids program in FY 2021-22. The increase includes one-time only startup costs and a monthly cost, annualized for the duration of the implementation year.

#### **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 76.5/23.5 FMAP, Title XXI 65/35 FMAP, and Title XIX 50/50 FMAP. The EQRO contract cost is eligible for Title XIX 50/50 FMAP only. Hearing Aids costs are eligible for 100% GF.
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:



## OTLICP, MCAP, SPECIAL POPULATIONS ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 11

(Dollars in Thousands)

Program	FY 2020-21	FY 2021-22
OTLICP	\$24,993	\$23,126
MCAP	\$4,251	\$3,927
Medi-Cal Special Populations	\$1,702	\$1,912
CCHIP	\$4,403	\$4,226
Hearing Aids	\$0	\$6,711

5. Contract costs and administrative vendor service costs by cost category are as follows:

(Dollars in Thousands)

FY 2020-21	TF	GF	FF
Contract Costs	\$26,885	\$8,768	\$18,117
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee	\$888	\$444	\$444
Call Minute Rate per Minute	\$3,874	\$1,937	\$1,937
Implementation Costs	\$2,000	\$1,000	\$1,000
Special Populations Publications	\$1,702	\$851	\$851
<b>Total</b>	<b>\$35,349</b>	<b>\$13,000</b>	<b>\$22,349</b>

FY 2021-22	TF	GF	FF
Contract Costs	\$25,065	\$8,883	\$16,182
Applications Processing, Printing and Courier Services, Letters and Notices, Transaction Forwarding Fee, Pregnancy Materials	\$638	\$319	\$319
Call Minute Rate per Minute	\$3,576	\$1,788	\$1,788
Implementation Costs	\$2,000	\$1,000	\$1,000
Special Populations Publications	\$1,912	\$956	\$956
Hearing Aids	\$6,711	\$6,711	\$0
<b>Total</b>	<b>\$39,902</b>	<b>\$19,657</b>	<b>\$20,245</b>

\*Totals may differ due to rounding.

**OTLIP, MCAP, SPECIAL POPULATIONS ADMIN COSTS**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 11**

**Funding:**

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$9,198	\$4,599	\$4,599
76.5% Title XXI / 23.5% GF (4260-113-0890/0001)	\$6,538	\$1,536	\$5,002
65% Title XXI / 35% GF (4260-113-0890/0001)	\$19,613	\$6,865	\$12,748
<b>Total</b>	<b>\$35,349</b>	<b>\$13,000</b>	<b>\$22,349</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$8,860	\$4,430	\$4,430
65% Title XXI / 35% GF (4260-113-0890/0001)	\$24,331	\$8,516	\$15,815
100% GF (4260-101-0001)	\$6,711	\$6,711	\$0
<b>Total</b>	<b>\$39,902</b>	<b>\$19,657</b>	<b>\$20,245</b>

\*Totals may differ due to rounding.

\*\* COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP - Other Admin policy change

\*\*\* COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin

## CHDP COUNTY ALLOCATION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 12  
**IMPLEMENTATION DATE:** 7/1996  
**ANALYST:** Sasha Jetton  
**FISCAL REFERENCE NUMBER:** 229

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$33,962,000	\$33,962,000
<b>STATE FUNDS</b>	\$11,957,000	\$11,957,000
<b>FEDERAL FUNDS</b>	\$22,005,000	\$22,005,000

**Purpose:**

This policy change estimates the county allocation for the Child Health and Disability Prevention (CHDP) Program activities.

**Authority:**

Health & Safety Code 124075(a), 124025-124110  
 Welfare & Institutions Code 10507

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The CHDP County Allocation is provided to individual counties and controlled on an accrual basis. The purpose of the funding is for county activities for CHDP case management and provider enrollment and training.

Medi-Cal eligible children are entitled to Title XIX EPSDT provisions, including access to case management services. Most children in Medi-Cal receive these case management services through their Medi-Cal managed care plan. In addition to case management services being available through managed care, children have access to case management services from Fee-for Service providers, CHDP providers, county California Children's Services (CCS) programs, county Health Care Program for Children in Foster Care programs, home and community based service wavier providers and county behavioral health programs.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21 or between fiscal years in current estimate.

**Methodology:**

The allocation amount for both FY 2020-21 and FY 2021-22 is \$33,962,000 (\$11,957,000 GF)

**CHDP COUNTY ALLOCATION**  
OTHER ADMIN. POLICY CHANGE NUMBER: 12

**Funding:**

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total</b>	<b>\$33,962,000</b>	<b>\$11,957,000</b>	<b>\$22,005,000</b>
<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total</b>	<b>\$33,962,000</b>	<b>\$11,957,000</b>	<b>\$22,005,000</b>

## SMHS COUNTY UR & QA ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 13  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1729

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$53,136,000	\$35,030,000
<b>STATE FUNDS</b>	\$963,000	\$964,000
<b>FEDERAL FUNDS</b>	\$52,173,000	\$34,066,000

**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 2020-21, is increase due to:

- Updating payment lag percentages for claims paid in FY 2019-20 and FY 2020-21, resulting in more payments in the year claims were submitted,
- Updating CPI percentages used for growth trends, and
- Adding payments to be paid in FY 2020-21 that were scheduled for payment in FY 2019-20.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to higher estimated growth rate for FY 2021-22 resulting in more claims to be paid in FY 2021-22.

**SMHS COUNTY UR & QA ADMIN**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 13**

**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 2014-15 through FY 2017-18, assume 45% of each fiscal year claims will be paid in the year the services occur. Assume 53% is paid in the following year and the remaining 3% is assumed to be claimed through cost settlements and not included in this policy change. Assume the same payment lags for Foster Family Agencies (FFA) and Special Terms and Conditions (STC) payments.

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
2019-20	\$44,548	\$23,611	\$1,337
2020-21	\$45,974	\$20,688	\$24,366
2021-22	\$47,445	\$0	\$21,350
Total SPMP & Other		\$44,299	\$47,053

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 2019-20 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 STC related to the SMHS waiver. Assume the payment lags for FFA and STC are the same as listed above.

(Dollars in Thousands)

<b>STC</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
FY 2019-20	\$3,075	\$1,630	\$0
FY 2020-21	\$3,075	\$1,384	\$1,630
FY 2021-22	\$3,075	\$0	\$1,384
Total for STC		\$3,014	\$3,014

**SMHS COUNTY UR & QA ADMIN**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 13**

6. Beginning in January 2017, counties will incur costs to certify 184 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. The FFA costs, on a cash basis, are:

(Dollars in Thousands)

FFA	Rate	Accrual	FY 2020-21	FY 2021-22
FY 2019-20	\$58.12	\$428	\$227	\$0
FY 2020-21	\$58.12	\$428	\$192	\$227
FY 2021-22	\$58.12	\$428	\$0	\$192
Total for FFA			\$419	\$419

7. On a cash basis, the estimated payments in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

Personnel	TF	GF	FF	CF
SPMP	\$51,891	\$0	\$38,918	\$12,973
Other	\$23,075	\$0	\$11,538	\$11,537
STC	\$3,014	\$754	\$1,507	\$753
FFA	\$419	\$209	\$210	\$0
<b>FY 2020-21 Total</b>	<b>\$78,399</b>	<b>\$963</b>	<b>\$52,173</b>	<b>\$25,263</b>

(Dollars in Thousands)

Personnel	TF	GF	FF	CF
SPMP	\$35,290	\$0	\$26,467	\$8,823
Other	\$11,763	\$0	\$5,882	\$5,881
STC	\$3,014	\$754	\$1,507	\$753
FFA	\$419	\$210	\$210	\$0
<b>FY 2021-22 Total</b>	<b>\$50,486</b>	<b>\$964</b>	<b>\$34,066</b>	<b>\$15,457</b>

**Funding:**

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

100% GF (4260-101-0001)

## HEALTH ENROLLMENT NAVIGATORS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 14  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 2144

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$28,638,000	\$30,744,000
<b>STATE FUNDS</b>	\$14,319,000	\$15,372,000
<b>FEDERAL FUNDS</b>	\$14,319,000	\$15,372,000

**Purpose:**

This policy change estimates the funding provided to counties and community-based organizations (CBOs) for Medi-Cal outreach, enrollment, and retention activities.

**Authority:**

AB 74 (Chapter 23, Statutes of 2019)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CBOs play a vital role in assisting counties to reach out to marginalized populations and help eligible individuals apply and successfully complete the health coverage enrollment process, retain coverage, navigate the health care system, and gain timely access to medical care through community-based care management.

Adequate funding for outreach, enrollment, retention, and community-based assistance with utilization and care management is necessary to ensure all Medi-Cal eligible individuals are enrolled in health care coverage and have access to the care they need.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to project delays resulting from COVID-19 impacts and the timing of prior estimate decisions. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight increase based on payment timing for activities provided.

**Methodology:**

1. Assume an implementation date of March 1, 2020.
2. Assume selected counties that partner with local CBOs to conduct outreach, enrollment, and retention activities in their applicable area shall receive supplemental funding.
3. On a cash basis, assume **\$28,638,000 Total Fund (\$14,319,000 General Fund)** will be paid in FY 2020-21 and **\$30,744,000 Total Fund (\$15,372,000 General Fund)** will be paid in FY 2021-22.

**Funding:**

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



## POSTAGE & PRINTING

**OTHER ADMIN. POLICY CHANGE NUMBER:** 15  
**IMPLEMENTATION DATE:** 7/1993  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 231

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$27,600,000	\$27,600,000
<b>STATE FUNDS</b>	\$13,928,500	\$13,928,500
<b>FEDERAL FUNDS</b>	\$13,671,500	\$13,671,500

**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  
 SB 78 (Chapter 38, Statutes of 2019)

**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. IRS Form 1095-B is mailed by the Department to serve as proof of insurance for beneficiaries enrolled in Medi-Cal and required to report their health insurance coverage to the Internal Revenue Service (IRS) and the Franchise Tax Board (FTB). The NFRA is a letter that the Department sends to beneficiaries whose record contains inconsistent information that prevents it from being accepted by the IRS. This item also includes additional costs for printing, storage, and mailing of important Department publications and applications to counties and beneficiaries on request.

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).

## POSTAGE & PRINTING

**OTHER ADMIN. POLICY CHANGE NUMBER: 15**

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.

### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to removing the documents services and mailing costs. These costs are now budgeted in the OTLICP, MCAP, Special Populations Admin Costs policy change. Additionally, there is an expected increase in 1095-B Mailings due to a projected increase in caseload for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

### **Methodology:**

1. Based on FY 2019-20 actuals and estimated increases to the reported population, assume that 14,500,000 1095-B mailings are conducted each fiscal year.
2. Assume that the cost per mailing is \$0.58.

$$14,500,000 \text{ mailings} \times \$0.58 \text{ per mailing} = \$8,410,000 \text{ (rounded)}$$

3. Based on FY 2019-20 actuals, 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 \$0.58 per unit.

$$8\% \times 14,500,000 \text{ mailings} = 1,160,000 \text{ returned mailings}$$

$$1,160,000 \text{ returned mailings} \times \$0.58 \text{ per unit} = \$673,000 \text{ (rounded)}$$

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 \$0.58 per unit and based on FY 2019-20 actuals, assume 150,000 mailers will be sent out to beneficiaries.

$$150,000 \text{ mailings} \times \$0.58 \text{ per mailing} = \$87,000 \text{ (rounded)}$$

5. TAR postage costs for Medi-Cal are assumed to be \$80,000 for FY 2020-21 and FY 2021-22.
6. The Department estimates the printing and postage costs for FY 2020-21 and FY 2021-22 are:

**POSTAGE & PRINTING**  
OTHER ADMIN. POLICY CHANGE NUMBER: 15

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Base Mass Mailing	\$15,750,000	\$8,003,000	\$7,747,000
1095B			
1095 Mailings	\$8,410,000	\$4,205,000	\$4,205,000
Reprinted/Corrected Form 1095-B	\$673,000	\$337,000	\$336,000
Notice for Requested Action	\$87,000	\$43,000	\$44,000
1095 B Subtotal	\$9,170,000	\$4,585,000	\$4,585,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$80,000	\$40,000	\$40,000
<b>Total</b>	<b>\$27,600,000</b>	<b>\$13,928,000</b>	<b>\$13,672,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Base Mass Mailing	\$15,750,000	\$8,003,000	\$7,747,000
1095B			
1095 Mailings	\$8,410,000	\$4,205,000	\$4,205,000
Reprinted/Corrected Form 1095-B	\$673,000	\$337,000	\$336,000
Notice for Requested Action	\$87,000	\$43,000	\$44,000
1095 B Subtotal	\$9,170,000	\$4,585,000	\$4,585,000
Emergency Mailings	\$2,600,000	\$1,300,000	\$1,300,000
TAR Postage	\$80,000	\$40,000	\$40,000
<b>Total</b>	<b>\$27,600,000</b>	<b>\$13,928,000</b>	<b>\$13,672,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

100% GF (4260-101-0001)

## DRUG MEDI-CAL COUNTY UR & QA ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 16  
**IMPLEMENTATION DATE:** 5/2018  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1871

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$22,977,000	\$10,695,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$22,977,000	\$10,695,000

**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 2020-21, is due to the following:

- More counties UR and QA activities cost are added to the estimate.
- FY 2018-19 and FY 2019-20 claims previously budgeted to be paid in FY 2019-20, shifted to FY 2020-21 due to invoicing delays.

The change in the current estimate, from FY 2019-20 to FY 2020-21, is due to FY 2019-20 including more prior year claims for the UR and QA.

## DRUG MEDI-CAL COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 16

**Methodology:**

1. UR and QA expenditures are shared between FF and county funds (CF). Payments began in May 2018.
2. For FY 2020-21 and FY 2021-22, 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.
3. For counties that submit claims annually, assume claims will be submitted and paid the following fiscal year.

<b>DMC UR &amp; QA</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
FY 2018-19 Claims	\$7,627,000	\$5,128,000	\$0
FY 2019-20 Claims	\$10,583,000	\$10,583,000	\$0
FY 2020-21 Claims	\$10,695,000	\$7,266,000	\$3,429,000
FY 2021-22 Claims	\$9,688,000		\$7,266,000
<b>Total</b>		\$22,977,000	\$10,695,000

4. Assume 70% of the total claims are for SPMP costs and the remaining 30% are for other personnel costs.
5. UR and QA costs for SPMP will receive enhanced federal reimbursement of 75%. All other personnel will receive 50% federal reimbursement.
6. The estimated UR and QA administrative cost for FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>TF</b>	<b>FFP</b>	<b>CF</b>
SPMP	\$21,445,000	\$16,084,000	\$5,361,000
Other Personnel	\$13,786,000	\$6,893,000	\$6,893,000
<b>Total</b>	\$35,231,000	<b>\$22,977,000</b>	\$12,254,000

<b>FY 2021-22</b>	<b>TF</b>	<b>FFP</b>	<b>CF</b>
SPMP	\$9,982,000	\$7,486,000	\$2,496,000
Other Personnel	\$6,418,000	\$3,209,000	\$3,209,000
<b>Total</b>	\$16,400,000	<b>\$10,695,000</b>	\$5,705,000

**Funding:**

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

## DRUG MEDI-CAL COUNTY ADMINISTRATION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 17  
**IMPLEMENTATION DATE:** 7/2014  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1813

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$20,836,000	\$21,470,000
<b>STATE FUNDS</b>	\$1,021,000	\$1,027,000
<b>FEDERAL FUNDS</b>	\$19,815,000	\$20,443,000

**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.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to updated FY 2019-20 interim claims data.

## DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 17

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to a higher estimated annual settlements claims in FY 2021-22.

### Methodology:

1. Interim claims for the first two quarters (Q1 – Q2) are paid in the same fiscal year. Claims for the last two quarters (Q3 – Q4) are paid the following fiscal year.
2. Annual settlements for county administration claims are paid annually:
  - o FY 2015-16 annual settlement claims payments will be paid in FY 2020-21.
  - o FY 2021-22 annual settlement claims payments is expected to be paid in FY 2021-22.
3. ODS waiver county administrative claims are included in the current estimate for counties that submit quarterly interim claims.
4. The estimated DMC county administration costs for FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>County Admin Cost</b>	<b>General Fund</b>	<b>Title XIX</b>	<b>County Funds</b>
FY 2015-16, Annual Settlement	\$25,111,000	\$121,000	\$12,555,000	\$12,435,000
FY 2019-20 Claims, Q3-Q4	\$7,260,000	\$450,000	\$3,630,000	\$3,180,000
FY 2020-21 Claims, Q1-Q2	\$7,260,000	\$450,000	\$3,630,000	\$3,180,000
<b>Total for FY 2020-21</b>	<b>\$39,631,000</b>	<b>\$1,021,000</b>	<b>\$19,815,000</b>	<b>\$18,795,000</b>

<b>FY 2021-22</b>	<b>County Admin Cost</b>	<b>General Fund</b>	<b>Title XIX</b>	<b>County Funds</b>
FY 2016-17, Annual Settlement	\$26,366,000	\$127,000	\$13,183,000	\$13,056,000
FY 2020-21 Claims, Q3-Q4	\$7,260,000	\$450,000	\$3,630,000	\$3,180,000
FY 2021-22 Claims, Q1-Q2	\$7,260,000	\$450,000	\$3,630,000	\$3,180,000
<b>Total for FY 2021-22</b>	<b>\$40,886,000</b>	<b>\$1,027,000</b>	<b>\$20,443,000</b>	<b>\$19,416,000</b>

### Funding:

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

100% GF (4260-101-0001)

## ACTUARIAL COSTS FOR RATE DEVELOPMENT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 18  
**IMPLEMENTATION DATE:** 8/2015  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1937

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$19,706,000	\$21,104,000
<b>STATE FUNDS</b>	\$9,853,000	\$10,552,000
<b>FEDERAL FUNDS</b>	\$9,853,000	\$10,552,000

**Purpose:**

This policy change estimates the costs for contracted actuarial rate development services.

**Authority:**

Welfare & Institutions Code 14301.1  
42 Code of Federal Regulations 438.4

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Federal requirements for obtaining federal financial participation require that managed care capitation rates be actuarially sound. Actuarially sound capitation rates require:

- Having been developed in accordance with standards specified in Title 42, Code of Federal Regulations (CFR) 438.5, and generally accepted actuarial principles and practices,
- Being appropriate for the populations to be covered and the services to be furnished under the contract, and
- Being certified by an actuary as meeting applicable federal requirements specified in Title 42 CFR 438.4.

The Department entered into a contract with an actuarial services consultant to ensure development of actuarially sound capitation rates.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is an increase due to updated actuarial contractor cost projections. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to newly added GEMT IGT contractor costs as well as accounting for estimated ongoing actuarial contractor costs.

**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: 18

4. Specific costs are identified for existing workloads (Coordinated Care Initiative (CCI), Health Homes Program, Hospital Quality Assurance Fee (HQAF) program, and GEMT Public Provider IGT 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 2020-21 and FY 2021-22 amounts on an accrual basis are estimated to be:

Policy	FY 2020-21	FY 2021-22
CCI - Administrative Costs	\$1,010,000	\$1,010,000
Health Homes Program - Contractor Costs	\$650,000	\$325,000
Ongoing Actuarial Services	\$18,140,000	\$19,465,000
HQAF Program	\$200,000	\$200,000
GEMT Public Provider IGT Program-Contractor Costs	\$0	\$250,000
<b>Total</b>	<b>\$20,000,000</b>	<b>\$21,250,000</b>

The FY 2020-21 and FY 2021-22 amounts on a cash basis are estimated to be:

(Dollars in Thousands)

Fiscal Year	TF	GF	HHP Fund	HQAF	FF
<b>FY 2020-21</b>	<b>\$19,706</b>	\$9,434	\$320	\$99	\$9,853
<b>FY 2021-22</b>	<b>\$21,104</b>	\$10,292	\$161	\$99	\$10,552

**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)

## MANAGED CARE REGULATIONS - MH PARITY

**OTHER ADMIN. POLICY CHANGE NUMBER:** 19  
**IMPLEMENTATION DATE:** 3/2020  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2076

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$19,155,000	\$19,155,000
<b>STATE FUNDS</b>	\$2,737,000	\$2,737,000
<b>FEDERAL FUNDS</b>	\$16,418,000	\$16,418,000

**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 issued 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: 19

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 MHPs and MCPs. The inconsistencies identified were for authorization of outpatient and inpatient services. As a result, the Department will implement changes to authorization of Specialty Mental Health Services (SMHS) policies for compliance with the Parity Final Rule. On May 31, 2019, the Department issued Mental Health and Substance Use Disorder Services Information Notice No. 19-026, which details the new statewide policy regarding authorization of SMHS. 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/residential SMHS:

- The Department will align the requirements for MHP authorizations of psychiatric inpatient hospital services and residential treatment 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.

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 2020-21, is a minor decrease due to outpatient pre-authorization estimates, and concurrent inpatient reviews, based on total service units updated to FY 2017-18 from FY 2016-17.

There is no change from FY 2020-21 to FY 2021-22, in the current estimate.

#### **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 reviews and the amount of time, in hours, county staff would spend performing these reviews.

**MANAGED CARE REGULATIONS - MH PARITY**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 19**

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).
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 379,886 reviews at a cost of \$56.67 per hour, including benefits. The total estimated annual costs for outpatient pre-authorizations are \$5,382,000 TF.
5. For inpatient reviews, assume counties will need an additional 30 minutes for 640,848 reviews at a cost of \$56.67 per hour, including benefits. The total estimated annual costs for concurrent inpatient reviews are \$18,157,000 TF.
6. On a cash basis for FY 2020-21, the Department will be paying for 64% of FY 2019-20 claims and 29% of FY 2020-21 claims. For FY 2021-22, the Department will be paying 64% of FY 2020-21 claims and 29% of FY 2021-22 claims. Assume the remaining claims will be paid through cost settlement.

(Dollars in Thousands)

<b>Cash Basis</b>	<b>Accrual</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
FY 2019-20	TF	TF	TF
Outpatient Pre-Authorizations	\$5,382	\$3,444	\$0
Inpatient – Concurrent Review	\$18,157	\$11,620	\$0
Total FY 2019-20	\$23,539	\$15,065	\$0
FY 2020-21			
Outpatient Pre-Authorizations	\$5,382	\$1,561	\$3,444
Inpatient – Concurrent Review	\$18,157	\$5,266	\$11,620
Total FY 2020-21	\$23,539	\$6,826	\$15,065
FY 2021-22			
Outpatient Pre-Authorizations	\$5,382	\$0	\$1,561
Inpatient – Concurrent Review	\$18,157	\$0	\$5,266
Total FY 2021-22	\$23,539	\$0	\$6,826
<b>Grand Total</b>		\$21,891	\$21,891

**MANAGED CARE REGULATIONS - MH PARITY**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 19**

7. The estimated cost in FY 2020-21 and FY 2021-22 are:

(Dollars in Thousands)

<b>Treatment Plan Authorizations</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF</b>
Outpatient - Pre-Authorizations	\$5,005	\$626	\$3,754	\$625
Inpatient – Concurrent Review	\$16,886	\$2,111	\$12,664	\$2,111
<b>FY 2020-21</b>	<b>\$21,891</b>	<b>\$2,737</b>	<b>\$16,418</b>	<b>\$2,736</b>

(Dollars in Thousands)

<b>Treatment Plan Authorizations</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF</b>
Outpatient - Pre-Authorizations	\$5,005	\$626	\$3,754	\$625
Inpatient – Concurrent Review	\$16,886	\$2,111	\$12,664	\$2,111
<b>FY 2021-22</b>	<b>\$21,891</b>	<b>\$2,737</b>	<b>\$16,418</b>	<b>\$2,736</b>

**Funding:**

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

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

## HCBA WAIVER ADMINISTRATIVE COST

**OTHER ADMIN. POLICY CHANGE NUMBER:** 20  
**IMPLEMENTATION DATE:** 7/2019  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 2152

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$13,947,000	\$15,670,000
<b>STATE FUNDS</b>	\$6,973,500	\$7,835,000
<b>FEDERAL FUNDS</b>	\$6,973,500	\$7,835,000

**Purpose:**

This policy change estimates the administrative cost of the Home and Community-Based Alternatives (HCBA) Waiver.

**Authority:**

Welfare and Institutions Code, Section 14132.991

**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 2017 HCBA waiver authorization, 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;
- 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 primary model for the administration and operation of the Waiver is through contracted Waiver Agencies. The Waiver Agencies are responsible for local Waiver Administration functions and for the delivery of the Comprehensive Care Management Waiver service. The reimbursement structure for Waiver Administration services will be a per member per month rate. The

## HCBA WAIVER ADMINISTRATIVE COST

OTHER ADMIN. POLICY CHANGE NUMBER: 20

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 medically 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 2020-21, is an increase due to a higher amount of projected eligibles based on prior year actuals. The projected eligibles increased from 100 new participants a month to 135 new participants a month. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase in costs due to the additional enrollment of beneficiaries to the HCBA Waiver.

### Methodology:

1. There are currently 5,343 waiver participants. Assume 1,620 new participants will be enrolled in FY 2020-21 and FY 2021-22.
2. The renewed waiver was approved on May 16, 2017, with an effective date of January 1, 2017.
3. Assume 95% of all current and new waiver participants will enroll with a Waiver Agency and receive administrative services.
4. Assume the monthly cost for administration is \$186.56.

Fiscal Year	TF	GF	FF
FY 2020-21	<b>\$13,947,000</b>	<b>\$6,974,000</b>	<b>\$6,973,000</b>
FY 2021-22	<b>\$15,670,000</b>	<b>\$7,835,000</b>	<b>\$7,835,000</b>

### Funding:

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

## CCI-ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 21  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Shannon Hoerner  
**FISCAL REFERENCE NUMBER:** 1677

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$11,213,000	\$11,213,000
<b>STATE FUNDS</b>	\$5,606,500	\$5,606,500
<b>FEDERAL FUNDS</b>	\$5,606,500	\$5,606,500

**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).

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.

The MSSP benefit was proposed to be carved out from managed care under the CalAIM proposal, effective January 1, 2021. This proposed carve out will be delayed due to the



**CCI-ADMINISTRATIVE COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 21

postponement of CalAIM and pending approved extension of the 1115 waiver, due to the COVID-19 public health emergency.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

1. The CCI development, implementation, and operation costs began July 2012 and will continue through FY 2021-22.
2. All costs for FY 2020-21 and FY 2021-22 will be funded at 50/50 FMAP.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total</b>	<b>\$11,213,000</b>	<b>\$5,606,500</b>	<b>\$5,606,500</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total</b>	<b>\$11,213,000</b>	<b>\$5,606,500</b>	<b>\$5,606,500</b>

**Funding:**

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

## MITA

**OTHER ADMIN. POLICY CHANGE NUMBER:** 22  
**IMPLEMENTATION DATE:** 1/2011  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1137

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$11,002,000	\$11,405,000
<b>STATE FUNDS</b>	\$1,427,560	\$1,492,250
<b>FEDERAL FUNDS</b>	\$9,574,440	\$9,912,750

**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)  
 45 Code of Federal Regulations 95-626(b)  
 Interagency Agreement (IA) 13-90390 A01

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**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 modernization 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. CMS requires Medi-Cal Enterprise Systems (MES) Certification in order to approve ongoing enhanced funding, including the use of an Independent Verification and Validation (IV&V) resources as it relates to the CMS enterprise certification process. In addition, CMS requires the IV&V contract to be held outside of the State Agency that owns the systems requiring certification. To ensure compliance with the federal requirement for

## **MITA**

### **OTHER ADMIN. POLICY CHANGE NUMBER: 22**

IV&V certification services the California Department of Technology (CDT) is holding the contract and will provide services to support certification requirements.

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.

Pursuant to an IA with the Regents of the University of California, San Diego (UCSD), an analyst and programmer provides support for data management and analytics to assist the Department in reaching MITA maturity.

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 from the prior estimate, for FY 2020-21, is a net decrease in CDT services due to services that are no longer necessary.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to:

- The expected procurement of the MITA support services, as the current contract expires December 17, 2021. Costs are included to estimate a potential increase.
- CMS IV&V cost have fully implemented and the current FY 2020-21 rates are carried forward for FY 2021-22 cost.

#### **Methodology:**

1. The FY 2020-21 and FY 2021-22 contract amounts are associated with the MITA initiative throughout the Department in order to meet federal regulations and guidelines.
2. FY 2021-22 includes cost for the MITA support services contract procurement estimates beginning December 2021.
3. Costs for an IA with UCSD to implement analytics as a service to support MITA began in December 2019.
4. FY 2020-21 and FY 2021-22 include costs to support the CMS Enterprise IV&V, CDT Contract Management Services, CDT Procurement Services, and technical consultant to help further support the MITA initiative. The technical consultant resource will support the Clarity application.

**MITA**  
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5. The projected FY 2020-21 and FY 2021-22 costs are:

<b>FY 2020-21</b>	<b>APD</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
MITA Contract	MITA	\$4,215,000	\$522,000	\$3,693,000
UCSD IA	MITA	\$487,000	\$61,000	\$426,000
CMS Enterprise Certification IV&V	IV&V	\$3,413,000	\$427,000	\$2,986,000
Technical Consultant	N/A	\$167,000	\$83,000	\$84,000
Provider Management	PROV.	\$800,000	\$98,000	\$702,000
Enterprise Certification IV&V Support Services	IV&V	\$1,920,000	\$237,000	\$1,683,000
<b>Total</b>		<b>\$11,002,000</b>	<b>\$1,428,000</b>	<b>\$9,574,000</b>

<b>FY 2021-22</b>	<b>APD</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
MITA Contract	MITA	\$4,886,000	\$590,000	\$4,297,000
UCSD IA	MITA	\$487,000	\$62,000	\$425,000
CMS Enterprise Certification IV&V	IV&V	\$4,232,000	\$537,000	\$3,694,000
Technical Consultant	N/A	\$200,000	\$100,000	\$100,000
Provider Management	PROV.	\$250,000	\$32,000	\$218,000
Enterprise Certification IV&V Support Services	IV&V	\$1,350,000	\$171,000	\$1,179,000
<b>Total</b>		<b>\$11,405,000</b>	<b>\$1,492,000</b>	<b>\$9,913,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

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

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

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

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

## PAVE SYSTEM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 23  
**IMPLEMENTATION DATE:** 4/2016  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1932

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$10,238,000	\$11,234,000
<b>STATE FUNDS</b>	-\$4,483,770	\$2,953,750
<b>FEDERAL FUNDS</b>	\$14,721,770	\$8,280,250

**Purpose:**

This policy change estimates the costs for the implementation and ongoing maintenance and operations (M&O) 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:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The Department deployed an enrollment portal and associated business process application to digitize provider management activities to comply with provider integrity mandates under the Affordable Care Act. Some of the requirements are:

- Monthly database checks on enrolled providers and associated entities that manage, own, or have a controlling interest;
- Enroll all ordering, referring, or prescribing 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.

PAVE entered the M&O phase in FY 2018-19. Beginning FY 2020-21, the Department will request funding to cover ongoing PAVE M&O costs.

**Reason for Change:**

The change from the prior estimate for FY 2020-21 is a decrease due to slight decreases in M&O costs for the Digital Harbor contract.

The change from FY 2020-21 to FY 2021-22 is an increase due to projected ongoing M&O costs for the Digital Harbor contract.

**Methodology:**

1. The Department is continuing to add programs and benefits to PAVE on a phase-in basis with costs beginning in FY 2019-20. M&O costs continue to increase due to the inclusion of additional providers which increases system volume and associated support activities.

**PAVE SYSTEM**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 23**

2. CMS Certification Analysis costs are for June 2019 to May 2020. Payments started July 2019 for services that began June 2019.
3. CMS certification is expected to be issued in FY 2020-21 and will allow the M&O Federal Financial Participation (FFP) to be claimed at 75% FF / 25% GF. The Department expects to receive CMS certification by December 2020 and claim enhanced federal funding for the period April 2016 to December 2020. Once the system is certified, the Department will retro-claim the additional 25% FFP which had been paid at 50% FF / 50% GF. The FFP recoupment is expected in September 2020.
4. Beginning January 2021, PAVE post-certification M&O activities are funded at the enhanced rate of 75% FFP / 25% GF.
5. The total cost for FY2020-21 is \$10,238,000. The total cost for FY 2021-22 is \$11,234,000. These funds are for the monthly service fee associated with the use of the PAVE system which is based upon the number of providers in the system, number of calls received in the call center, and other key metrics. With these numbers constantly increasing, as more providers are apply and are enrolled, the monthly rates continuously increase.
6. The FY 2020-21 and FY 2021-22 costs are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O Pre-Certification	\$5,031,000	\$2,453,000	\$2,578,000
M&O Post-Certification	\$5,207,000	\$1,369,000	\$3,838,000
M&O Recoupment of Funds Post Certification	\$0	(\$8,306,000)	\$8,306,000
<b>Total</b>	<b>\$10,238,000</b>	<b>(\$4,484,000)</b>	<b>\$14,722,000</b>

Totals may differ due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	\$11,234,000	\$2,954,000	\$8,280,000
<b>Total</b>	<b>\$11,234,000</b>	<b>\$2,954,000</b>	<b>\$8,280,000</b>

Totals may differ due to rounding.

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

100% GF (4260-101-0001)

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

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

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## LITIGATION RELATED SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 24  
**IMPLEMENTATION DATE:** 7/2009  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1381

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$9,980,000	\$9,980,000
<b>STATE FUNDS</b>	\$4,990,000	\$4,990,000
<b>FEDERAL FUNDS</b>	\$4,990,000	\$4,990,000

**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 2020-21.

There is no change from FY 2020-21 to FY 2021-22 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 2020-21 and FY 2021-22.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in both FY 2020-21 and FY 2021-22.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
<b>Total</b>	<b>\$9,980</b>	<b>\$4,990</b>	<b>\$4,990</b>

**LITIGATION RELATED SERVICES**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 24**

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Litigation Representation	\$7,880	\$3,940	\$3,940
Consulting Actuaries	\$2,100	\$1,050	\$1,050
<b>Total</b>	<b>\$9,980</b>	<b>\$4,990</b>	<b>\$4,990</b>

**Funding:**

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



## CAPMAN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 25  
**IMPLEMENTATION DATE:** 10/2012  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1318

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$8,324,000	\$8,904,000
<b>STATE FUNDS</b>	\$2,168,070	\$2,194,200
<b>FEDERAL FUNDS</b>	\$6,155,930	\$6,709,800

**Purpose:**

This policy change estimates the contract costs to make improvements, maintain, and operate the existing Capitation Payment Reporting system (CAPMAN).

**Authority:**

45 CFR Part 162

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The HIPAA imposes transaction requirements, including 5010 and Operating Rules. 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 efficacy of monthly reconciliations and supporting research efforts to perform recoveries. In May 2019, a paperless accounting interface was implemented to interface between the Department's CAPMAN and the State Controller's Office (SCO).

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 to the accounting interface are being made to further enhance the system to incorporate Electronic Funds Transfer (EFT). The paperless accounting interface increases the Department's efficiency in making approximately \$4 billion in payments a month. The system will have to be maintained on an ongoing basis, as new functionality is required.

The Department's administrative activities related to HIPAA CAPMAN includes the following contract and other related costs:

CAPMAN (M&O)

The CAPMAN maintenance and operations (M&O) contract provides services which include continuing enhancements and maintenance needed to keep up with current technology, new federal and state mandates, and paperless accounting interface. The contract is effective for the period April 1, 2018, through March 31, 2021. An amendment is in progress to extend the contract through March 31, 2023.

The CAPMAN Certified Product Owner (CPO) contract is responsible for optimizing performance of system maintenance and operations services. The CPO will also ensure the CAPMAN M&O vendor team is operating efficiently and effectively by tracking and prioritizing

## CAPMAN

### OTHER ADMIN. POLICY CHANGE NUMBER: 25

change requests and M&O activities. The contract is effective for the period April 1, 2019, through March 31, 2021, and includes three one-year optional extensions.

The CAPMAN web services engineer (WSE) contract ensures performance system monitoring, address unresolved issues, and provide infrastructure support. The WSE contract is effective for the period December 3, 2019, through December 2, 2021, and includes three one-year optional extensions.

#### SCO Contract

In March 2018, an Interagency Agreement (IAA) with SCO was executed for the period of December 14, 2017, through December 13, 2022, in order to submit electronic claim schedules from the paperless accounting interface to SCO, implement EFT, and issue warrants in response to submitted claim schedules. This contract also includes a testing period with SCO and allows for walkthroughs of existing and future systems within the Department.

#### Hardware

In FY 2020-21, the CAPMAN system will require additional hardware/virtual environments/software to accommodate anticipated changes due to work efforts to implement EFT and upgrade and redesign the non-managed care portion of the system.

#### Future Capitated Management System Planning

The CAPMAN system requires planning for continuously increasing healthcare policies and populations to be able to support complex growth.

#### **Reason for Change:**

There is no change from the prior estimate for FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to system planning costs.

#### **Methodology:**

1. CAPMAN M&O is estimated to cost \$7,784,000 TF in FY 2020-21, and \$7,784,000 TF in FY 2021-22.
2. The SCO IAA contract is estimated to be \$40,000 TF in FY 2020-21 and \$40,000 in FY 2021-22.
3. Additional hardware/virtual environment costs are estimated to be \$500,000 TF in FY 2020-21.
4. Future capitated management system plan costs are estimated to be \$1,080,000 TF in FY 2021-22.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CAPMAN M&O	\$7,784,000	\$2,027,000	\$5,757,000
SCO IAA	\$40,000	\$11,000	\$29,000
Hardware/Virtual Environments	\$500,000	\$130,000	\$370,000
<b>Total</b>	<b>\$8,324,000</b>	<b>\$2,168,000</b>	<b>\$6,156,000</b>

**CAPMAN**  
OTHER ADMIN. POLICY CHANGE NUMBER: 25

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CAPMAN M&O	\$7,784,000	\$2,046,000	\$5,738,000
SCO IA	\$40,000	\$11,000	\$29,000
Future Capitated Mgmt. System Planning	\$1,080,000	\$137,000	\$943,000
<b>Total</b>	<b>\$8,904,000</b>	<b>\$2,194,000</b>	<b>\$6,710,000</b>

**Funding:**

90% HIPAA FF / 10% HIPAA Fund (4260-117-0001/0890)

75% HIPAA FF / 25% HIPAA Fund (4260-117-0001/0890)

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

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

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP – Other Admin policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

## MEDI-CAL RECOVERY CONTRACTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 26  
**IMPLEMENTATION DATE:** 2/2008  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 1551

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$7,785,000	\$9,177,000
<b>STATE FUNDS</b>	\$1,946,250	\$2,294,250
<b>FEDERAL FUNDS</b>	\$5,838,750	\$6,882,750

**Purpose:**

This policy change estimates the cost of third party liability contracts to identify and recover Medi-Cal expenditures from responsible third parties. The policy change also includes contracts for disability determinations, online database contracts to access public records, 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)	19-96030
Department of Social Services	15-92000
Department of Social Services	20-10026
Health Management Systems Inc. (HI)	18-95310
RELX Inc.	17-94636 A01

**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, unless certain restrictions apply. The above contracts provide:

- Data matches between the Department's Medi-Cal beneficiary eligibility file and the carrier'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 beneficiaries,
- Access to disability determinations for applicants requesting an exemption from estate recovery claims on the basis of a disability, and
- Cost avoidance activities.

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.

## MEDI-CAL RECOVERY CONTRACTS

### OTHER ADMIN. POLICY CHANGE NUMBER: 26

The Department awarded the Health Insurance contract (18-95310) to Health Management Systems, Inc. (HMS). This contract became effective on December 1, 2018 and will run through November 30, 2023. The contingency fee is 8.5 percent.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- For the HMS – Health Insurance contract, there is a net increase from the prior FY 2020-21 estimate. There is an increase from shifting FY 2019-20 invoices to be paid in FY 2020-21 due to processing delays. However, there is a decrease due to a Kaiser settlement that was lower than previously estimated.
- There is no material change for the Online Database Contracts.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- For the HMS – Health Insurance contract, the change is an increase due to the implementation of new recovery initiatives for Behavioral Health, Dental, Fee-for-Service Pharmacy, and Managed Care in FY 2021-22.
- For the Online Database Contracts, there is no change in the current estimate from FY 2020-21 to FY 2021-22.

#### 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. The HI recovery contract's timeframe is from December 1, 2018, through November 30, 2023.

Recoveries x Contingency Fee % = Total Contingency Fee

Contractor	FY 2020-21 Recoveries	FY 2021-22 Recoveries	Contingency Fee %	FY 2020-21 Contingency Fee	FY 2021-22 Contingency Fee
HMS 18	\$91,131,000	\$107,500,000	8.50%	\$7,746,000	\$9,138,000

2. The amounts paid to the Online Database contractors are either based upon usage or billed at a flat monthly rate:

Online Database Contracts	FY 2020-21	FY 2021-22
Department of Industrial Relations - EAMS	\$5,000	\$5,000
Department of Industrial Relations – WCIS	\$2,000	\$2,000
Department of Social Services	\$4,000	\$4,000
RELX Inc.	\$28,000	\$28,000
Total	\$39,000	\$39,000

**MEDI-CAL RECOVERY CONTRACTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 26

3. The payments shown below include recent recovery activity.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Health Insurance	\$7,746,000	\$1,936,000	\$5,810,000
Online Database Contracts	\$39,000	\$10,000	\$29,000
<b>Total</b>	<b>\$7,785,000</b>	<b>\$1,946,000</b>	<b>\$5,839,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Health Insurance	\$9,138,000	\$2,284,000	\$6,854,000
Online Database Contracts	\$39,000	\$10,000	\$29,000
<b>Total</b>	<b>\$9,177,000</b>	<b>\$2,294,000</b>	<b>\$6,883,000</b>

**Funding:**

75% Title XIX / 25% GF (4260-101-0001/0890)

## PASRR

**OTHER ADMIN. POLICY CHANGE NUMBER:** 27  
**IMPLEMENTATION DATE:** 7/2013  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 1720

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$7,441,000	\$6,056,000
<b>STATE FUNDS</b>	\$1,860,250	\$1,514,000
<b>FEDERAL FUNDS</b>	\$5,580,750	\$4,542,000

**Purpose:**

This policy change estimates the contractor costs for the Preadmission Screening and Resident Review (PASRR) Level II evaluations, and system build-out 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 Level II Evaluations contract expired June 30, 2020. A new service contract to provide Level II Evaluations was effective July 3, 2020.

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: 27

The PASRR Information Technology (IT) system build-out contract is effective November 2019 through November 2020. The contract engages a business analyst and software engineers to develop and implement the following updates to the existing PASRR system:

- 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.
- Update the existing Determination Wizard and Determination Letter.
- Update the existing electronic Reconsideration process that ensures facilities and the Department have complete records for patient care plans.
- Update existing dashboards for each role.

#### Reason for Change:

The change in FY 2020-21, from the prior estimate, a net decrease is due to:

- Decrease in Evaluations estimate is due to a new Evaluations contract effective July 2020 with payments that started in August 2020.
- Removal of M&O cost because M&O is no longer estimated in this policy change.
- Increase in system build out estimate is due to the contract work that started in December 2019.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to:

- Revised evaluations estimate based on trends and contract amount for FY 2021-22.
- Completed system build out contract work.

#### Methodology:

1. Expenditures for new Evaluations contract started in August 2020.
2. The PASRR payments on a cash basis are estimated at:

FY 2020-21	TF	GF	FF
Evaluations	\$6,734,000	\$1,683,000	\$5,051,000
System Build Out	\$707,000	\$177,000	\$530,000
<b>Total</b>	<b>\$7,441,000</b>	<b>\$1,860,000</b>	<b>\$5,581,000</b>

FY 2021-22	TF	GF	FF
Evaluations	<b>\$6,056,000</b>	<b>\$1,514,000</b>	<b>\$4,542,000</b>

#### Funding:

75% Title XIX / 25% GF (4260-101-0001/0890)



## MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

**OTHER ADMIN. POLICY CHANGE NUMBER:** 28  
**IMPLEMENTATION DATE:** 7/2009  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1441

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$6,139,000	\$6,139,000
<b>STATE FUNDS</b>	\$1,784,750	\$1,784,750
<b>FEDERAL FUNDS</b>	\$4,354,250	\$4,354,250

**Purpose:**

This policy change estimates the maintenance and operations (M&O) expenses resulting from legislative mandates, federal and/or state directives, and Medi-Cal program policy changes which impact the Medi-Cal Eligibility Data System (MEDS).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The 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 M&O functions:

- 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;
- Supporting eligibility and enrollment functions; and
- Enabling counties to perform online statistical analysis and MEDS-alert reporting as well as allowing them to track and report county workers' MEDS transactions.

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, In Home Support Services, and other Health and Human Services programs such as Covered California's Advance Premium Tax Credit.

The Department implements MEDS functionality to support the Medi-Cal program related to beneficiary eligibility and interfacing with the county consortia and state and county business partners. The California Department of Technology (CDT) houses MEDS and charges the Department for all associated data storage, processing, networking, data archiving, and backup

## MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 28

costs. CDT invoices the Department on a monthly basis for the services provided. CDT data center charges remain consistent and change based on the volume of beneficiaries enrolled within the MEDS system.

### Reason for Change:

There is no change from the prior estimate for FY 2020-21.

There is no change from FY 2020-21 to FY 2021-22.

### Methodology:

1. Reporting and tracking costs include non-production support costs consisting of CDT data center charges for development, testing, quality assurance, and all system related charges not related to essential M&O functions.
2. M&O costs include, but are not limited to, the MEDS Reconciliation Process for both the counties and the State, Third Party Liability file matches related to recipients that may have other health coverage, and Medicaid related system and production support costs to cover the M&O functions described in the background section.
3. A 5% increase was applied to the prior year estimate for FY 2019-20 since trends of enrollments would likely increase.
4. The projected costs for FY 2020-21 and FY 2021-22 are:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Reporting and Tracking (50% FF / 50% GF)	\$1,000,000	\$500,000	\$500,000
Maintenance & Operations (75% FF / 25% GF)	\$5,139,000	\$1,285,000	\$3,854,000
<b>Total</b>	<b>\$6,139,000</b>	<b>\$1,785,000</b>	<b>\$4,354,000</b>

Totals differ due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Reporting and Tracking (50% FF / 50% GF)	\$1,000,000	\$500,000	\$500,000
Maintenance & Operations (75% FF / 25% GF)	\$5,139,000	\$1,285,000	\$3,854,000
<b>Total</b>	<b>\$6,139,000</b>	<b>\$1,785,000</b>	<b>\$4,354,000</b>

Totals differ due to rounding.

### Funding:

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

75% Title XIX / 25% GF (4260-101-0890/0001)

## NEWBORN HEARING SCREENING PROGRAM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 29  
**IMPLEMENTATION DATE:** 7/2014  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1824

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$6,131,000	\$6,131,000
<b>STATE FUNDS</b>	\$3,065,500	\$3,065,500
<b>FEDERAL FUNDS</b>	\$3,065,500	\$3,065,500

**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 19-96295  
 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 contract breakdowns are as follows:

- Data management contract
  - The California Department of Technology (CDT), on behalf of the Department, released a Request for Proposal on March 7, 2018. CDT provided a Notification of Intent to Award to the current vendor on June 25, 2018.
  - Contract # 18-95011 is effective August 1, 2018, through July 31, 2021, with two 1-year options to renew. Effective August 1, 2018, Amendment A01 reduced annual costs for data management services from \$1.2 million to \$1.08 million annually for Contract # 18-95011.
- HCC contract #19-96295 began June 1, 2020, and expires June 30, 2024.

## NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 29

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to a reduced HCC contract amount for technical assistance and consultation in newly implemented Contract # 19-96295. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

1. The HCC contract for tracking and monitoring services costs for FY 2020-21 and FY 2021-22 are \$5,051,000.
2. The Data Management Contract for the use of a vendor's data management system cost for FY 2020-21 and FY 2021-22 is \$1,080,000.
3. The estimated costs for FY 2020-21 and FY 2021-22 are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
HCC Contract	\$5,051,000	\$2,526,000	\$2,525,000
Data Management Contract	\$1,080,000	\$540,000	\$540,000
<b>Total</b>	<b>\$6,131,000</b>	<b>\$3,066,000</b>	<b>\$3,065,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
HCC Contract	\$5,051,000	\$2,526,000	\$2,525,000
Data Management Contract	\$1,080,000	\$540,000	\$540,000
<b>Total</b>	<b>\$6,131,000</b>	<b>\$3,066,000</b>	<b>\$3,065,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

## PERFORMANCE OUTCOMES SYSTEM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 30  
**IMPLEMENTATION DATE:** 4/2019  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1948

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$4,379,000	\$3,270,000
<b>STATE FUNDS</b>	\$1,899,500	\$1,418,500
<b>FEDERAL FUNDS</b>	\$2,479,500	\$1,851,500

**Purpose:**

This policy change estimates the cost to the State to reimburse mental health plans (MHP) the cost they incur to capture and report new functional assessment data. County MHP will collect, manage, use, and report additional functional assessment data to inform performance dashboards as part of the Performance Outcomes System (POS) for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services.

**Authority:**

Welfare & Institutions Code 14707.5

**Interdependent Policy Changes:**

Not Applicable

**Background:**

W&I Code, Section 14707.5 requires the Department to develop a 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, MHPs 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. MHPs 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: 30

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 2020-21 is a net decrease due to:

- Adjusting the estimate based on actual claims received. The prior estimate was based on assuming fewer claims would be received for FY 2019-20 to be paid in FY 2020-21, and
- Assuming IT costs are complete in FY 2019-20.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to a decrease in FY 2021-22 annual costs due to:

- Updated payment lags, and
- Assuming three percent growth rate increase beginning for FY 2020-21 claims based on anticipated claims to be submitted for payment in FY 2021-22.

### Methodology:

1. The Department has received invoices from counties for costs incurred to implement the POS in FY 2017-18, FY 2018-19, and FY 2019-20. The costs are for county personnel for clinical staff to assess beneficiaries, data entry staff to key data for beneficiaries into the POS, and POS training costs.
2. The Department estimates county costs to implement the POS will continue to grow at a rate of 3% in FY 2020-21 and FY 2021-22.

(Dollars in Thousands)

Fiscal Year	Expenditures	Rate of Growth	Expenditure Increase
FY 2019-20	\$3,139	3%	\$94
FY 2020-21	\$3,233	3%	\$97
FY 2021-22	\$3,330		

**PERFORMANCE OUTCOMES SYSTEM**  
OTHER ADMIN. POLICY CHANGE NUMBER: 30

3. On a cash basis for FY 2019-20, assume the POS claims will be \$3,139,000 in total funds. Due to a delay in processing invoices, the Department will pay 88% of FY 2019-20 claims in FY 2020-21. Assume for FY 2020-21 claims and FY 2021-22 claims, 50% of the will be paid in the year the claims were submitted, 38% in the second year, and 12% in the third year. The estimated total costs on an accrual basis for FY 2019-20, FY 2020-21, and FY 2021-22:

(Dollars in Thousands)

Fiscal Year	Accrual Expenditures	FY 2020-21	FY 2021-22
FY 2019-20	\$3,139	\$2,762	\$377
FY 2020-21	\$3,233	\$1,617	\$1,228
FY 2021-22	\$3,330	\$0	\$1,665
<b>Totals</b>		<b>\$4,379</b>	<b>\$3,270</b>

4. Assume the training costs and data entry staffing are eligible for reimbursement at 50%, and costs for clinical staffing is eligible for enhanced FF at 75%.
5. The cash basis payments in FY 2020-21 and FY 2021-22 are estimated to be:

(Dollars in Thousands)

Claim Type	2020-21			2021-22		
	TF	GF	FFP	TF	GF	FFP
<b>SPMP</b>	\$1,160	\$290	\$870	\$866	\$216	\$650
<b>Other</b>	\$3,219	\$1,609	\$1,610	\$2,404	\$1,202	\$1,202
<b>Totals</b>	<b>\$4,379</b>	<b>\$1,899</b>	<b>\$2,479</b>	<b>\$3,270</b>	<b>\$1,418</b>	<b>\$1,852</b>

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

## ELECTRONIC ASSET VERIFICATION PROGRAM

**OTHER ADMIN. POLICY CHANGE NUMBER:** 31  
**IMPLEMENTATION DATE:** 12/2017  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 2002

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$3,960,000	\$3,960,000
<b>STATE FUNDS</b>	\$1,980,000	\$1,980,000
<b>FEDERAL FUNDS</b>	\$1,980,000	\$1,980,000

**Purpose:**

This policy change estimates the administrative costs associated with implementing an electronic asset verification program.

**Authority:**

Welfare & Institutions Code (W&I), Section 14013.5  
 Title 42 U.S. Code, Sections 1396w and 1383(e)(1)  
 California Financial Code, Section 293  
 State Plan Amendment (SPA) 09-003  
 Contract 20-10158

**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 (Non-MAGI) 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 SPA 09-003, Asset Verification System, was approved on April 16, 2009, and State legislation (W&I, 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 with an average of \$4.00 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.

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.



## **ELECTRONIC ASSET VERIFICATION PROGRAM**

**OTHER ADMIN. POLICY CHANGE NUMBER: 31**

Due to changes in federal law, the Department's objective is full implementation prior to January 1, 2021.

### **Reason for Change:**

There is no change from the prior estimate for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

### **Methodology:**

1. The policy does not apply to applicants or recipients of federal Supplemental Security Income/State Supplementary Payment, 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 1,000,000 in FY 2020-21 and FY 2021-22.
4. The reimbursement rate, based on estimated query volume, is estimated to be \$330,000 per month for FY 2020-21 and FY 2021-22.
5. The estimated vendor cost are:

**FY 2020-21:** \$330,000 x 12 months = **\$3,960,000 TF (\$1,980,000 GF)**

**FY 2021-22:** \$330,000 x 12 months = **\$3,960,000 TF (\$1,980,000 GF)**

### **Funding:**

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

## PACES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 32  
**IMPLEMENTATION DATE:** 9/2016  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1972

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$2,725,000	\$2,850,000
<b>STATE FUNDS</b>	\$407,120	\$429,700
<b>FEDERAL FUNDS</b>	\$2,317,880	\$2,420,300

**Purpose:**

This policy change estimates the costs to modify the Department's existing Post-Adjudicated Claims and Encounter System (PACES) to stay in compliance with federal law.

**Authority:**

Section 1903(i)(4) of the Social Security Act  
 Title 42 of the Code of Federal Regulations (CFR), Part 438  
 Title 22 of the California Code of Regulations, Section 51476

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – Other Admin

**Background:**

Federal law mandates the Department to collect and report on Medi-Cal claims and encounters, whether they be submitted as part of a Fee-for-Services (FFS) or a contracted managed care arrangement. PACES plays a vital role in the collection of encounter and provider network data from Medi-Cal's numerous managed care plans. PACES accepts encounter transactions from both medical and dental managed care plans as well as encounter-related pharmacy transactions.

PACES Interfaces and New Data Sources

42 CFR 438.10(e)(2)(vi) requires the Department to provide Medi-Cal enrollees with provider directory information for contracted managed care entities on a regular basis. Furthermore, 42 CFR 438.68 requires the Department to enforce network adequacy standards for contracted managed care entities. In order to fulfill these federal regulations, the Department must collect provider network information from participating managed care organizations as well as managed models, such as county behavioral health systems, that are considered managed care for the purpose of regulation.

The Department is in the process of extending the use of the 274 transaction to cover dental managed care plans. In addition, the Department has completed the analysis to expand the use of the 274 transaction to the county mental health plans and the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. Extending the 274 process to behavioral health and dental will allow the Department to more closely monitor the networks within those models.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a net decrease due to a shift of clinical data exchange cost from this PC to the formerly CA Health Information Exchange Onboarding Program PC.

## PACES

### OTHER ADMIN. POLICY CHANGE NUMBER: 32

The change in the current estimate, from FY 2020-21 to FY 2021-22, is a net increase due to interface contracts ending September 2021.

#### Methodology:

1. Effective November 1, 2017, a vendor concurrently provides DD&I and M&O services. The first phase of implementation was completed in December 2018.
2. A Solution Architect contractor in support of new efforts to extend PACES interfaces and process new data sources is expected to start providing services at the beginning of December 2020 through November 2022 for an estimated total contract value of \$500,000.
3. A Software Engineer contractor in support of new efforts to extend PACES interfaces and process new data sources is expected to start providing services at the beginning of December 2020 through November 2021 for an estimated total contract value of \$250,000.
4. A Project Manager contractor in support of new efforts to extend PACES interfaces and process new data sources is expected to start providing services at the beginning of December 2020 through November 2021 for an estimated total contract value of \$250,000.
5. A Business Analyst contractor in support of new efforts to extend PACES interfaces and process new data sources is expected to start providing services at the beginning of December 2020 through November 2021 for an estimated total contract value of \$250,000.
6. Ongoing cloud platform and services costs of approximately \$350,000 annually.
7. Total costs are estimated to be:

FY 2020-21	TF	GF	FF
DD&I	\$2,225,000	\$277,000	\$1,948,000
M&O	\$500,000	\$130,000	\$370,000
<b>Total</b>	<b>\$2,725,000</b>	<b>\$407,000</b>	<b>\$2,318,000</b>

FY 2021-22	TF	GF	FF
DD&I	\$2,350,000	\$299,000	\$2,051,000
M&O	\$500,000	\$131,000	\$369,000
<b>Total</b>	<b>\$2,850,000</b>	<b>\$430,000</b>	<b>\$2,420,000</b>

#### Funding:

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

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

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021, is identified in the COVID-19 Increased FMAP –

Other Admin policy change

COVID-19 funding after July 1, 2021, is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – Other Admin policy change

## MEDCOMPASS SOLUTION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 33  
**IMPLEMENTATION DATE:** 7/2017  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 1982

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$2,401,000	\$2,736,000
<b>STATE FUNDS</b>	-\$18,070	\$704,450
<b>FEDERAL FUNDS</b>	\$2,419,070	\$2,031,550

**Purpose:**

This policy change estimates contractor costs to implement the MedCompass system changes and ongoing licensing and operations costs.

**Authority:**

Title XIX of the Federal Social Security Act 1903(a)(3)  
 Contract # 16-93448  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The MedCompass is a Software-as-a-Service solution that was implemented for the Integrated Systems of Care Division (ISCD) with solution provider, AssureCare. MedCompass replaced the Case Management Information System and Microsoft Access Databases that ISCD used to manage cases under the Home and Community-Based Alternatives Waiver, Early Periodic Screening, Diagnostics and Treatment, and Assisted Living Waiver Programs.

MedCompass entered Maintenance and Operations (M&O) on December 18, 2017. Centers for Medicare and Medicaid Services (CMS) certification is expected to be issued in March 2021, which will allow the M&O FFP to be claimed at 75% FF / 25% GF. Once certified, the Department expects to recoup 25% of the funds paid at 50% FF / 50% GF that is eligible to be paid at 75% FF / 25% GF from March 2019 to March 2021.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to a decrease in the Change Request (CR) costs projection based on current data.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to an increase in cost.

**MEDCOMPASS SOLUTION**  
OTHER ADMIN. POLICY CHANGE NUMBER: 33

**Methodology:**

1. The estimated costs are based upon the contract provisions.
2. All costs are currently paid at 50% FF / 50% GF. Once certified, the FMAP will be claimed at 75% FF/ 25% GF. FY 2020-21 reflects both the shift in FMAP and the anticipated recoupment for M&O activities paid at 50% FF / 50% GF.
3. The current contract with MedCompass vendor, AssureCare, is expiring on July 31, 2021. DHCS will exercise the contract extension option of one year (first of three years) for the total amount of \$2,736,000 to prevent any lapse in services for FY 2021-22.
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
M&O	\$2,271,000	\$960,000	\$1,302,000	\$9,000
10% Payment to vendor (Post Certification)	\$130,000	\$55,000	\$75,000	\$0
M&O Recoupment of Funds Post Certification	\$0	(\$1,033,000)	\$1,033,000	\$0
<b>Total FY 2020-21</b>	<b>\$2,401,000</b>	<b>(\$18,000)</b>	<b>\$2,410,000</b>	<b>\$9,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	<b>\$2,736,000</b>	<b>\$705,000</b>	<b>\$2,031,000</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)  
 75% Title XIX / 25% GF (4260-101-0001/0890)  
 100% Title XIX FFP (4260-101-0890)  
 100% GF (4260-101-0001)  
 76.5% Title XXI / 23.5% GF (4260-113-0001/0890)  
 65% Title XXI / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## SDMC SYSTEM M&O SUPPORT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 34  
**IMPLEMENTATION DATE:** 7/2013  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1732

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$2,325,000	\$2,325,000
<b>STATE FUNDS</b>	\$1,162,500	\$1,162,500
<b>FEDERAL FUNDS</b>	\$1,162,500	\$1,162,500

**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). 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 ended June 30, 2020. The Department has received approval for one-year optional extension from July 1, 2020, to June 30, 2021. Moving forward, the Department is planning to utilize the remaining one-year optional extension from July 1, 2021, to June 30, 2022.

**Reason for Change:**

There is a decrease from the prior estimate for FY 2020-21 for M&O costs due to overall lower M&O expenses in the contract extension with Cambria Solutions. There is an increase of Software costs from the prior estimate for FY 2020-21 as Program has not purchased any software for FY 2020-21 at this time, a software purchase will be made in November 2020. There is no change in the overall total from the prior estimate for FY 2020-21.

There is no change in either M&O or Software costs from FY 2020-21 to FY 2021-22 in this current estimate.

**Methodology:**

1. The contractor cost for the new two-year contract with two one-year optional extensions, that began July 2018, is \$8,000,000.
2. Projections include the contractor cost related to processing SMHS and SUDS claims payments. Software costs are related to system upgrades.

**SDMC SYSTEM M&O SUPPORT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 34

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	\$1,992,000	\$996,000	\$996,000
Software	\$333,000	\$167,000	\$166,000
<b>Total</b>	<b>\$2,325,000</b>	<b>\$1,163,000</b>	<b>\$1,162,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	\$1,992,000	\$996,000	\$996,000
Software	\$333,000	\$167,000	\$166,000
<b>Total</b>	<b>\$2,325,000</b>	<b>\$1,163,000</b>	<b>\$1,162,000</b>

Totals may differ due to rounding.

**Funding:**

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

## SSA COSTS FOR HEALTH COVERAGE INFO.

**OTHER ADMIN. POLICY CHANGE NUMBER:** 35  
**IMPLEMENTATION DATE:** 1/1989  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 237

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$2,066,000	\$1,920,000
<b>STATE FUNDS</b>	\$1,033,000	\$960,000
<b>FEDERAL FUNDS</b>	\$1,033,000	\$960,000

**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 in FY 2020-21, from the prior estimate, is a decrease due to including two additional quarters of actual payments resulting in decreased projections using the most current 12 quarters of actual billings received from the SSA.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease based upon lower quarterly estimates used to project FY 2021-22. The FY 2021-22 estimate is based on the most current actual billings from SSA for FY 2018-19, FY 2019-20, and the projection for FY 2020-21.

**Methodology:**

1. The following projections are averaged based upon the most current actual billings from SSA.

Fiscal Year	TF	GF	FF
FY 2020-21	\$2,066,000	\$1,033,000	\$1,033,000
FY 2021-22	\$1,920,000	\$960,000	\$960,000



**SSA COSTS FOR HEALTH COVERAGE INFO.**  
OTHER ADMIN. POLICY CHANGE NUMBER: 35

**Funding:**

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

## T-MSIS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 36  
**IMPLEMENTATION DATE:** 9/2013  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1768

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,585,000	\$3,349,000
<b>STATE FUNDS</b>	\$246,940	\$472,650
<b>FEDERAL FUNDS</b>	\$1,338,060	\$2,876,350

**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) and the planning, analysis and testing to achieve technical compliance with the Centers for Medicare & Medicaid Services (CMS) standard operating procedure guidelines for production implementations that impact T-MSIS reporting.

**Authority:**

Affordable Care Act (ACA)  
 Medicaid Managed Care Final Rule  
 42 Code of Federal Regulations (CFR) 433.120  
 CMS Informational Bulletin: T-MSIS State Compliance

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS Admin  
 COVID-19 Increased FMAP Extension – DHCS Admin

**Background:**

The 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 received approval for an Operational Advance Planning Document (OAPD) from CMS which provides funding for M&O through FFY 2019 (Oct. 2018 to Sept. 2019). In July 2019, the Department submitted an updated OAPD to CMS requesting the continuation of enhanced funding for M&O costs for FFY 2020 (Oct. 2019 to Sept. 2020). The software support renewals for Data Quality (data cleansing) and PowerCenter (data repository) are considered M&O costs.

On August 10, 2018, CMS issued a State Health Official (SHO) letter providing guidance to states regarding expectations for Medicaid and Children's Health Insurance Program data and ongoing T-MSIS implementation, and access to enhanced funding for future costs to California's Medicaid Enterprise System (MES). Enhanced funding for additional system enhancement and

## **T-MSIS**

### **OTHER ADMIN. POLICY CHANGE NUMBER: 36**

operational costs associated with MES is contingent upon the Department's continued ability to meet T-MSIS requirements of complete, accurate, and timely data reporting. Specifically, CMS expects that:

- T-MSIS data quality should be a permanent and ongoing process of state operations;
- States commit the necessary resources to make steady progress in improving their data quality;
- States resolve data quality issues for the 12 Top Priority Items no later than six months after release of SHO letter #18-008.

The Department procured contractor services to manage the additional workload to meet the T-MSIS requirements and submitted an IAPDU in July 2020 to request enhanced funding. The Department expects to receive CMS approval of the IAPDU by September 2020.

Beginning FY 2020-21, the contractors will support the following efforts:

- Testing, as defined in CMS' Standard Operating Procedures (SOP) document, and gap analysis to ensure that there is no degradation in the accuracy, completeness, or timeliness of T-MSIS data resulting from the implementation of system, operational, or programmatic changes.
- Analyze the work required to migrate from use of the proprietary 35C file format to the Health Insurance Portability and Accountability Act (HIPAA) standard 835/837 format. The HIPAA standard 835/837 format will resolve several T-MSIS Data Quality issues, which result from data being modified in the transmission of the 35C files.
- Perform the planning, analysis, and SOP testing to achieve technical compliance as defined in the CMS SOP guidelines for production implementations that impact T-MSIS reporting.

#### **Reason for Change:**

There is a change from the prior estimate for FY 2020-21, which is a decrease due to the delay in the proposed contract start date from October 2020 to January 2021 for both of the two proposed contracts.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to including a full-year of funding to cover contractor services.

#### **Methodology:**

1. Support and maintenance for Data Quality was procured in March 2019 and the re-procurement was executed in February 2020. Data Quality is a module within the Informatica tool which validates system data.
2. The software maintenance renewal for PowerCenter was executed December 2019. PowerCenter is a separate module within the Informatica tool which extracts, transforms, and loads system data.
3. The FFY 2022 IAPDU will request funding for ongoing M&O (75% Title XIX / 25% GF funding) activities and request enhanced federal funding (90% Title XIX / 10% GF funding) for the next phase of the 35C migration work and to continue the planning, analysis, and SOP testing to achieve technical compliance as defined in the CMS SOP guidelines for production implementations that impact T-MSIS reporting.

**T-MSIS**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 36**

4. It is estimated that twelve (12) contractor staff will be needed to perform Quality Assurance and data analysis, replace the 35C file format with the HIPAA standard format, and perform the planning, analysis and SOP testing to achieve technical compliance as defined in the CMS SOP guidelines for production implementations that impact T-MSIS reporting. The contracts will be executed in January 2021 and payments will begin in February 2021. The estimated cost for the three years contract is \$9,000,000.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	\$334,000	\$88,000	\$247,000
Design, Development and Implementation (DD&I)	\$1,251,000	\$159,000	\$1,091,000
<b>Total</b>	<b>\$1,585,000</b>	<b>\$247,000</b>	<b>\$1,338,000</b>

Totals may differ due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
M&O	\$350,000	\$92,000	\$258,000
DD&I	\$2,999,000	\$381,000	\$2,618,000
<b>Total</b>	<b>\$3,349,000</b>	<b>\$473,000</b>	<b>\$2,876,000</b>

Totals may differ due to rounding.

**Funding:**

75% Title XIX / 25% GF (4260-101-0890/0001)

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

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

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

100% State GF (4260-101-0001)

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## FAMILY PACT PROGRAM ADMIN.

**OTHER ADMIN. POLICY CHANGE NUMBER:** 37  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1675

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,207,000	\$1,207,000
<b>STATE FUNDS</b>	\$120,700	\$120,700
<b>FEDERAL FUNDS</b>	\$1,086,300	\$1,086,300

**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 19-96361  
 AB 1464 (Chapter 21, Statutes of 2012)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Family PACT program has two main objectives, to increase (1) access to services for low-income women and men, including adolescents; and (2) 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/human immunodeficiency virus training and technical assistance services; and
- Toll-free referral number.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**FAMILY PACT PROGRAM ADMIN.**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 37****Methodology:**

1. The administrative costs for the Family PACT program are estimated in the table below:

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$1,207,000</b>	<b>\$120,700</b>	<b>\$1,086,300</b>
<b>FY 2021-22</b>	<b>\$1,207,000</b>	<b>\$120,700</b>	<b>\$1,086,300</b>

**Funding:**

90% Family Planning / 10% GF (4260-101-0890/0001)

## MANAGED CARE REGULATIONS - MENTAL HEALTH

**OTHER ADMIN. POLICY CHANGE NUMBER:** 38  
**IMPLEMENTATION DATE:** 3/2019  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 2019

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$981,000	\$981,000
<b>STATE FUNDS</b>	\$285,000	\$285,000
<b>FEDERAL FUNDS</b>	\$696,000	\$696,000

**Purpose:**

This policy change estimates the costs to reimburse County Mental Health Plans (MHPs) for administrative activities arising from the implementation of 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: 38

#### Reason for Change:

There is no change from the prior estimate for FY 2020-21.

There is no change from FY 2020-21 to FY 2021-22, in the current estimate.

#### Methodology:

The estimated costs of Managed Care and Parity Regulations are based on actual claims data. The data is condensed into three categories in place of the seven categories listed in the prior estimate. The Department assumes the non-federal share is funded with County Funds (CF) and General Funds (GF), consistent with the California Constitution, Article 13, Section 36 (c)(5)(A).

1. The category types and funding is assumed to be:

Category	GF	FF	CF
Manage Care Admin	25%	50%	25%
Manage Care Enhanced UR/QA	12.5%	75%	12.5%
Manage Care Regular UR/QA	25%	50%	25%

2. 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.

- e. Network Adequacy:

Collect and submit detailed provider data to the State for federally required reporting of provider networks and provider capacity.

3. Assume on a cash basis for FY 2020-21, the Department will be paying for all of the claims submitted in FY 2020-21. For FY 2021-22, the Department will be paying for all claims submitted in FY 2021-22.

4. The estimated costs in FY 2020-21 and FY 2021-22 are:



**MANAGED CARE REGULATIONS - MENTAL HEALTH**  
OTHER ADMIN. POLICY CHANGE NUMBER: 38

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF</b>
Managed Care/Final Rule Admin	\$568	\$150	\$269	\$149
Managed Care/Enhanced UR/QA	\$374	\$50	\$273	\$51
Managed Care/Regular UR/QA	\$325	\$85	\$154	\$86
<b>Total</b>	<b>\$1,267</b>	<b>\$285</b>	<b>\$696</b>	<b>\$286</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>CF</b>
Managed Care/Final Rule Admin	\$568	\$150	\$269	\$149
Managed Care/Enhanced UR/QA	\$374	\$50	\$273	\$51
Managed Care/Regular UR/QA	\$325	\$85	\$154	\$86
<b>Total</b>	<b>\$1,267</b>	<b>\$285</b>	<b>\$696</b>	<b>\$286</b>

**Funding:**

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

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

## CALIFORNIA HEALTH INTERVIEW SURVEY

**OTHER ADMIN. POLICY CHANGE NUMBER:** 39  
**IMPLEMENTATION DATE:** 7/2015  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 1902

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$977,000	\$1,100,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$977,000	\$1,100,000

**Purpose:**

This policy change estimates the California Health Interview Survey (CHIS) contract services costs.

**Authority:**

Interagency Agreement (IA) 15-92271 A01

**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 \$1,000,000 to \$1,100,000, to align the contract to updated salary costs and operating expenses for the CHIS contractors.

**Reason for Change:**

There is no change from the previous estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to anticipated invoices for FY 2020-21 and FY 2021-22 being higher than actual invoices received in FY 2019-20.

**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.

**CALIFORNIA HEALTH INTERVIEW SURVEY**  
OTHER ADMIN. POLICY CHANGE NUMBER: 39

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. The estimated administrative costs reimbursements for FY 2020-21 and FY 2021-22, on a cash basis, are:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>
FY 2019-20 Claims	\$427	\$427
FY 2020-21 Claims	\$550	\$550
<b>Total</b>	<b>\$977</b>	<b>\$977</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
FY 2020-21 Claims	\$550	\$550
FY 2021-22 Claims	\$550	\$550
<b>Total</b>	<b>\$1,100</b>	<b>\$1,100</b>

\*Totals may differ due to rounding.

**Funding:**

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

## ENCRYPTION OF PHI DATA

**OTHER ADMIN. POLICY CHANGE NUMBER:** 40  
**IMPLEMENTATION DATE:** 5/2010  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1452

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$750,000	\$750,000
<b>STATE FUNDS</b>	\$375,000	\$375,000
<b>FEDERAL FUNDS</b>	\$375,000	\$375,000

**Purpose:**

This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining and securing electronic Protected Health Information (PHI).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department has designed security and backup systems to protect, monitor and secure electronic PHI data to minimize the amount of encrypted data flowing across the Wide Area Network. 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 the Department's electronic data from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;
- 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 data protection and the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies, such as 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 data protection, 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 data protection management.

## ENCRYPTION OF PHI DATA

**OTHER ADMIN. POLICY CHANGE NUMBER: 40**

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21.

There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

1. The Department is continuously enhancing the hardware and software used for data protection. This allows controlling and monitoring staff access and controls to sensitive and confidential data as well as data encryption at rest to prevent the risk of data loss.
2. The costs include annual hardware and software maintenance and support for:
  - a. EMC Data Domain - a solution that stores data and includes a data protection software suite that protects data by limiting and monitoring staff access, and encrypting data at rest. (\$440,000)
  - b. Rubrik - a solution that protects data and prevents data loss by delivering data archival, monitoring, access control, encryption at rest, backup, and point in time recovery. (\$150,000)
  - c. Imperva SecureSphere - a database firewall that has data security profiles designed to protect databases, monitor activities, provide staff access control, and capture security events. (\$160,000)
3. The following amounts are based upon the latest projections of cost:

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$750,000</b>	<b>\$375,000</b>	<b>\$375,000</b>
<b>FY 2021-22</b>	<b>\$750,000</b>	<b>\$375,000</b>	<b>\$375,000</b>

**Funding:**

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

## MMA - DSH ANNUAL INDEPENDENT AUDIT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 41  
**IMPLEMENTATION DATE:** 7/2009  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 266

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$731,000	\$800,000
<b>STATE FUNDS</b>	\$365,500	\$400,000
<b>FEDERAL FUNDS</b>	\$365,500	\$400,000

**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.

DSH-eligible Designated Public Hospitals participating in the Global Payment Program are not subject to the DSH audit.

The audits are 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 change in FY 2020-21, from the prior estimate, is due to lower actual May 2020 and June 2020 invoice amounts than originally estimated.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to projecting payments based on a monthly average of the contract costs in FY 2021-22.

**Methodology:**

1. The current contract period began on January 1, 2020, and is valid through June 30, 2022 for a total amount of \$2,000,000, with an optional extension through December 31, 2024 for an additional \$2,000,000.

**MMA - DSH ANNUAL INDEPENDENT AUDIT**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 41**

2. In FY 2020-21, the Department will make payments for the FY 2016-17 and FY 2017-18 audits.
3. In FY 2021-22, the Department will make payments for the FY 2017-18 and FY 2018-19 audits.

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$731,000</b>	<b>\$365,000</b>	<b>\$366,000</b>
<b>FY 2021-22</b>	<b>\$800,000</b>	<b>\$400,000</b>	<b>\$400,000</b>

**Funding:**

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

## LTSS ACTUARIAL STUDY

**OTHER ADMIN. POLICY CHANGE NUMBER:** 42  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 2143

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$423,000	\$0
<b>STATE FUNDS</b>	\$423,000	\$0
<b>FEDERAL FUNDS</b>	\$0	\$0

**Purpose:**

This policy change estimates the costs for a long-term services and supports (LTSS) feasibility and actuarial study.

**Authority:**

Budget Act of 2019 (AB 74)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The LTSS actuarial study will analyze the potential costs of various benefits designs targeted at older adults and individuals living with disabilities. The study will be based on a baseline benefit design and the associated cost impacts as well as cost impacts related to altering various eligibility and benefit parameters.

**Reason for Change:**

The change from the prior estimate for FY 2020-21, is a decrease due to payment timing. Some payments were shifted and paid in the prior fiscal year. All remaining payments for this PC are expected to be made in FY 2020-21.

**Methodology:**

1. This policy change budgets for an LTSS feasibility study and actuarial analysis to be performed.
2. The cost impact is estimated to be:

Fiscal Year	TF	GF
FY 2020-21	\$423,000	\$423,000

**Funding:**

100% GF (4260-101-0001)



## CCT OUTREACH - ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 43  
**IMPLEMENTATION DATE:** 4/2011  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1556

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$360,000	\$360,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$360,000	\$360,000

**Purpose:**

This policy change budgets the federal funding to cover California Community Transitions (CCT) administrative costs to increase the community-based network of service providers that serve the CCT-eligible population.

**Authority:**

Federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171), Section 6071  
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403  
 Medicaid Extenders Act of 2019 (P.L. 116-3), Section 2  
 Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), Section 5  
 Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 4  
 Further Consolidated Appropriations Act, 2020 (P.L. 116-94), Section 205  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020 (P.L. 116-136) Section 3811

**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 the community-based network of service providers that serve the CCT-eligible population. 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 community-based network of service providers that serve the CCT-eligible population. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

## **CCT OUTREACH - ADMINISTRATIVE COSTS**

**OTHER ADMIN. POLICY CHANGE NUMBER: 43**

On January 24, 2019, the federal Medicaid Extenders Act of 2019 was passed into law and authorized MFP state grantees to continue to transition people to through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with authority to allocate new funding to state grantees for FY 2019-20, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the federal Sustaining Excellence in Medicaid Act of 2019 was signed into law and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extend the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020. These short-term extensions of the MFP grant allows the Department to continue to support the development of community-based services and supports through administrative marketing and outreach activities.

On March 27, 2020, H.R. 748, the CARES Act was passed. Section 3811 of the CARES Act extends the end date of MFP grant from May 22, 2020, to November 30, 2020, and appropriates \$337,500,000 for January to October 2020. CMS has not awarded funding appropriated under the CARES Act to state grantees; however, the new appropriation ensures states will receive an award in 2021.

### **Reason for Change:**

There is no change, from the prior estimate, for FY 2020-21. There is no change, in the current estimate, from FY 2020-21 to FY 2021-22.

### **Methodology:**

1. Assume \$360,000 from the MFP grant administrative funding is expected to be paid in FY 2020-21 and FY 2021-22.
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.

## CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 43

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCT Costs (PC 38):			
Non-DD GF costs and Total FFP	\$6,750,000	\$1,623,000	\$5,128,000
Newly CCT Population	\$1,483,000	\$1,089,000	\$394,000
FFCRA 3.1% Increased FFP	\$0	(\$284,000)	\$284,000
Accounting Memos and DDS Invoices	\$1,787,000	(\$155,000)	\$1,942,000
<b>Total Costs</b>	<b>\$10,020,000</b>	<b>\$2,273,000</b>	<b>\$7,748,000</b>
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$27,936,000)	(\$13,102,000)	(\$14,834,000)
CCT Fund Transfer to CDSS (PC 44):			
CCT Fund Transfer Costs	\$235,000	\$0	\$235,000
FFCRA 3.1% Increased FFP	\$32,000	\$0	\$32,000
<b>Total Costs</b>	<b>\$267,000</b>	<b>\$0</b>	<b>\$267,000</b>
<b>CCT Outreach - Admin costs (OA 43)</b>	<b>\$360,000</b>	<b>\$0</b>	<b>\$360,000</b>
<b>Total of CCT PCs including pass through</b>	<b>(\$17,289,000)</b>	<b>(\$10,829,000)</b>	<b>(\$6,459,000)</b>

\*The savings are included in the total, however, they are fully reflected in the base estimates.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCT Costs (PC 38):			
Non-DD GF costs and Total FFP	\$6,992,000	\$1,678,000	\$5,314,000
Newly CCT Population	\$6,806,000	\$4,229,000	\$2,577,000
<b>Total Cost</b>	<b>\$13,798,000</b>	<b>\$5,907,000</b>	<b>\$7,891,000</b>
CCT Savings:			
Total Non-DD GF savings and Total FFP	(\$51,362,000)	(\$25,681,000)	(\$25,681,000)
CCT Fund Transfer to CDSS (PC 44)	\$196,000	\$0	\$196,000
<b>CCT Outreach - Admin costs (OA 43)</b>	<b>\$360,000</b>	<b>\$0</b>	<b>\$360,000</b>
<b>Total of CCT PCs including pass through</b>	<b>(\$37,008,000)</b>	<b>(\$19,774,000)</b>	<b>(\$17,234,000)</b>

\*The savings are included in the total, however, they are fully reflected in the base estimates.

### Funding:

MFP Federal Grant (4260-106-0890)

## DRUG MEDI-CAL PARITY RULE ADMINISTRATION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 44  
**IMPLEMENTATION DATE:** 11/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2206

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$4,407,000
<b>STATE FUNDS</b>	\$0	\$1,469,000
<b>FEDERAL FUNDS</b>	\$0	\$2,938,000

**Purpose:**

This policy change estimates the administration cost related to Parity Rule activities for Drug Medi-Cal (DMC) State Plan counties.

**Authority:**

42 Code of Federal Regulations (CFR) Part 438

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Under Title 42 CFR Part 438, the Parity Rule prescribes requirements States must address to ensure Medicaid beneficiaries are able to access mental health substance use disorder services in the same way they are able to access physical health services.

The Parity Rule requires that Medi-Cal beneficiaries are able to access mental health and substance use disorder treatment services in the same way they are able to access physical health services. Through continued assessment of the Parity Rule, the Department has identified additional requirements that are necessary to align standards for beneficiary access to substance abuse disorder treatment services with standards and requirements for access to medical/surgical health services.

Effective July 1, 2021, the Department will standardize and align requirements for SUD services with the requirements for medical/surgical health services for the DMC State Plan.

**Reason for Change:**

This is a new policy change.

**Methodology:**

1. Assume payments for the Parity Rule activities will begin November 2021.
2. Non-federal share of the costs will be funded through 50% General Fund (GF) and 50% County Fund (CF).
3. The estimated Parity Rule administrative costs for FY 2021-22 are:

**DRUG MEDI-CAL PARITY RULE ADMINISTRATION**  
OTHER ADMIN. POLICY CHANGE NUMBER: 44

<b>Parity Rule Activities</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>CF</b>
DMC Administration - Regular	\$5,655,000	\$1,414,000	\$2,827,000	\$1,414,000
DMC Administration - UR & QA	\$221,000	\$55,000	\$111,000	\$55,000
<b>Total</b>	<b>\$5,876,000</b>	<b>\$1,469,000</b>	<b>\$2,938,000</b>	<b>\$1,469,000</b>

**Funding:**

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

100% General Fund (4260-101-0001)

## COVID-19 INCREASED FMAP - OTHER ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 45  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2216

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	-\$1,824,000	-\$365,000
<b>FEDERAL FUNDS</b>	\$1,824,000	\$365,000

**Purpose:**

This policy change estimates the impact on CHIP administrative expenditures of assuming the availability of increased federal medical assistance percentage (FMAP) from January 2020 through June 2021. For the estimated impact of assuming increased FMAP from January 2020 through June 2021 on benefits expenditures, see the COVID-19 Increased FMAP – DHCS policy change. For the estimated impact of assuming an extension of the availability of increased FMAP from July 2021 through December 2021, see the COVID-19 Increased FMAP Extension - DHCS and COVID-19 Increased FMAP Extension – Other Admin policy changes.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – DHCS  
 COVID-19 Increased FMAP Extension - Other Admin

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children’s Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

## COVID-19 INCREASED FMAP - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 45

**Reason for Change:**

There is a decrease in general fund savings from the prior estimate for FY 2020-21 due to an updated lag methodology. There is a decrease in general fund savings from FY 2020-21 to FY 2021-22 due to updates and policy changes as well as the end of the public health emergency.

**Methodology:**

1. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures, including CHIP Administration expenditures.
2. The increased FMAP is assumed to continue through June 30, 2021, in this policy change.
3. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.
4. Assume a two-month cash lag.
5. The following estimates are on a cash basis:

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$2,395,838)	\$0	\$2,395,838
FFCRA 4.34% Increased FFP	\$0	(\$121,910)	\$0	\$121,910
BCCTP 4.34% Increased FFP	\$0	(\$10)	\$0	\$10
Medicare Part D FFCRA 6.20% Incr. FFP	(\$220,134)	(\$220,134)	\$0	\$0
<b>Total COVID-19 Incr. FMAP - DHCS:</b>	<b>(\$220,134)</b>	<b>(\$2,737,892)</b>	<b>\$0</b>	<b>\$2,517,758</b>
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$1,824)	\$0	\$1,824
<b>Total COVID-19 Incr. FMAP - Other Admin:</b>	<b>\$0</b>	<b>(\$1,824)</b>	<b>\$0</b>	<b>\$1,824</b>
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$1,925,194	(\$8,110)	(\$404,736)	\$2,338,040
FFCRA 4.34% Increased FFP	\$14,310	(\$7,371)	(\$4,302)	\$25,983
FFCRA 4.34% Incr. FFP - Other Admin	\$0	(\$925)	\$0	\$925
Medicare Part D FFCRA 6.20% Incr. FFP	(\$165,695)	(\$165,695)	\$0	\$0
<b>Total COVID-19 Incr. FMAP In other PCs:</b>	<b>\$1,773,809</b>	<b>(\$182,101)</b>	<b>(\$409,038)</b>	<b>\$2,364,948</b>
<b>Total of PCs including COVID-19 Increased FMAP</b>	<b>\$1,553,675</b>	<b>(\$2,921,818)</b>	<b>(\$409,038)</b>	<b>\$4,884,531</b>

**COVID-19 INCREASED FMAP - OTHER ADMIN**  
OTHER ADMIN. POLICY CHANGE NUMBER: 45

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>SF</b>	<b>FF</b>
COVID-19 Increased FMAP - DHCS:				
FFCRA 6.20% Increased FFP	\$0	(\$692,136)	\$0	\$692,136
FFCRA 4.34% Increased FFP	\$0	(\$40,688)	\$0	\$40,688
BCCTP 4.34% Increased FFP	\$0	(\$2)	\$0	\$2
Medicare Part D FFCRA 6.20% Increased FFP	(\$50,094)	(\$50,094)	\$0	\$0
<b>Total COVID-19 Incr. FMAP - DHCS:</b>	<b>(\$50,094)</b>	<b>(\$782,920)</b>	<b>\$0</b>	<b>\$732,826</b>
COVID-19 Increased FMAP - Other Admin:				
FFCRA 4.34% Increased FFP	\$0	(\$365)	\$0	\$365
<b>Total COVID-19 Incr. FMAP - Other Admin:</b>	<b>\$0</b>	<b>(\$365)</b>	<b>\$0</b>	<b>\$365</b>
COVID-19 Increased FMAP In other PCs:				
FFCRA 6.20% Increased FFP	\$376,229	(\$13,718)	(\$105,227)	\$495,174
FFCRA 4.34% Increased FFP	\$10,086	(\$700)	(\$4,583)	\$15,369
FFCRA 4.34% Incr. FFP - Other Admin	\$0	\$0	\$0	\$0
<b>Total COVID-19 Incr. FMAP In other PCs:</b>	<b>\$386,315</b>	<b>(\$14,418)</b>	<b>(\$109,810)</b>	<b>\$510,543</b>
COVID-19 Increased FMAP Extension – DHCS	\$513,836	(\$1,433,282)	(\$150,129)	\$2,097,247
COVID-19 Increased FMAP Extension - Other Admin	\$0	(\$1,558)	\$0	\$1,558
<b>Total COVID-19 Increased FMAP Extension</b>	<b>\$513,836</b>	<b>(\$1,434,840)</b>	<b>(\$150,129)</b>	<b>\$2,098,805</b>
<b>Total of PCs including COVID-19 Increased FMAP</b>	<b>\$850,057</b>	<b>(\$2,232,543)</b>	<b>(\$259,939)</b>	<b>\$3,342,539</b>

**Funding:**

FFCRA 4.34% Increased FFP (4260-113-0890)  
FFCRA 4.34% GF (4260-113-0001)  
FFCRA 4.34% Increased FFP FI (4260-113-0890)  
FFCRA 4.34% GF FI (4260-113-0001)



## CMS DEFERRED CLAIMS - OTHER ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 46  
**IMPLEMENTATION DATE:** 8/2020  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2123

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$182,984,000	-\$216,398,000
<b>FEDERAL FUNDS</b>	-\$182,984,000	\$216,398,000

**Purpose:**

This policy change estimates the repayment of 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 administrative deferred claims are included in this policy change and are separate from the CMS Deferred Claims and CMS Deferred Claims – FI policy changes. See the CMS Deferred Claims and CMS Deferred Claims – FI policy changes for more information.

## CMS DEFERRED CLAIMS - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 46

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to the updated FFY 2019 Quarter 3, FFY 2019 Quarter 4, FFY 2020 Quarter 1, and FFY 2020 Quarter 2 repayment amounts based on the actual CMS deferrals, and the revised timing for the resolved deferrals.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to only resolved deferrals expected to be reclaimed in FY 2021-22.

### Methodology:

- In FY 2020-21, the Department expects to repay a net total of \$182.984 million FF which includes \$258.373 million FF in repayments for CMS deferrals issued for FFY 2019 Quarter 3, FFY 2019 Quarter 4, FFY 2020 Quarter 1, and FFY 2020 Quarter 2, \$150 million FF in estimated repayments for FFY 2020 Quarters 3 and 4, and an estimated \$225.389 million FF reclaimed for resolved cost allocation deferrals.
- In FY 2021-22, the Department expects an estimated \$216.398 million FF will be reclaimed for resolved cost allocation deferrals.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>Total Estimated Repayment</b>
FFY 2019 Quarter 3 (Apr-Jun 2019)	\$85,068
FFY 2019 Quarter 4 (Jul-Sep 2019)	\$3,551
FFY 2020 Quarter 1 (Oct-Dec 2019)	\$66,844
FFY 2020 Quarter 2 (Jan-Mar 2020)	\$102,910
FFY 2020 Quarter 3 (Apr-Jun 2020)	\$75,000
FFY 2020 Quarter 4 (Jul-Sep 2020)	\$75,000
Subtotal Estimated Repayments	\$408,373
Estimated Resolved Deferrals	(\$225,389)
<b>Total FY 2020-21</b>	<b>\$182,984</b>

<b>FY 2021-22</b>	<b>Total Estimated Resolved</b>
Estimated Resolved Deferrals	(\$216,398)
<b>Total FY 2021-22</b>	<b>(\$216,398)</b>

### Funding:

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

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

## MH/UCD & BTR – LIHP – ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 47  
**IMPLEMENTATION DATE:** 5/2019  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 1589

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	-\$9,113,000	\$0
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	-\$9,113,000	\$0

**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: 47

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to the delay of the remaining DY 2007-08, DY 2012-13, and DY 2013-14 recoupments which shifted from FY 2019-20 to FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the completion of the outstanding recoupments in FY 2020-21.

### 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. The outstanding recoupments are:

FY 2020-21	TF	FF
DY 2007-08	(\$151,000)	(\$151,000)
DY 2012-13	(\$6,630,000)	(\$6,630,000)
DY 2013-14	(\$2,332,000)	(\$2,332,000)
<b>Total FY 2020-21</b>	<b>(\$9,113,000)</b>	<b>(\$9,113,000)</b>

### Funding:

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

## MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 48  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2119

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$52,284,000	\$45,517,000
<b>STATE FUNDS</b>	\$13,275,630	\$11,963,700
<b>FEDERAL FUNDS</b>	\$39,008,370	\$33,553,300

**Purpose:**

This policy change estimates the cost of the DXC Medical Fiscal Intermediary (FI) contract IT Operations and Development Services.

**Authority:**

DXC Contract # 18-95357  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The DXC 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 started in 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 Application Maintenance and Support Services (AMSS):

- Application Development Services
- Application Maintenance and Operations Services
- Project Management Office

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

## MEDICAL FI IT DEVELOPMENT AND OPERATIONS SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 48

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21, and an increase in System Development Notice (SDN) hours from the baseline established in the IBM contract.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays and projected reductions in operation costs in FY 2021-22.

### Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. Beginning FY 2020-21 and forward, 12 months of costs are used to estimate the annual budget.
3. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Application Development Services	\$33,627,000	\$8,538,000	\$24,960,000	\$129,000
Application Maintenance and Operations Services	\$10,805,000	\$2,743,000	\$8,020,000	\$42,000
Project Management Office	\$7,852,000	\$1,995,000	\$5,827,000	\$30,000
<b>Total:</b>	<b>\$52,284,000</b>	<b>\$13,276,000</b>	<b>\$38,807,000</b>	<b>\$201,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Application Development Services	\$31,104,000	\$8,176,000	\$22,928,000
Application Maintenance and Operations Services	\$8,702,000	\$2,287,000	\$6,415,000
Project Management Office	\$5,711,000	\$1,501,000	\$4,210,000
<b>Total:</b>	<b>\$45,517,000</b>	<b>\$11,964,000</b>	<b>\$33,553,000</b>

### Funding:

FI 75% Title XIX FF/ 25% GF (4260-101-0001/0890)  
 FI 100% GF (4260-101-0001)  
 FI 76.5% Title XXI CHIP / 23.5% GF (4260-113-0001/0890)  
 FI 65% Title XXI CHIP / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO & IT COST REIMBURSEMENT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 49  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2115

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$45,377,000	\$43,739,000
<b>STATE FUNDS</b>	\$12,514,240	\$12,488,350
<b>FEDERAL FUNDS</b>	\$32,862,760	\$31,250,650

**Purpose:**

This policy change estimates the total cost reimbursement of the DXC Medical Fiscal Intermediary (FI) contracts.

**Authority:**

DXC Contract # 18-95357  
 IBM Contract # 18-95302  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**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 started in 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
  - o 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
  - o 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: 49

- Equipment and Services (Personal Computers, Monitors, Printers, Related Equipment, and Software)
  - Installation and monthly charges for data lines;
  - Purchase, lease, installation, and maintenance of desktops for State staff at Field Offices and Contractor facilities; and
  - Point-of-Sale (POS) devices.
- Facilities Lease, Improvement, Modifications
  - The direct costs for the Medi-Cal Operations Center (MOC) as well as any required modifications and improvements.
- 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.



## MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 49

### Audits and Research

- o 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.
- Change Order and/or Amendments
  - o 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21 and cost estimates are projected to increase.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays.

### Methodology:

1. Takeover costs are not paid with Local Assistance funds.
2. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
3. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

## MEDICAL FI BO & IT COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 49

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Postage (50% FF / 50% GF)	\$2,136,000	\$1,025,000	\$1,102,000	\$9,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$100,000	\$48,000	\$51,000	\$1,000
Equipment & Services (75% FF / 25% GF)	\$9,790,000	\$2,486,000	\$7,266,000	\$38,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$9,113,000	\$2,314,000	\$6,764,000	\$35,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$19,352,000	\$4,865,000	\$14,413,000	\$74,000
Telecommunications & Data Center (75% FF / 25% GF)	\$1,835,000	\$466,000	\$1,362,000	\$7,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$3,051,000	\$1,311,000	\$1,729,000	\$11,000
<b>Total:</b>	<b>\$45,377,000</b>	<b>\$12,515,000</b>	<b>\$32,687,000</b>	<b>\$175,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Postage (50% FF / 50% GF)	\$2,136,000	\$1,045,000	\$1,091,000
Parcel Services & Common Carriers (50% FF / 50% GF)	\$100,000	\$49,000	\$51,000
Equipment & Services (75% FF / 25% GF)	\$5,834,000	\$1,534,000	\$4,300,000
Facilities Improvement & Modification (75% FF / 25% GF)	\$8,913,000	\$2,343,000	\$6,570,000
Consultant Contracts (50% FF / 50% GF, 75% FF / 25% GF, 90% FF / 10% GF)	\$21,870,000	\$5,698,000	\$16,172,000
Telecommunications & Data Center (75% FF / 25% GF)	\$1,835,000	\$482,000	\$1,353,000
Other Cost Reimbursable Items (50% FF / 50% GF, 75% FF / 25% GF)	\$3,051,000	\$1,338,000	\$1,713,000
<b>Total:</b>	<b>\$43,739,000</b>	<b>\$12,489,000</b>	<b>\$31,250,000</b>

**Funding:**

FI 50% Title XIX/ 50% GF (4260-101-0001/0890)  
 FI 75% Title XIX/ 25% 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)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO & IT CHANGE ORDERS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 50  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2117

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$37,656,000	\$33,028,000
<b>STATE FUNDS</b>	\$9,562,120	\$8,682,450
<b>FEDERAL FUNDS</b>	\$28,093,880	\$24,345,550

**Purpose:**

This policy change estimates the cost of the DXC Medical Fiscal Intermediary (FI) contract Change Orders (i.e. Change Requests).

**Authority:**

DXC Contract # 18-95357  
 IBM Contract # 18-95302  
 Senate Bill (SB) 853 (Chapter 717, Statutes of 2010)  
 Welfare & Institutions (W&I) Code Section 14105.05  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The DXC 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 (BO) and Information Technology Maintenance and Operations (IT M&O) FI contracts started in October 2019. The DXC 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 Change Orders (CO) 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. IT Infrastructure Services estimated in this PC are comprised of work that is outside the scope of work that is estimated in the Medical FI IT Infrastructure Services policy change.

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 CO 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.

## MEDICAL FI BO & IT CHANGE ORDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 50

While COs are generally not known at the time the contract was executed, in this case, the COs were identified and known but detailed scope and line item costs were not finalized. These items were termed “unanticipated tasks” by DGS when they approved the contract.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children’s Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to:

- Increased costs due to COVID FI expenditures;
- Delayed payments for FY 2019-20 to be paid in FY 2020-21;
- Extending IBM’s Statement of Work (SOW) as a result of unanticipated tasks; and
- Stabilization and refresh of subsystems.

The change from FY 2020-21 to FY 2021-22, in the current estimate, a net decrease is due to:

- No expected delayed payments from prior years to be paid in FY 2021-22;
- Extending IBM’s Statement of Work (SOW) as a result of unanticipated tasks; and
- Continued stabilization and refresh of subsystems, hardware and software.

### 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. Costs are shared between Federal Funds (FF) and General Funds (GF).
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

**MEDICAL FI BO & IT CHANGE ORDERS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 50

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
COVID-19 Expenditures	\$6,190,000	\$1,572,000	\$4,594,000	\$24,000
IT Infrastructure Services				
CMS 64, SIT, UAT, and PROD	\$501,000	\$128,000	\$371,000	\$2,000
Infrastructure Software License Assessment	\$867,000	\$221,000	\$643,000	\$3,000
IT Development & Operations Services				
Level 1 Help Desk	\$911,000	\$231,000	\$676,000	\$4,000
COGNOS	\$304,000	\$77,000	\$226,000	\$1,000
File Maintenance	\$5,336,000	\$1,354,000	\$3,961,000	21000
State Level Registry	\$1,962,000	\$497,000	\$1,457,000	\$8,000
Security Encryption Services	\$4,483,000	\$1,139,000	\$3,327,000	\$17,000
Testing Services	\$8,569,000	\$2,175,000	\$6,361,000	\$33,000
Security Services – Certes	\$411,000	\$104,000	\$305,000	\$2,000
Formulary Liaison Services	\$1,321,000	\$335,000	\$981,000	\$5,000
EOL EOS Network	\$1,300,000	\$331,000	\$964,000	\$5,000
Field Office Automated Groups	\$2,123,000	\$539,000	\$1,576,000	\$8,000
HE Portal	\$1,840,000	\$468,000	\$1,365,000	\$7,000
McWeb UAT Servers Refresh	\$150,000	\$38,000	\$111,000	\$1,000
Production Environment Hardware Refresh	\$802,000	\$204,000	\$595,000	\$3,000
Software License – Part II	\$146,000	\$37,000	\$108,000	\$1,000
TPL Liaison Services	\$276,000	\$70,000	\$205,000	\$1,000
PPFS File Server and RDWEB	\$56,000	\$14,000	\$42,000	\$0
AppDynamics Performance Monitoring	\$108,000	\$28,000	\$80,000	\$0
<b>Total:</b>	<b>\$37,656,000</b>	<b>\$9,562,000</b>	<b>\$27,948,000</b>	<b>\$146,000</b>

**MEDICAL FI BO & IT CHANGE ORDERS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 50

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
COVID-19 Expenditures	\$25,000	\$7,000	\$18,000
IT Infrastructure Services			
CMS 64, SIT, UAT, and PROD	\$1,594,000	\$419,000	\$1,175,000
Infrastructure Software License Assessment	800,000	210,000	590,000
IT Development & Operations Services			
Level 1 Help Desk	\$1,043,000	\$274,000	\$769,000
COGNOS	\$278,000	\$73,000	\$205,000
File Maintenance	\$6,453,000	\$1,696,000	\$4,757,000
State Level Registry	\$1,794,000	\$472,000	\$1,322,000
Security Encryption Services	\$4,475,000	\$1,176,000	\$3,299,000
Testing Services	\$7,895,000	\$2,075,000	\$5,820,000
Security Services – Certes	\$38,000	\$10,000	\$28,000
Formulary Liaison Services	\$1,213,000	\$319,000	\$894,000
Field Office Automated Groups	\$1,962,000	\$516,000	\$1,446,000
McWeb UAT Servers Refresh	\$3,092,000	\$813,000	\$2,279,000
Production Environment Hardware Refresh	\$402,000	\$106,000	\$296,000
Software License – Part II	\$1,549,000	\$407,000	\$1,142,000
TPL Liaison Services	\$253,000	\$66,000	\$187,000
PPFS File Server and RDWEB	\$54,000	\$14,000	\$40,000
AppDynamics Performance Monitoring	\$108,000	\$29,000	\$79,000
<b>Total:</b>	<b>\$33,028,000</b>	<b>\$8,682,000</b>	<b>\$24,346,000</b>

**Funding:**

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

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

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI IT INFRASTRUCTURE SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 51  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2118

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$33,989,000	\$29,588,000
<b>STATE FUNDS</b>	\$8,625,780	\$7,777,150
<b>FEDERAL FUNDS</b>	\$25,363,220	\$21,810,850

**Purpose:**

This policy change estimates the cost of the IBM Medical Fiscal Intermediary (FI) contract Information Technology (IT) Infrastructure Services.

**Authority:**

IBM Contract # 18-95302  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**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) IBM contract started in October 2019. The FI contract term is five years with two one-year optional extensions.

IT Infrastructure Services of the IBM Medical FI IT M&O 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. Application Hosting and Managed Network Support Services (AH/MNS) include:

- 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

## MEDICAL FI IT INFRASTRUCTURE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 51

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays and projected operations cost.

### Methodology:

1. Costs are paid under an hourly rate or via a fixed price negotiated during the procurement phase of the contract.
2. Beginning FY 2020-21 and forward, 12 months of costs are used to estimate the annual budget.
3. Contract costs are shared between Federal Funds (FF) and General Funds (GF).
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Mainframe Data Center Operations Services	\$5,642,000	\$1,432,000	\$4,188,000	\$22,000
Midrange Data Center Operations Services	\$3,642,000	\$924,000	\$2,704,000	\$14,000
Midrange Storage Operations Services	\$269,000	\$67,000	\$200,000	\$2,000
Managed Network Services	\$4,125,000	\$1,047,000	\$3,062,000	\$16,000
Disaster Recovery	\$2,144,000	\$544,000	\$1,592,000	\$8,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$7,566,000	\$1,921,000	\$5,616,000	\$29,000
Fixed Security Services	\$2,865,000	\$727,000	\$2,127,000	\$11,000
Hardware and Refresh	\$678,000	\$171,000	\$504,000	\$3,000
Software	\$7,058,000	\$1,793,000	\$5,238,000	\$27,000
<b>Total:</b>	<b>\$33,989,000</b>	<b>\$8,626,000</b>	<b>\$25,231,000</b>	<b>\$132,000</b>



**MEDICAL FI IT INFRASTRUCTURE SERVICES**

OTHER ADMIN. POLICY CHANGE NUMBER: 51

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Mainframe Data Center Operations Services	\$5,201,000	\$1,367,000	\$3,834,000
Midrange Data Center Operations Services	\$2,804,000	\$737,000	\$2,067,000
Midrange Storage Operations Services	\$245,000	\$65,000	\$180,000
Managed Network Services	\$3,783,000	\$994,000	\$2,789,000
Disaster Recovery	\$1,812,000	\$477,000	\$1,335,000
Service Delivery Mgmt, Asset Mgmt, and Facilities	\$6,491,000	\$1,706,000	\$4,785,000
Fixed Security Services	\$2,466,000	\$648,000	\$1,818,000
Hardware and Refresh	\$570,000	\$150,000	\$420,000
Software	\$6,216,000	\$1,634,000	\$4,582,000
<b>Total:</b>	<b>\$29,588,000</b>	<b>\$7,778,000</b>	<b>\$21,810,000</b>

**Funding:**

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001)

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

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

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO OTHER ESTIMATED COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 52  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2112

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$23,272,000	\$19,400,000
<b>STATE FUNDS</b>	\$6,766,220	\$5,825,300
<b>FEDERAL FUNDS</b>	\$16,505,780	\$13,574,700

**Purpose:**

This policy change estimates the other estimated costs of the DXC Medical Fiscal Intermediary (FI) contract.

**Authority:**

DXC Contract # 18-95357  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The DXC FI contract requires 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 started in October 2019. The FI contract term is five years with five one-year optional extensions.

Some functions and services of the DXC 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.

## **MEDICAL FI BO OTHER ESTIMATED COSTS**

### **OTHER ADMIN. POLICY CHANGE NUMBER: 52**

- 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.
- 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

## MEDICAL FI BO OTHER ESTIMATED COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 52

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays.

**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. Costs are shared between Federal Funds (FF) and General Funds (GF).
3. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Process Appeals (75% FF/25% GF)	\$810,000	\$206,000	\$600,000	\$4,000
Support Audits (75% FF/25% GF)	\$173,000	\$43,000	\$129,000	\$1,000
Process Drug Rebates (75% FF/25% GF)	\$1,605,000	\$408,000	\$1,191,000	\$6,000
Provide Litigation Support (75% FF/25% GF)	\$177,000	\$45,000	\$131,000	\$1,000
Service Delivery Support (75% FF/25% GF)	\$10,170,000	\$2,582,000	\$7,549,000	\$39,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$3,298,000	\$1,360,000	\$1,925,000	\$13,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$4,736,000	\$1,202,000	\$3,516,000	\$18,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$2,119,000	\$874,000	\$1,237,000	\$8,000
Perform Proactive Provider Research (75% FF/25% GF)	\$184,000	\$47,000	\$136,000	\$1,000
<b>Total:</b>	<b>\$23,272,000</b>	<b>\$6,767,000</b>	<b>\$16,414,000</b>	<b>\$91,000</b>

**MEDICAL FI BO OTHER ESTIMATED COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 52

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Process Appeals (75% FF/25% GF, 100% GF)	\$686,000	\$180,000	\$506,000
Support Audits (75% FF/25% GF)	\$146,000	\$39,000	\$107,000
Process Drug Rebates (75% FF/25% GF)	\$1,040,000	\$273,000	\$767,000
Provide Litigation Support (75% FF/25% GF)	\$150,000	\$39,000	\$111,000
Service Delivery Support (75% FF/25% GF)	\$8,618,000	\$2,265,000	\$6,353,000
Publish Provider Communication Materials (75% FF/25% GF, 50% FF/50% GF)	\$2,795,000	\$1,178,000	\$1,617,000
Conduct Provider Outreach and Education (75% FF/25% GF)	\$4,013,000	\$1,055,000	\$2,958,000
Print and Mail Medi-Cal Information (75% FF/25% GF, 50% FF/50% GF)	\$1,796,000	\$756,000	\$1,040,000
Perform Proactive Provider Research (75% FF/25% GF)	\$156,000	\$41,000	\$115,000
<b>Total:</b>	<b>\$19,400,000</b>	<b>\$5,826,000</b>	<b>\$13,574,000</b>

**Funding:**

FI 50% Title XIX / 50% GF (4260-101-0001/0890)  
 FI 75% Title XIX / 25% GF (4260-101-0001/0890)  
 FI 100% GF (4260-101-0001/0890)  
 FI 76.5% Title XXI CHIP / 23.5% GF (4260-113-0001/0890)  
 FI 65% Title XXI CHIP / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO TELEPHONE SERVICE CENTER

**OTHER ADMIN. POLICY CHANGE NUMBER:** 53  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2116

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$15,899,000	\$13,509,000
<b>STATE FUNDS</b>	\$4,618,320	\$4,043,550
<b>FEDERAL FUNDS</b>	\$11,280,680	\$9,465,450

**Purpose:**

This policy change estimates the Telephone Service Center (TSC) costs of the DXC Medical Fiscal Intermediary (FI) contract.

**Authority:**

DXC Contract # 18-95357  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**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 started in October 2019. The FI contract term is five years with five one-year optional extensions.

The TSC functions and services of the DXC 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 TSC 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)

**MEDICAL FI BO TELEPHONE SERVICE CENTER**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 53**

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays.

**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. Costs are shared between Federal Funds (FF) and General Funds (GF).
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$8,956,000	\$2,601,000	\$6,321,000	\$34,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$5,228,000	\$1,519,000	\$3,689,000	\$20,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,715,000	\$498,000	\$1,210,000	\$7,000
<b>Total</b>	<b>\$15,899,000</b>	<b>\$4,618,000</b>	<b>\$11,220,000</b>	<b>\$61,000</b>

**MEDICAL FI BO TELEPHONE SERVICE CENTER**  
OTHER ADMIN. POLICY CHANGE NUMBER: 53

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
TSC – Conduct Provider Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$7,698,000	\$2,304,000	\$5,394,000
TSC – Conduct Member Customer Services (75% FF/25% GF, 50% FF/50% GF)	\$4,359,000	\$1,305,000	\$3,054,000
TSC – Provide Financial Services (75% FF/25% GF, 50% FF/50% GF)	\$1,452,000	\$434,000	\$1,018,000
<b>Total</b>	<b>\$13,509,000</b>	<b>\$4,043,000</b>	<b>\$9,466,000</b>

**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 76.5% Title XXI CHIP / 23.5% GF (4260-113-0001/0890)  
 FI 65% Title XXI CHIP / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)



## MEDICAL FI BUSINESS OPERATIONS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 54  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2111

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$15,289,000	\$12,947,000
<b>STATE FUNDS</b>	\$3,881,630	\$3,403,300
<b>FEDERAL FUNDS</b>	\$11,407,370	\$9,543,700

**Purpose:**

This policy change estimates the operational costs of the DXC Medical Fiscal Intermediary (FI) contract.

**Authority:**

DXC Contract # 18-95357  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**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 DXC Business Operations FI contract started in October 2019. The DXC Business Operations FI contract term is five years with five one-year optional extensions.

The Operations functions and services of the DXC 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.

## MEDICAL FI BUSINESS OPERATIONS

### OTHER ADMIN. POLICY CHANGE NUMBER: 54

- **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 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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children’s Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

#### **Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no delayed payments projected for FY 2021-22 and projected operations cost.

#### **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.

**MEDICAL FI BUSINESS OPERATIONS**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 54**

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).
6. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Process Paper Claims	\$8,340,000	\$2,118,000	\$6,190,000	\$32,000
Process Suspended Claims	\$3,454,000	\$877,000	\$2,564,000	\$13,000
Manage Records	\$1,307,000	\$331,000	\$970,000	\$6,000
Process Member Card Requests	\$1,809,000	\$460,000	\$1,342,000	\$7,000
Process Paper TAR	\$379,000	\$96,000	\$282,000	\$1,000
<b>Total:</b>	<b>\$15,289,000</b>	<b>\$3,882,000</b>	<b>\$11,348,000</b>	<b>\$59,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Process Paper Claims	\$7,141,000	\$1,877,000	\$5,264,000
Process Suspended Claims	\$2,833,000	\$745,000	\$2,088,000
Manage Records	\$1,114,000	\$293,000	\$821,000
Process Member Card Requests	\$1,536,000	\$403,000	\$1,133,000
Process Paper TAR	\$323,000	\$85,000	\$238,000
<b>Total:</b>	<b>\$12,947,000</b>	<b>\$3,403,000</b>	<b>\$9,544,000</b>

**Funding:**

FI 50% Title XIX / 50% GF (4260-101-0001/0890)  
 FI 75% Title XIX / 25% GF (4260-101-0001/0890)  
 FI 100% GF (4260-101-0001/0890)  
 FI 76.5% Title XXI CHIP / 23.5% GF (4260-113-0001/0890)  
 FI 65% Title XXI CHIP / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO HOURLY REIMBURSEMENT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 55  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2113

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$10,776,000	\$10,309,000
<b>STATE FUNDS</b>	\$2,735,730	\$2,709,900
<b>FEDERAL FUNDS</b>	\$8,040,270	\$7,599,100

**Purpose:**

This policy change estimates the hourly reimbursement costs of the DXC Medical Fiscal Intermediary (FI) contract.

**Authority:**

DXC Contract # 18-95357  
Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**Background:**

The DXC 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 started in October 2019. The FI contract term is five years with five one-year optional extensions.

Under the DXC Medical 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.

## MEDICAL FI BO HOURLY REIMBURSEMENT

**OTHER ADMIN. POLICY CHANGE NUMBER: 55**

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

### Reason for Change:

The change in FY 2020-21, from the prior estimate, is due to delayed payments for FY 2019-20 to be paid in FY 2020-21 and an increase in Systems Group (SG) hours via Systems Development Notice (SDN) hours/projects.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to no anticipated payment delays.

### Methodology:

1. Hourly costs are paid using hourly rates which vary depending on the service being performed and the expertise required.
2. Costs are shared between Federal Funds (FF) and General Funds (GF).
3. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Perform Medical Review Services	\$6,162,000	\$1,564,000	\$4,574,000	\$24,000
Service Changes (formerly Systems Group)	\$4,614,000	\$1,172,000	\$3,425,000	\$17,000
<b>Total:</b>	<b>\$10,776,000</b>	<b>\$2,736,000</b>	<b>\$7,999,000</b>	<b>\$41,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Perform Medical Review Services	\$5,901,000	\$1,551,000	\$4,350,000
Service Changes (formerly Systems Group)	\$4,408,000	\$1,159,000	\$3,249,000
<b>Total:</b>	<b>\$10,309,000</b>	<b>\$2,710,000</b>	<b>\$7,599,000</b>

### Funding:

FI 75% Title XIX / 25% GF (4260-101-0001/0890)  
 FI 100% GF (4260-101-0001/0890)  
 FI 76.5% Title XXI CHIP / 23.5% GF (4260-113-0001/0890)  
 FI 65% Title XXI CHIP / 35% GF (4260-113-0001/0890)  
 FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)

## MEDICAL FI BO MISCELLANEOUS EXPENSES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 56  
**IMPLEMENTATION DATE:** 11/2019  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 2114

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$2,468,000	\$2,468,000
<b>STATE FUNDS</b>	\$764,280	\$786,050
<b>FEDERAL FUNDS</b>	\$1,703,720	\$1,681,950

**Purpose:**

This policy change estimates the cost of miscellaneous expenses of the DXC Medical Fiscal Intermediary (FI) contract.

**Authority:**

DXC Contract # 18-95357  
 Interagency Agreement (IA) # 18-95321, 18-85091, 16-93264, & 18-95090  
 Families First Coronavirus Response Act (FFCRA)

**Interdependent Policy Changes:**

COVID-19 Increased FMAP Extension – Other Admin

**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 started in October 2019. The DXC 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 IAs, Optional Contract Services (OCS), and Facilities provisioning.

Pursuant to an 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.

Pursuant to an IA 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: 56

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.

The FFCRA provides increased federal funding by increasing the federal medical assistance percentage (FMAP) by 6.2 percentage points for certain expenditures in Medicaid and by 4.34 percentage points for certain expenditures in the Children's Health Insurance Program (CHIP). The FFCRA increased FMAP is effective January 1, 2020 and extends through the last day of the calendar quarter of the national public health emergency. National public health emergencies are effective for 90 days unless extended or terminated. The Secretary of Health and Human Services last extended the COVID-19 national public health emergency on October 23, 2020.

### Reason for Change:

There is no change from the prior estimate in FY 2020-21.

There is no change from FY 2020-21 to FY 2021-22.

### 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. Costs are shared between Federal Funds (FF) and General Funds (GF).
4. The 4.34% Title XXI FFCRA increased FMAP is assumed for expenditures through June 30, 2021 for this policy change. The impact of a six month extension of the FFCRA increased FMAP on Medi-Cal spending is roughly estimated and separately budgeted in the COVID-19 Increased FMAP Extension – Other Admin policy change.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>FFCRA</b>
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,468,000	\$764,000	\$1,694,000	\$10,000
<b>Total:</b>	<b>\$2,468,000</b>	<b>\$764,000</b>	<b>\$1,694,000</b>	<b>\$10,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Interagency Agreements (75% FF/25% GF, 50% FF/50% GF)	\$2,468,000	\$786,000	\$1,682,000
<b>Total:</b>	<b>\$2,468,000</b>	<b>\$786,000</b>	<b>\$1,682,000</b>

**MEDICAL FI BO MISCELLANEOUS EXPENSES**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 56**

**Funding:**

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

FI 100% GF (4260-101-0001/0890)

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

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

FFCRA 4.34% Increased FFP (4260-113-0890)

FFCRA 4.34% GF (4260-113-0001)



**CMS DEFERRED CLAIMS - FI**

**OTHER ADMIN. POLICY CHANGE NUMBER:** 57  
**IMPLEMENTATION DATE:** 9/2019  
**ANALYST:** Joy Oda  
**FISCAL REFERENCE NUMBER:** 2202

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$920,000	\$0
<b>FEDERAL FUNDS</b>	-\$920,000	\$0

**Purpose:**

This policy change estimates the repayment of Fiscal Intermediary (FI) 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 deferred claims are included in this policy change and are separate from the CMS Deferred Claims and CMS Deferred Claims Other Admin policy changes. See the CMS Deferred Claims and CMS Deferred Claims Other Admin policy changes for more information.

**CMS DEFERRED CLAIMS - FI**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 57**

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is due to the updated FFY 2019 Quarter 3, FFY 2019 Quarter 4, and FFY 2020 Quarter 2 repayment amounts based on the actual CMS deferrals.

The change from FY 2020-21 to FY 2021-22, in the current estimate, is due to the inclusion of estimated repayments for FY 2020-21 only.

**Methodology:**

1. In FY 2020-21, the Department will repay \$920,000 FF for the CMS deferrals issued which includes \$393,000 FF for FFY 2019 Quarter 3, \$317,000 FF for FFY 2019 Quarter 4, and \$210,000 FF FFY 2020 Quarter 2.

<b>FY 2020-21</b>	<b>Total Estimated Repayment</b>
FFY 2019 Quarter 3 (Apr-Jun 2019)	\$393,000
FFY 2019 Quarter 4 (Jul-Sep 2019)	\$317,000
FFY 2020 Quarter 2 (Jan-Mar 2020)	\$210,000
<b>Total FY 2020-21</b>	<b>\$920,000</b>

**Funding:**

FI 100% Title XXI FFP (4260-101-0890)  
 FI 100% Title XXI GF (4260-101-0001)

## HCO OPERATIONS 2017 CONTRACT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 58  
**IMPLEMENTATION DATE:** 11/2018  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2051

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$40,500,000	\$40,836,000
<b>STATE FUNDS</b>	\$19,888,060	\$20,111,700
<b>FEDERAL FUNDS</b>	\$20,611,940	\$20,724,300

**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:**

COVID-19 Increased FMAP – DHCS Admin  
 COVID-19 Increased FMAP Extension – DHCS Admin

**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 2020-21.  
 The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to bid price adjustments.

**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.

## HCO OPERATIONS 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 58

### CONTRACTUAL BID RATE

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>GF</b>	<b>FF</b>
		<b>Title XIX</b>	<b>Title XIX</b>	<b>Enhanced Title XXI</b>	<b>Enhanced Title XXI</b>
Transactions	\$7,727	\$3,670	\$3,670	\$124	\$263
Packet Mailings	\$7,197	\$3,419	\$3,419	\$115	\$244
BDA/Call Center	\$25,576	\$12,149	\$12,149	\$411	\$867
<b>Total</b>	<b>\$40,500</b>	<b>\$19,238</b>	<b>\$19,238</b>	<b>\$650</b>	<b>\$1,374</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>GF</b>	<b>FF</b>
		<b>Title XIX</b>	<b>Title XIX</b>	<b>Enhanced Title XXI</b>	<b>Enhanced Title XXI</b>
Transactions	\$7,469	\$3,548	\$3,548	\$131	\$242
Packet Mailings	\$7,531	\$3,577	\$3,577	\$132	\$245
BDA/Call Center	\$25,836	\$12,272	\$12,272	\$452	\$840
<b>Total</b>	<b>\$40,836</b>	<b>\$19,397</b>	<b>\$19,397</b>	<b>\$715</b>	<b>1,327</b>

**Funding:**

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

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

FI 65% Title XXI / 35% 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.

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## HCO COST REIMBURSEMENT 2017 CONTRACT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 59  
**IMPLEMENTATION DATE:** 11/2018  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2052

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$20,646,000	\$20,646,000
<b>STATE FUNDS</b>	\$10,138,530	\$10,168,200
<b>FEDERAL FUNDS</b>	\$10,507,470	\$10,477,800

**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

**Interdependent Policy Changes:**

COVID-19 Increased FMAP – DHCS Admin  
 COVID-19 Increased FMAP Extension – DHCS Admin

**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 no change in the prior estimate for FY 2020-21. The overall total has not changed.

There is an increase in GF and an increase in FF for enhanced funding from FY 2020-21 to FY 2021-22 in the current estimate. The overall total has not changed.

**Methodology:**

1. Contract costs are shared between federal funds (FF) and General Fund (GF).

## HCO COST REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 59

(Dollars in Thousands)

	TF	GF	FF	GF	FF
<b>(FY 2020-21)</b>		<b>Title XIX</b>	<b>Title XIX</b>	<b>Enhanced Title XXI</b>	<b>Enhanced Title XXI</b>
Postage	\$10,315	\$4,900	\$4,900	\$165	\$350
Printing	\$3,035	\$1,442	\$1,442	\$49	\$102
Materials Maintenance and Development	\$2,522	\$1,198	\$1,198	\$40	\$86
Mass Mailings	\$800	\$380	\$380	\$13	\$27
Other Cost. Reimb.	\$1,010	\$480	\$480	\$16	\$34
Additional Systems Group Staff	\$2,505	\$1,190	\$1,190	\$40	\$85
Miscellaneous	\$459	\$218	\$218	\$7	\$16
<b>Total*</b>	<b>\$20,646</b>	<b>\$9,808</b>	<b>\$9,808</b>	<b>\$330</b>	<b>\$700</b>

**\*Total Rounded**

(Dollars in Thousands)

	TF	GF	FF	GF	FF
<b>(FY 2021-22)</b>		<b>Title XIX</b>	<b>Title XIX</b>	<b>Enhanced Title XXI</b>	<b>Enhanced Title XXI</b>
Postage	\$10,315	\$4,900	\$4,900	\$181	\$334
Printing	\$3,035	\$1,442	\$1,442	\$53	\$98
Materials Maintenance and Development	\$2,522	\$1,198	\$1,198	\$44	\$82
Mass Mailings	\$800	\$380	\$380	\$14	\$26
Other Cost. Reimb.	\$1,010	\$480	\$480	\$18	\$32
Additional Systems Group Staff	\$2,505	\$1,190	\$1,190	\$44	\$81
Miscellaneous	\$459	\$218	\$218	\$6	\$17
<b>Total*</b>	<b>\$20,646</b>	<b>\$9,808</b>	<b>\$9,808</b>	<b>\$360</b>	<b>\$670</b>

**\*Total rounded****Funding:**

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

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

FI 65% Title XXI / 35% 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.

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 60  
**IMPLEMENTATION DATE:** 11/2018  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 2053

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$14,171,000	\$14,720,000
<b>STATE FUNDS</b>	\$6,958,800	\$7,249,600
<b>FEDERAL FUNDS</b>	\$7,212,200	\$7,470,400

**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:**

COVID-19 Increased FMAP – DHCS Admin  
 COVID-19 Increased FMAP Extension – DHCS Admin

**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 was no change from the prior estimate for FY 2020-21.  
 The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to bid price adjustments.

**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 2020-21 and FY 2021-22 are based on 210 ESRs per year.

## HCO ESR HOURLY REIMBURSEMENT 2017 CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

### CONTRACTUAL BID RATE

(Dollars in thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX (50% FF / 50% GF)	\$13,462	\$6,731	\$6,731
Title XXI (88% FF / 12% GF)	\$177	\$42	\$135
Title XXI (76.5% FF / 23.5% GF)	\$532	\$186	\$346
<b>Total</b>	<b>\$14,171</b>	<b>\$6,959</b>	<b>\$7,212</b>

(Dollars in thousands)

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX (50% FF / 50% GF)	\$13,984	\$6,992	\$6,992
Title XXI (65% FF / 35% GF)	\$736	\$258	\$478
<b>Total</b>	<b>\$14,720</b>	<b>\$7,250</b>	<b>\$7,470</b>

**Funding:**

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

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

FI 65% Title XXI / 35% 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.

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change



## DENTAL ASO ADMINISTRATION 2016 CONTRACT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 61  
**IMPLEMENTATION DATE:** 3/2018  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2007

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$34,722,000	\$47,467,000
<b>STATE FUNDS</b>	\$12,867,750	\$16,908,500
<b>FEDERAL FUNDS</b>	\$21,854,250	\$30,558,500

**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 Service 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

A 2% withhold is being administered on operation invoices which are calculated using ACSL and TAR. The 2% withhold will be released if the ASO meets performance requirements set in the ASO contract; if the ASO does not meet performance measures, the 2% withhold will not be released.

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. Postage
2. Parcel Services and Common Carriers

## **DENTAL ASO ADMINISTRATION 2016 CONTRACT**

**OTHER ADMIN. POLICY CHANGE NUMBER: 61**

3. Printing
4. Telephone Toll Charges
5. Special Training Sessions
6. Conventions, Provider Enrollment Workshops, and Health Fairs
7. Facilities Improvement and Modifications
8. Personal Computers, Monitors, Printers, Related Equipment, and Software
9. Cost Reimbursed Audits and Research
10. Independent Contractor Consideration
11. Annual Risk Assessments
12. Business Analyst
13. Miscellaneous

The ASO 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. Outreach and education will help increase beneficiary awareness about dental benefits and provide assistance in locating a dentist to schedule an appointment.

### **Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a decrease due to changes in invoice payment timing, lower volumes overall, and a recoupment due to a change order related to TAR processing volumes. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to contract rate increases, the return to volumes closer to prior year levels, and the recoupment occurring in FY 2020-21.

### **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 caseload 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. The 2% withhold is based on actual invoices received. If performance requirements were met for calendar year 2019, the funds will be released in FY 2020-21.
4. TSC minutes are based on actual invoices with a caseload growth factor and funded at 50% FF and 50% GF.

**DENTAL ASO ADMINISTRATION 2016 CONTRACT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 61

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Administration/Operations (75% FF / 25% GF)	\$17,790,000	\$4,448,000	\$13,342,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$3,141,000	\$1,029,000	\$2,112,000
2% Withhold (net of prior year withhold release)	\$126,000	\$33,000	\$93,000
Change Order Recoupment (75%FF / 25% GF)	(\$2,519,000)	(\$630,000)	(\$1,889,000)
Total ACSL/TAR	\$18,538,000	\$4,880,000	\$13,658,000
TSC – Provider (50% FF / 50% GF)	\$5,294,000	\$2,647,000	\$2,647,000
TSC – Beneficiary (50% FF / 50% GF)	\$8,653,000	\$4,326,000	\$4,327,000
Total TSC	\$13,947,000	\$6,973,000	\$6,974,000
<b>Total Operations Costs</b>	<b>\$32,485,000</b>	<b>\$11,853,000</b>	<b>\$20,632,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Administration/Operations (75% FF / 25% GF)	\$23,919,000	\$5,979,000	\$17,940,000
Provider Enrollment (50% FF / 50% GF & 75% FF / 25% GF)	\$4,220,000	\$1,382,000	\$2,838,000
2% Withhold (net of prior year withhold release)	\$56,000	\$15,000	\$41,000
Total ACSL/TAR	\$28,195,000	\$7,376,000	\$20,819,000
TSC – Provider (50% FF / 50% GF)	\$6,964,000	\$3,482,000	\$3,482,000
TSC – Beneficiary (50% FF / 50% GF)	\$9,794,000	\$4,897,000	\$4,897,000
Total TSC	\$16,758,000	\$8,379,000	\$8,379,000
<b>Total Operations Costs</b>	<b>\$44,953,000</b>	<b>\$15,755,000</b>	<b>\$29,198,000</b>

5. Cost reimbursements are based on actual invoices with a caseload growth factor.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>Total Cost Reimbursable</b>	<b>\$2,237,000</b>	<b>\$1,015,000</b>	<b>\$1,222,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>Total Cost Reimbursable</b>	<b>\$2,511,000</b>	<b>\$1,152,000</b>	<b>\$1,359,000</b>

6. Total Administration Cost

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$34,722,000</b>	<b>\$12,868,000</b>	<b>\$21,854,000</b>
<b>FY 2021-22</b>	<b>\$47,467,000</b>	<b>\$16,908,000</b>	<b>\$30,559,000</b>

**Funding:**

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

FI 75% Title XIX / 25% GF (4260-101-0001/0890)

**DENTAL ASO ADMINISTRATION 2016 CONTRACT**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 61**

\*\*\*This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

## DENTAL FI ADMINISTRATION 2016 CONTRACT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 62  
**IMPLEMENTATION DATE:** 11/2017  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2006

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$20,897,000	\$21,942,000
<b>STATE FUNDS</b>	\$5,894,500	\$6,137,000
<b>FEDERAL FUNDS</b>	\$15,002,500	\$15,805,000

**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
3. Parcel Services and Common Carriers
4. Data Center Access
5. Special Training Sessions
6. Facilities Improvement and Modifications
7. Personal Computers, Monitors, Printers, Related Equipment, and Software
8. Cost Reimbursed Audits and Research
9. Independent Contractor Consideration
10. Annual Risk Assessments

## DENTAL FI ADMINISTRATION 2016 CONTRACT

### OTHER ADMIN. POLICY CHANGE NUMBER: 62

11. Miscellaneous
12. 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 2020-21, is a decrease due to lower invoice actuals from the prior fiscal year paying in FY 2020-21. The change from FY 2020-21 to FY 2021-22, in the current estimate, is an increase due to rate increases for several categories of services.

#### 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 2019-20 actual document counts and projected forward.
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.

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Scanned Claims/TAR	\$10,846,000	\$2,712,000	\$8,134,000
Check Write	\$269,000	\$67,000	\$202,000
Change Orders	\$602,000	\$301,000	\$301,000
<b>Total</b>	<b>\$11,717,000</b>	<b>\$3,080,000</b>	<b>\$8,637,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Scanned Claims/TAR	\$11,645,000	\$2,911,000	\$8,734,000
Check Write	\$249,000	\$62,000	\$187,000
Change Orders	\$770,000	\$385,000	\$385,000
<b>Total</b>	<b>\$12,664,000</b>	<b>\$3,358,000</b>	<b>\$9,306,000</b>

4. Cost reimbursements are based on actual invoices.

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$2,292,000</b>	<b>\$1,093,000</b>	<b>\$1,199,000</b>
<b>FY 2021-22</b>	<b>\$2,134,000</b>	<b>\$993,000</b>	<b>\$1,141,000</b>

**DENTAL FI ADMINISTRATION 2016 CONTRACT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 62

## 5. Hourly Reimbursables:

<b>System Group</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$6,888,000</b>	<b>\$1,722,000</b>	<b>\$5,166,000</b>
<b>FY 2021-22</b>	<b>\$7,144,000</b>	<b>\$1,786,000</b>	<b>\$5,358,000</b>

## 6. Total Administration Cost:

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$20,897,000</b>	<b>\$5,895,000</b>	<b>\$15,002,000</b>
<b>FY 2021-22</b>	<b>\$21,942,000</b>	<b>\$6,137,000</b>	<b>\$15,805,000</b>

**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.

## PERSONAL CARE SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 64  
**IMPLEMENTATION DATE:** 4/1993  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 236

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$406,386,000	\$404,661,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$406,386,000	\$404,661,000

**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 the 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:**

The change for FY 2020-21, from the prior estimate, is a slight increase due to updated expenditure data provided by CDSS. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a slight decrease due to updated expenditure data provided by CDSS.

**Methodology:**

The estimates, on a cash basis, were provided by CDSS.



**PERSONAL CARE SERVICES**  
OTHER ADMIN. POLICY CHANGE NUMBER: 64

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
EW Time & Health Related	\$675,024	\$337,512	\$337,512
CMIPS II	\$93,548	\$46,774	\$46,774
CMIPS II EVV	\$44,200	\$22,100	\$22,100
Total	\$812,772	<b>\$406,386</b>	\$406,386
<b>FY 2021-22</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
EW Time & Health Related	\$688,472	\$344,236	\$344,236
CMIPS II	\$93,560	\$46,780	\$46,780
CMIPS II EVV	\$27,290	\$13,645	\$13,645
Total	\$809,322	<b>\$404,661</b>	\$404,661

\*Totals may differ due to rounding.

**Funding:**

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

## HEALTH-RELATED ACTIVITIES - CDSS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 65  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 233

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$298,645,000	\$300,852,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$298,645,000	\$300,852,000

**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:**

CWS Interagency Agreement (IA) 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:**

There is a decrease from the prior estimate for FY 2020-21 due to updated expenditure data provided by CDSS. The change from FY 2020-21 to FY 2021-22 in the current estimate is an increase due to updated expenditure data provided by CDSS on a cash basis.

**Methodology:**

The estimates, on a cash basis, were provided by CDSS.

## HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 65

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
CWS	\$301,314	\$150,657	\$150,657
CWS/CMS	\$7,030	\$3,515	\$3,515
CSBG/APS	\$288,946	\$144,473	\$144,473
<b>TOTAL</b>	<b>\$597,290</b>	<b>\$298,645</b>	<b>\$298,645</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
CWS	\$317,228	\$158,614	\$158,614
CWS/CMS	\$7,030	\$3,515	\$3,515
CSBG/APS	\$277,446	\$138,723	\$138,723
<b>TOTAL</b>	<b>\$601,704</b>	<b>\$300,852</b>	<b>\$300,852</b>

\*Totals may differ due to rounding.

**Funding:**

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

## CALHEERS DEVELOPMENT

**OTHER ADMIN. POLICY CHANGE NUMBER:** 66  
**IMPLEMENTATION DATE:** 6/2012  
**ANALYST:** Latoya Brown  
**FISCAL REFERENCE NUMBER:** 1679

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$129,262,000	\$116,227,000
<b>STATE FUNDS</b>	\$30,411,440	\$27,039,340
<b>FEDERAL FUNDS</b>	\$98,850,560	\$89,187,660

**Purpose:**

This policy change estimates the cost for the development, implementation, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This policy change also includes the cost for contractors to 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:**

COVID-19 Increased FMAP – Other Admin  
 COVID-19 Increased FMAP Extension – DHCS Admin

**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 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 and Health Exchange and Medi-Cal Interface (HEMI) web services.

## **CALHEERS DEVELOPMENT**

**OTHER ADMIN. POLICY CHANGE NUMBER: 66**

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 was 88/12 until September 30, 2019, 76.5/23.5 from October 1, 2019, through September 30, 2020, and 65/35 beginning October 1, 2020, onward. 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. In December 2019, CMS approved funding through federal fiscal year (FFY) 2021. The Department submitted an IAPDU in August 2020 to seek approval for funding through subsequent fiscal years.

### **Reason for Change:**

For the CalHEERS portion, the change for FY 2020-21, from the prior estimate is a decrease. The decrease is due to slight adjustments to projected costs in the FY 2020-21 budget.

The change from FY 2020-21 and FY 2021-22, in the current estimate, is a decrease due to a reduction in the system integrator contract costs for FY 2021-22, which also resulted in reduced support contract costs.

For the Enterprise Technology Services (ETS) portion, there is no change from the prior estimate for FY 2020-21, and there is no change from FY 2020-21 to FY 2021-22 in the current estimate.

### **Methodology:**

1. Contractors began D&I work in July 2012 with payments beginning in August 2012. M&O started in January 2015.
2. CalHEERS' costs are shared between Covered California and Medi-Cal based on the Cost Allocation Plan.
  - From October 1, 2018, to September 30, 2019, the cost share was 12.38% from Covered California and 87.62% from the Department,
  - Effective October 1, 2019, the cost share is 12.59% from Covered California and 87.41% from the Department;
  - All costs directly attributable to the Department will be the responsibility of the Department.
3. In FY 2020-21 and FY 2021-22, costs incurred are for CalHEERS' D&I and M&O.

The D&I period is eligible for:

  - 87.41% at 90% federal reimbursement,
  - 12.59% at 76.5% federal reimbursement from October 1, 2019, to September 30, 2020; and 65% federal reimbursement from October 1, 2020, and after.

The M&O period is eligible for:

  - 87.41% at 75% federal reimbursement,

**CALHEERS DEVELOPMENT**  
OTHER ADMIN. POLICY CHANGE NUMBER: 66

- 12.59% at 76.5% federal reimbursement from October 1, 2019, to September 30, 2020; and 65% federal reimbursement from October 1, 2020, and after.

4. The estimate for FY 2020-21 and FY 2021-22 are as follows:

<b>FY 2020-21</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
75% Title XIX FF / 25% GF	\$87,302,000	\$21,826,000	\$65,477,000
76.5% Title XXI FF / 23.5% GF	\$4,314,000	\$1,014,000	\$3,300,000
65% Title XXI FF / 35% GF	\$12,942,000	\$4,530,000	\$8,412,000
90% Title XIX FF / 10% GF	\$21,124,000	\$2,112,000	\$19,012,000
CalHEERS Subtotal	\$125,682,000	\$29,481,000	\$96,201,000
75% Title XIX FF / 25% GF	\$3,088,000	\$772,000	\$2,316,000
76.5 Title XXI FF / 23.5% GF	\$123,000	\$29,000	\$94,000
65% Title XXI FF / 35% GF	\$369,000	\$129,000	\$240,000
DHCS ETS Subtotal	\$3,580,000	\$930,000	\$2,650,000
<b>Total</b>	<b>\$129,262,000</b>	<b>\$30,411,000</b>	<b>\$98,851,000</b>

Totals may differ due to rounding.

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX (90% FF / 10% GF)	\$21,124,000	\$2,112,000	\$19,012,000
Title XIX (75% FF / 25% GF)	\$76,056,000	\$19,014,000	\$57,042,000
Title XXI (76.5% FF / 23.5% GF)	\$3,867,000	\$909,000	\$2,958,000
Title XXI (65% FF / 35% GF)	\$11,600,000	\$4,060,000	\$7,540,000
CalHEERS Subtotal	\$112,647,000	\$26,095,000	\$86,552,000
75% Title XIX FF / 25% GF	\$3,088,000	\$772,000	\$2,316,000
65% Title XXI FF / 35% GF	\$492,000	\$172,000	\$319,000
DHCS ETS Subtotal	\$3,580,000	\$944,000	\$2,636,000
<b>Total</b>	<b>\$116,227,000</b>	<b>\$27,039,000</b>	<b>\$89,188,000</b>

Totals may differ due to rounding.

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**CALHEERS DEVELOPMENT**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 66**

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

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

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

COVID-19 funding through June 30, 2021 is identified in the COVID-19 Increased FMAP – DHCS Admin policy change

COVID-19 funding after July 1, 2021 is roughly estimated and separately identified in the COVID-19 Increased FMAP Extension – DHCS Admin policy change

## CDDS ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 67  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Pang Moua  
**FISCAL REFERENCE NUMBER:** 243

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$80,796,000	\$66,507,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$80,796,000	\$66,507,000

**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 2020-21, from the prior estimate, is due to having more recent expenditure trends that inform the updated accrual estimate and paid expenditures that are updated through October 2020.

The change from FY 2020-21 to FY 2021-22, is due to accrual estimates reflecting updated expenditure trend data. Updated paid expenditure data informs assumed timing of payment of future expenditures.

**Methodology:**

CDDS provides the following cash estimates of its administrative cost components:



**CDDS ADMINISTRATIVE COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 67

FY 2020-21		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$2,226,000	\$2,226,000	03-75282/83
	DC/SOCF HIPAA*	\$180,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$525,000	\$525,000	01-15378
3	HCBS Waiver Admin.	\$40,677,000	\$40,677,000	01-15834
4	RC Medicaid Admin.	\$19,225,000	\$6,408,000	03-75734
5	NHR Admin.	\$351,000	\$351,000	03-75285
6	TCM Headquarters Admin.	\$16,974,000	\$16,974,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	<b>Total</b>	<b>\$80,796,000</b>	<b>\$67,160,000</b>	

FY 2021-22		DHCS FFP	CDDS GF	IA #
1	DC/SOCF Medi-Cal Admin.	\$2,055,000	\$2,055,000	03-75282/83
	DC/SOCF HIPAA*	\$180,000	\$0	03-75282/83
2	DC/SOCF Medi-Cal Elig	\$525,000	\$525,000	01-15378
3	HCBS Waiver Admin.	\$35,693,000	\$35,693,000	01-15834
4	RC Medicaid Admin.	\$18,168,000	\$6,056,000	03-75734
5	NHR Admin.	\$262,000	\$262,000	03-75285
6	TCM Headquarters Admin.	\$8,986,000	\$8,986,000	03-75284
	TCM HIPAA*	\$638,000	\$0	03-75284
	<b>Total</b>	<b>\$66,507,000</b>	<b>\$53,577,000</b>	

**Funding:**

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)\*

## MATERNAL AND CHILD HEALTH

**OTHER ADMIN. POLICY CHANGE NUMBER:** 68  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 234

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$51,251,000	\$47,668,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$51,251,000	\$47,668,000

**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 enrolled beneficiaries in accessing covered 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 enrolled 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 BIH Program.
- **Comprehensive Perinatal Services Program (CPSP):** Provides a wide range of services to Medi-Cal enrolled pregnant women, from conception through 60 days postpartum, and provide case management services and conduct follow-up to improve access to early obstetrical and post-partum care (60-days following the delivery) for Medi-Cal enrolled pregnant women.

## MATERNAL AND CHILD HEALTH

**OTHER ADMIN. POLICY CHANGE NUMBER: 68**

- 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 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 2020-21, is a decrease due to removing estimated costs for CHVP and PEI, previously assumed to be included in the estimate. The refined Title XIX guidance delayed submission of the prior year invoices for FY 2018-19 and FY 2019-20, resulting in FY 2019-20 and FY 2020-21 invoices to be reimbursed in FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to more prior year claims budgeted in FY 2020-21.

### 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)

<b>FY 2020-21</b>	<b>DHCS FFP</b>	<b>CDPH GF</b>	<b>County Match</b>
BIH	\$4,209	\$1,766	\$1,953
CPSP & PCG	\$45,738	\$0	\$32,452
AFLP	\$1,304	\$0	\$1,191
<b>Total for FY 2020-21</b>	<b>\$51,251</b>	<b>\$1,766</b>	<b>\$35,596</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>DHCS FFP</b>	<b>CDPH GF</b>	<b>County Match</b>
BIH	\$3,701	\$1,545	\$1,715
CPSP & PCG	\$42,590	\$0	\$30,197
AFLP	\$1,377	\$0	\$1,196
<b>Total for FY 2021-22</b>	<b>\$47,668</b>	<b>\$1,545</b>	<b>\$33,108</b>

### Funding:

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

## HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 69  
**IMPLEMENTATION DATE:** 7/1999  
**ANALYST:** Sabrina Blank  
**FISCAL REFERENCE NUMBER:** 246

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$41,379,000	\$41,379,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$41,379,000	\$41,379,000

**Purpose:**

This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

**Authority:**

Welfare & Institutions Code, Section 16501.3  
 AB 1111 (Chapter 147, Statutes of 1999)  
 SB 1013 (Chapter 35, Statutes of 2012)  
 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 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

## HEALTH OVERSIGHT & COORD. FOR FOSTER CARE CHILDREN

OTHER ADMIN. POLICY CHANGE NUMBER: 69

obligated to provide programs or levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100% General Funds.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

1. CDSS provides the annual Local Revenue Fund of \$13,793,000 for FY 2020-21 and FY 2021-22.

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>CDSS GF</b>	<b>DHCS FFP</b>
<b>FY 2020-21</b>	\$55,172	\$13,793	<b>\$41,379</b>
<b>FY 2021-22</b>	\$55,172	\$13,793	<b>\$41,379</b>

**Funding:**

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

## DEPARTMENT OF SOCIAL SERVICES ADMIN COST

**OTHER ADMIN. POLICY CHANGE NUMBER:** 70  
**IMPLEMENTATION DATE:** 7/2002  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 256

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$28,378,000	\$28,378,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$28,378,000	\$28,378,000

**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:**

IHSS PCSP Interagency Agreement (IA) 03-75676  
 IHSS Health Related IA 01-15931  
 CWS/CMS for Medi-Cal IA 06-55834  
 IHSS Plus Option Sec. 1915(j) IA 09-86307  
 SAWS IA 04-35639  
 Medi-Cal State Hearings IA 16-93214  
 Public Inquiry and Response IA 13-90113  
 Medicaid Disability Evaluation Services IA 13-90112  
 CECRIS IA 17-94471  
 Electronic Visit Verification IA 18-95714

**Interdependent Policy Changes:**

Not Applicable

**Background:**

These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Coordinated Care Initiative (CCI) IA, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

**Reason for Change:**

The change from the prior estimate, for FY 2020-21, is a slight increase due to revised expenditure data provided by CDSS. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

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

**DEPARTMENT OF SOCIAL SERVICES ADMIN COST**  
OTHER ADMIN. POLICY CHANGE NUMBER: 70

<b>FY 2020-21</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF</b>
IHSS PCSP	\$17,950,000	\$8,975,000	\$8,975,000
IHSS Health Related	\$128,000	\$64,000	\$64,000
CWS/CMS for Medi-Cal	\$2,000,000	\$1,000,000	\$1,000,000
IHSS Plus Option Sec. 1915(j)	\$5,928,000	\$2,964,000	\$2,964,000
SAWS	\$480,000	\$240,000	\$240,000
Medi-Cal State Hearings	\$19,304,000	\$9,652,000	\$9,652,000
Public Inquiry and Response	\$500,000	\$250,000	\$250,000
Medicaid Disability Evaluation Services	\$5,902,000	\$2,951,000	\$2,951,000
CECRIS	\$164,000	\$82,000	\$82,000
Electronic Visit Verification	\$4,400,000	\$2,200,000	\$2,200,000
<b>TOTAL</b>	<b>\$56,756,000</b>	<b>\$28,378,000</b>	<b>\$28,378,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF</b>
IHSS PCSP	\$17,950,000	\$8,975,000	\$8,975,000
IHSS Health Related	\$128,000	\$64,000	\$64,000
CWS/CMS for Medi-Cal	\$2,000,000	\$1,000,000	\$1,000,000
IHSS Plus Option Sec. 1915(j)	\$5,928,000	\$2,964,000	\$2,964,000
SAWS	\$480,000	\$240,000	\$240,000
Medi-Cal State Hearings	\$19,304,000	\$9,652,000	\$9,652,000
Public Inquiry and Response	\$500,000	\$250,000	\$250,000
Medicaid Disability Evaluation Services	\$5,902,000	\$2,951,000	\$2,951,000
CECRIS	\$164,000	\$82,000	\$82,000
Electronic Visit Verification	\$4,400,000	\$2,200,000	\$2,200,000
<b>TOTAL</b>	<b>\$56,756,000</b>	<b>\$28,378,000</b>	<b>\$28,378,000</b>

\* 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:** 71  
**IMPLEMENTATION DATE:** 7/2007  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1192

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$30,057,000	\$18,296,000
<b>STATE FUNDS</b>	\$8,606,500	\$5,007,000
<b>FEDERAL FUNDS</b>	\$21,450,500	\$13,289,000

**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 07-65693 A01  
 IA 10-87042 A02  
 IA 18-95089  
 AB 1559 (Chapter 565, Statutes of 2014)  
 SB 853 (Chapter 717, Statutes of 2010)

**Interdependent Policy Changes:**

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: Comprehensive Perinatal Services Program, 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: 71

The Office of AIDS operates and administers the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency 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 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. Federal Fund Participation (FFP) for targeted case management is subject to pending review and approval of State Plan Amendment 15-002B by CMS.

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.

SNF: 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 2020-21, is a net increase due to the FY 2018-19 and FY 2019-20 claims for MCAH previously budgeted in FY 2019-20 due to invoicing delays.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to more prior year claims in FY 2020-21 for SNF, and an increase in MCAH support costs in FY 2020-21.

### **Methodology:**

1. CDPH provides the General Fund match.
2. For MCAH, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel (SPMP) costs for eligible activities. The estimate also includes funding for the Black Infant Health Program.

## FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 71

3. CDPH provided the following estimates.

<b>FY 2020-21 (Cash Basis)</b>	<b>DHCS FFP*</b>	<b>DHCS SF**</b>	<b>CDPH GF</b>	<b>Other Match</b>
MCAH	\$7,083,000	\$0	\$7,083,000	\$0
Office of AIDS	\$869,000	\$0	\$869,000	\$0
CLPP	\$2,505,000	\$0	\$0	\$2,505,000
CHCQ	\$2,387,000	\$0	\$0	\$2,387,000
Skilled Nursing Facilities	\$8,606,000	\$8,607,000	\$0	\$0
<b>Total</b>	<b>\$21,450,000</b>	<b>\$8,607,000</b>	<b>\$7,952,000</b>	<b>\$4,892,000</b>

<b>FY 2021-22 (Cash Basis)</b>	<b>DHCS FFP*</b>	<b>DHCS SF**</b>	<b>CDPH GF</b>	<b>Other Match</b>
MCAH	\$2,728,000	\$0	\$2,728,000	\$0
Office of AIDS	\$735,000	\$0	\$735,000	\$0
CLPP	\$2,432,000	\$0	\$0	\$2,432,000
CHCQ	\$2,387,000	\$0	\$0	\$2,387,000
Skilled Nursing Facilities	\$5,007,000	\$5,007,000	\$0	\$0
<b>Total</b>	<b>\$13,289,000</b>	<b>\$5,007,000</b>	<b>\$3,463,000</b>	<b>\$4,819,000</b>

**Funding:**

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

SNF Quality & Accountability (non-GF) (4260-605-3167)\*\*

## DEPARTMENT OF AGING ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 72  
**IMPLEMENTATION DATE:** 7/1984  
**ANALYST:** Kalandie Coleman  
**FISCAL REFERENCE NUMBER:** 253

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$5,771,000	\$4,700,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$5,771,000	\$4,700,000

**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 individuals utilizing Aging and Disability Resource Centers (ADRC).

**Authority:**

Interagency Agreements:  
 CBAS 03-76137  
 MSSP 01-15976  
 ADRC 20-10268

**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 for FY 2020-21, from the prior estimate, is an increase due to updated invoicing and accounting data, funding increases included in the enacted budget, and estimated employee compensation and benefit adjustments. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to updated cash estimates provided by CDA.

**Methodology:**

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

**DEPARTMENT OF AGING ADMINISTRATIVE COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 72

(Dollars in Thousands)

<b>Program Support</b>	<b>FY 2020-21</b>		<b>FY 2021-22</b>	
<b>CBAS Support</b>	<b>CDA GF</b>	<b>FFP</b>	<b>CDA GF</b>	<b>FFP</b>
FY 2019-20 DOS	\$300	\$448	\$0	\$0
FY 2020-21 DOS	\$3,335	\$3,111	\$229	\$259
FY 2021-22 DOS	\$0	\$0	\$2,300	\$2,593
<b>Total CBAS</b>	\$3,635	\$3,559	\$2,529	\$2,852
<b>MSSP Support</b>				
FY 2019-20 DOS	\$97	\$154	\$0	\$0
FY 2020-21 DOS	\$1,969	\$1,701	\$127	\$142
FY 2021-22 DOS	\$0	\$0	\$1,305	\$1,416
<b>Total MSSP</b>	\$2,066	\$1,854	\$1,433	\$1,558
<b>ADRC Support*</b>				
FY 2019-20 DOS	\$0	\$68	\$0	\$0
FY 2020-21 DOS	\$0	\$290	\$0	\$0
FY 2021-22 DOS	\$0	\$0	\$0	\$290
<b>Total ADRC</b>	\$0	\$358	\$0	\$290
<b>Grand Total</b>	\$5,701	<b>\$5,771</b>	\$3,962	<b>\$4,700</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% MFP Federal Grant (4260-106-0890)\*

## CLPP CASE MANAGEMENT SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 73  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 239

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$8,346,000	\$4,200,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$8,346,000	\$4,200,000

**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 2020-21 is due to the delay in local jurisdictions invoicing to the State. Estimated FY 2018-19 and FY 2019-20 will be invoiced in FY 2020-21.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to more prior year claims paid in FY 2020-21.

**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: 73

2. The estimates are provided by CDPH on a cash basis.

(Dollars in Thousands)

<b>FY 2020-21</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
FY 2018-19 Claims	\$2,437	\$2,437
FY 2019-20 Claims	\$2,759	\$2,759
FY 2020-21 Claims	\$3,150	\$3,150
<b>Total for FY 2020-21</b>	<b>\$8,346</b>	<b>\$8,346</b>

(Dollars in Thousands)

<b>FY 2021-22</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
FY 2019-20 Claims	\$1,050	\$1,050
FY 2020-21 Claims	\$3,150	\$3,150
<b>Total for FY 2021-22</b>	<b>\$4,200</b>	<b>\$4,200</b>

**Funding:**

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

## CALIFORNIA SMOKERS' HELPLINE

**OTHER ADMIN. POLICY CHANGE NUMBER:** 74  
**IMPLEMENTATION DATE:** 1/2014  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1680

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$3,293,000	\$2,400,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$3,293,000	\$2,400,000

**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 helpline 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:**

There change from the prior estimate for FY 2020-21 is an increase due to shifting FY 2019-20 claims payment to FY 2020-21, previously budgeted to be paid in FY 2019-20.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to fewer prior year invoices paid in FY 2021-22.

**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 is \$3,293,000 for FY 2020-21 and \$2,400,000 for FY 2021-22. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

**CALIFORNIA SMOKERS' HELPLINE**  
OTHER ADMIN. POLICY CHANGE NUMBER: 74

3. The estimated administrative cost reimbursements, for FY 2020-21 and FY 2021-22, on a cash basis are:

<b>FY 2020-21</b>	<b>TF</b>	<b>FF</b>
FY 2018-19 Claims	\$1,293,000	\$1,293,000
FY 2019-20 Claims	\$2,000,000	\$2,000,000
<b>Total for FY 2020-21</b>	<b>\$3,293,000</b>	<b>\$3,293,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>FF</b>
FY 2019-20 Claims	\$400,000	\$400,000
FY 2020-21 Claims	\$2,000,000	\$2,000,000
<b>Total for FY 2021-22</b>	<b>\$2,400,000</b>	<b>\$2,400,000</b>

**Funding:**

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



## VITAL RECORDS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 75  
**IMPLEMENTATION DATE:** 5/2016  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 1774

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,404,000	\$890,000
<b>STATE FUNDS</b>	\$14,000	\$8,000
<b>FEDERAL FUNDS</b>	\$1,390,000	\$882,000

**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 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.

Beginning July 2018, the Department entered into a contract with CDPH to provide certified copies of vital records as required for business needs.

**Reason for Change:**

The change in FY 2020-21, from the prior estimate, is an increase due to late invoices received in July for FY 2019-20 Vital Records data. The change from FY 2020-21 to FY 2021-22, in the current estimate, is a decrease due to late FY 2019-20 invoices being paid in FY 2020-21.

## VITAL RECORDS

OTHER ADMIN. POLICY CHANGE NUMBER: 75

**Methodology:**

1. The annual contract to deliver vital records data is \$1,166,000 TF. The Department and CDPH receive 75% FFP for ongoing costs to deliver vital records data and 25% match from CDPH from the Health Statistics Special Fund (HSSF).
2. The annual contract to provide certified copies is \$16,632 TF (\$8,316 GF).
3. 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. The estimated reimbursements for FY 2020-21 and FY 2021-22 on a cash basis are:

*(Totals Rounded to Thousands)*

<b>FY 2020-21</b>	<b>TF</b>	<b>HSSF</b>	<b>GF</b>	<b>FF</b>
FY 2019-20 Records Data	\$960,000	\$240,000	\$0	\$720,000
FY 2019-20 Certified Copies	\$16,000	\$0	\$8,000	\$8,000
FY 2020-21 Records Data	\$874,000	\$218,000	\$0	\$656,000
FY 2020-21 Certified Copies	\$12,000	\$0	\$6,000	\$6,000
<b>Total</b>	<b>\$1,862,000</b>	<b>\$458,000</b>	<b>\$14,000</b>	<b>\$1,390,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>HSSF</b>	<b>GF</b>	<b>FF</b>
FY 2020-21 Records Data	\$291,000	\$73,000	\$0	\$218,000
FY 2020-21 Certified Copies	\$4,000	\$0	\$2,000	\$2,000
FY 2021-22 Records Data	\$874,000	\$218,000	\$0	\$656,000
FY 2021-22 Certified Copies	\$12,000	\$0	\$6,000	\$6,000
<b>Total</b>	<b>\$1,181,000</b>	<b>\$291,000</b>	<b>\$8,000</b>	<b>\$882,000</b>

\*Totals may differ due to rounding.

**Funding:**

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

## VETERANS BENEFITS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 76  
**IMPLEMENTATION DATE:** 12/1988  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 232

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,100,000	\$1,100,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,100,000	\$1,100,000

**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 (IA) # 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 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 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

- The contract amount is estimated to be \$1,100,000 for FY 2020-21 and FY 2021-22. The non-federal match is budgeted by CDVA.

FY	FY 2020-21			FY 2021-22		
	Cash Basis	TF	CDVA GF	DHCS FF	TF	CDVA GF
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
<b>Total</b>	<b>\$2,200,000</b>	<b>\$1,100,000</b>	<b>\$1,100,000</b>	<b>\$2,200,000</b>	<b>\$1,100,000</b>	<b>\$1,100,000</b>

**Funding:**

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

## KIT FOR NEW PARENTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 77  
**IMPLEMENTATION DATE:** 7/2001  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 249

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,536,000	\$912,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,536,000	\$912,000

**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 2020-21 is an increase due to:

- FY 2018-19 and FY 2019-20 invoices that were estimated to be paid in FY 2019-20, will be paid in FY 2020-21; and
- Updating the estimated number of kits to be distributed.

The change in the current estimate, from FY 2020-21 to FY 2021-22 is an increased annual estimated number of kits to be distributed in FY 2021-22 due to increasing outreach to hard-to-reach and low-income communities.

**Methodology:**

1. CCFC will distribute an estimated 175,000 kits in FY 2020-21 and 300,000 kits in FY 2021-22. Of these kits, 43.38% are expected to be distributed to Medi-Cal eligible newborns.
2. Each kit, basic or custom, costs \$15.63 for FY 2020-21 and FY 2021-22.
3. For FY 2020-21, the Department will pay for the estimated cost of kits distributed to parents of Medi-Cal eligible newborns in FY 2018-19 and in FY 2019-20. There were 176,268 kits distributed at a cost of \$15.63 each in FY 2018-19, and 145,597 kits distributed at a cost of \$15.63 each in FY 2019-20.

**KIT FOR NEW PARENTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 77

	<b>Annual Number of Kits</b>	<b>Medi-Cal</b>	<b>Total Medi-Cal Kits</b>	<b>Cost per kit</b>	<b>Total Cost (Accrual)</b>
FY 2018-19	176,268	43.38%	76,465	\$15.63	\$1,195,149
FY 2019-20	145,597	43.38%	63,160	\$15.63	\$987,190
FY 2020-21	175,000	43.38%	75,915	\$15.63	\$1,186,551
FY 2021-22	300,000	43.38%	130,140	\$15.63	\$2,034,088

4. Assume for FY 2021-22 and FY 2021-22, 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.

<b>Fiscal Year</b>	<b>Accrual (Rounded)</b>	<b>FY 2020-21</b>	<b>FY 2021-22</b>
FY 2018-19	\$1,195,000	\$1,195,000	\$0
FY 2019-20	\$987,000	\$987,000	\$0
FY 2020-21	\$1,187,000	\$890,000	\$297,000
FY 2021-22	\$2,034,000	\$0	\$1,526,000
Total		\$3,072,000	\$1,823,000
<b>Total FF (50%)</b>		<b>\$1,536,000</b>	<b>\$912,000</b>

**Funding:**

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

## MEDI-CAL INPATIENT SERVICES FOR INMATES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 78  
**IMPLEMENTATION DATE:** 3/2011  
**ANALYST:** Jedidiah Warren  
**FISCAL REFERENCE NUMBER:** 1665

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$1,036,000	\$1,036,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,036,000	\$1,036,000

**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. The County Administration Allocation Policy Change covers the county FFP associated with Medi-Cal eligibility determination activities for county inmates.

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## **MEDI-CAL INPATIENT SERVICES FOR INMATES**

**OTHER ADMIN. POLICY CHANGE NUMBER: 78**

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. There is no change from FY 2020-21 to FY 2021-22 in the current estimate.

**Methodology:**

1. Implementation of the Inmate Eligibility Program began April 1, 2011.
2. Interagency Agreement #15-92398 expires December 31, 2020. Assume a new contract will be in place by January 2021.
3. Reimbursements for administrative costs began in March 2011.
4. The federal share of ongoing administrative costs is **\$1,036,000** in **FY 2020-21** and **\$1,036,000** in **FY 2021-22**.

**Funding:**

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

## CHHS AGENCY HIPAA FUNDING

**OTHER ADMIN. POLICY CHANGE NUMBER:** 79  
**IMPLEMENTATION DATE:** 7/2001  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 257

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$1,004,000	\$1,022,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,004,000	\$1,022,000

**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; 20-10133

**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 with an end date of June 30, 2020. An IA beginning July 1, 2020 has been executed and it is with payments starting in August 2020.

**Reason for Change:**

There is no change from the prior estimate for FY 2020-21. The change from FY 2020-21 to FY 2021-22 is due to increased contract costs from the associated IA with CHHS.

**Methodology:**

The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
<b>FY 2020-21</b>	<b>\$1,004,000</b>	\$1,004,000
<b>FY 2021-22</b>	<b>\$1,022,000</b>	\$1,022,000

**Funding:**

100% HIPAA (4260-117-0890)



## FEDERAL FUNDING FOR HEALTH CARE PAYMENTS DATA PROG

**OTHER ADMIN. POLICY CHANGE NUMBER:** 80  
**IMPLEMENTATION DATE:** 7/2020  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 2244

	<b>FY 2020-21</b>	<b>FY 2021-22</b>
<b>TOTAL FUNDS</b>	\$1,050,000	\$5,009,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$1,050,000	\$5,009,000

**Purpose:**

This policy change estimates the federal reimbursement process between Department of Health Care Services (DHCS) and the Office of Statewide Health Planning and Development (OSHPD) for the Health Care Payments Data Program.

**Authority:**

Health & Safety Code (Division 107, Part 2, Chapter 8.5, §§127671-127674.1)  
 Interagency Agreement (IA) # 20-10306

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Health Care Payments Data Program will create a process to collect health care data in a standardized format in one statewide system and will provide greater transparency regarding health care costs, quality, and equity. The system will be managed by OSHPD and include data for all Medi-Cal beneficiaries. The information can be used to inform policy decisions regarding the provision of quality health care, reduce disparities, and reduce health care costs while preserving consumer privacy.

This policy change provides DHCS the appropriate mechanism to transfer the federal portion of the Health Care Data Payments system costs to OSHPD. OSHPD is providing the state share.

**Reason for Change:**

This is a new policy change.

**Methodology:**

- Costs are estimated at \$1,050,182 for FY 2020-21 and \$5,009,007 for FY 2021-22.

	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$1,050,000</b>	<b>\$0</b>	<b>\$1,050,000</b>
<b>FY 2021-22</b>	<b>\$5,009,000</b>	<b>\$0</b>	<b>\$5,009,000</b>

**Funding:**

100% Title XIX FF (4260-101-0890)  
 100% Title XXI FF (4260-113-0890)

## MERIT SYSTEM SERVICES FOR COUNTIES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 81  
**IMPLEMENTATION DATE:** 7/2003  
**ANALYST:** Matt Wong  
**FISCAL REFERENCE NUMBER:** 263

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$190,000	\$190,000
<b>STATE FUNDS</b>	\$95,000	\$95,000
<b>FEDERAL FUNDS</b>	\$95,000	\$95,000

**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 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:**

There is no change from the prior estimate for FY 2020-21. There is no change in the current estimate from FY 2020-21 to FY 2021-22.

**Methodology:**

1. CalHR provided the estimates on a cash basis.
2. The estimated reimbursement is \$190,000 TF (\$95,000 GF) in FY 2020-21 and \$190,000 TF (\$95,000 GF) in FY 2021-22.

**Funding:**

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

## CDPH I&E PROGRAM AND EVALUATION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 82  
**IMPLEMENTATION DATE:** 7/2003  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 261

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$277,000	\$187,000
<b>STATE FUNDS</b>	\$0	\$0
<b>FEDERAL FUNDS</b>	\$277,000	\$187,000

**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 Planning, Access, Care, and Treatment (FPACT) 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 program's administrative costs.

**Reason for Change:**

The change from the prior estimate, for FY 2020-21 is a decrease due to delayed submission of the invoices for FY 2018-19 and FY 2019-20.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to completion of FY 2019-20 claims paid in FY 2020-21.

**CDPH I&E PROGRAM AND EVALUATION**  
OTHER ADMIN. POLICY CHANGE NUMBER: 82

**Methodology:**

1. CDPH budgets the non-federal matching funds.
2. The estimates are provided by CDPH on a cash basis.

<b>FY 2020-21</b>	<b>TF</b>	<b>CDPH GF</b>	<b>DHCS FF</b>
FY 2018-20 Claims	\$16,000	\$8,000	\$8,000
FY 2019-20 Claims	\$374,000	\$187,000	\$187,000
FY 2020-21 Claims	\$164,000	\$82,000	\$82,000
<b>Total for FY 2020-21</b>	<b>\$554,000</b>	<b>\$277,000</b>	<b>\$277,000</b>

<b>FY 2021-22</b>	<b>TF</b>	<b>CDPH GF</b>	<b>DHCS FF</b>
FY 2020-21 Claims	\$210,000	\$105,000	\$105,000
FY 2021-22 Claims	\$164,000	\$82,000	\$82,000
<b>Total for FY 2021-22</b>	<b>\$374,000</b>	<b>\$187,000</b>	<b>\$187,000</b>

**Funding:**

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

## PIA EYEWEAR COURIER SERVICE

**OTHER ADMIN. POLICY CHANGE NUMBER:** 83  
**IMPLEMENTATION DATE:** 7/2003  
**ANALYST:** Autumn Recce  
**FISCAL REFERENCE NUMBER:** 1114

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$653,000	\$814,000
<b>STATE FUNDS</b>	\$326,500	\$407,000
<b>FEDERAL FUNDS</b>	\$326,500	\$407,000

**Purpose:**

This policy change estimates courier services costs for Prison Industry Authority (PIA) eyewear.

**Authority:**

Interagency Agreement (IA) #18-95000

**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. SB 78 (Chapter 38, Statutes of 2019) restored optician and optical lab services, including providing eyeglasses, to eligible individuals 21 years of age and older beginning January 1, 2020, and ending December 31, 2021.

**Reason for Change:**

The change from the prior estimate for FY 2020-21 is due to a reduction in utilization caused by the COVID-19 pandemic shut down and a decrease in the demand for eyeglasses resulting from public health concerns.

The change in the current estimate, from FY 2020-21 to FY 2021-22, is due to:

- An increase in couriers costs resulting from an estimated return to previous pre-COVID-19 utilization
- A decrease in couriers costs in FY 2021-22 Q4 resulting from the suspension of optician and optical lab services for beneficiaries 21 years of age and older.

**Methodology:**

1. PIA contracts with a courier service company for the pick-up and delivery of orders to optical providers. The Department is responsible for one-half of the delivery cost of \$2.13 per package, with no fuel surcharge.

**PIA EYEWEAR COURIER SERVICE**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 83**

2. Assume 306,700 packages will be paid in FY 2020-21 which includes actuals paid in FY 2020-21 Q1 and an estimated 25% reduction in usual estimated utilization for FY 2020-21 Q2 and Q3 due to the effects of COVID-19. FY 2020-21 Q4 assumes pre-COVID-19 estimated costs.

FY 2020-21 Q1: 30,707 actual packages  
 FY 2020-21 Q2: 82,798 estimated packages  
 FY 2020-21 Q3: 82,798 estimated packages  
 FY 2020-21 Q4: 110,397 estimated packages  
 Total 2020-21: 306,700 estimated packages

$\$2.13 * 306,700 = \$653,000$  (rounded)

3. Assume 382,024 packages will be paid in FY 2021-22 based upon a return to pre-COVID-19 estimated costs for Q1-Q3 and then a reduction in Q4 estimated costs due to the suspension of optician and optical lab services to beneficiaries 21 years of age and older.

FY 2021-22 Q1: 110,397 estimated packages  
 FY 2021-22 Q2: 110,397 estimated packages  
 FY 2021-22 Q3: 110,397 estimated packages  
 FY 2021-22 Q4: 50,833 estimated packages  
 Total 2020-21: 382,024 estimated packages

$\$2.13 \times 382,024 = \$814,000$  TF (rounded)

<b>Fiscal Year</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2020-21</b>	<b>\$653,000</b>	<b>\$326,000</b>	<b>\$327,000</b>
<b>FY 2021-22</b>	<b>\$814,000</b>	<b>\$407,000</b>	<b>\$407,000</b>

**Funding:**

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

## MEDI-CAL NONMEDICAL TRANSPORTATION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 84  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 2073

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$1,704,000
<b>STATE FUNDS</b>	\$0	\$477,000
<b>FEDERAL FUNDS</b>	\$0	\$1,227,000

**Purpose:**

This policy change estimates the Medical Fiscal Intermediary (FI) Contract and mileage reimbursement costs for Medi-Cal nonmedical transportation (NMT) services for Fee-for-Service (FFS) beneficiaries.

**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 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

Effective July 1, 2021, the Department will coordinate and facilitate mileage reimbursements for all FFS beneficiaries using the current manual process for beneficiary reimbursements. In addition, the Department will expand its Medical Fiscal Intermediary (FI) optional contractual services to cover the cost of NMT technology costs. By January 2022, the Department anticipates that the Medi-Cal FI will have

## MEDI-CAL NONMEDICAL TRANSPORTATION

### OTHER ADMIN. POLICY CHANGE NUMBER: 84

technology in place to process the beneficiary reimbursements. A State Plan Amendment will be necessary to implement mileage reimbursement.

#### Reason for Change:

This is a new policy change.

#### Methodology:

1. Phase I for NMT services was implemented on July 1, 2018; Costs for NMT are now incorporated 100% in FFS base data and therefore not included in this policy change.
2. Assume Phase II activities for NMT will start in July 2021 using the current manual process for beneficiary reimbursements. By January 2022, the Medical FI will have technology in place to process the beneficiary reimbursements.
3. Assume the Department will expand its Medical Fiscal Intermediary (FI) optional contractual services by \$1,500,000 TF in FY 2021-22 to cover the cost of NMT technology costs.
4. Assume that eligible FFS beneficiaries requesting mileage reimbursement will make approximately 43,500 round trips in FY 2021-22.
5. Assume that 90% of the trips will average 25 miles per round trip and 10% will average 50 miles per round trip.
6. Assume that Medi-Cal will pay the Internal Revenue Services' medical mileage reimbursement rate of 17 cents per mile for an average cost of \$4.25 per 25-mile roundtrip, and \$8.50 per 50-mile roundtrip.
7. Assume the total mileage reimbursements for round trips costs for FFS beneficiaries would total \$204,000 TF in FY 2020-21.
8. Total costs for NMT services is estimated to be:

<b>FY 2021-22</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Medical FI Contract*	\$1,500,000	\$375,000	\$1,125,000
Mileage Reimbursement	\$204,000	\$102,000	\$102,000
<b>Total</b>	<b>\$1,704,000</b>	<b>\$477,000</b>	<b>\$1,227,000</b>

#### Funding:

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

\*FI 75% Title XIX / 25% GF (4260-101-0001/0890)



## COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN

**OTHER ADMIN. POLICY CHANGE NUMBER:** 86  
**IMPLEMENTATION DATE:** 7/2021  
**ANALYST:** Jerrold Anub  
**FISCAL REFERENCE NUMBER:** 2258

	<u>FY 2020-21</u>	<u>FY 2021-22</u>
<b>TOTAL FUNDS</b>	\$0	\$0
<b>STATE FUNDS</b>	\$0	-\$1,556,000
<b>FEDERAL FUNDS</b>	\$0	\$1,556,000

**Purpose:**

This policy change estimates the CHIP administrative expenditures of an assumed extension of the availability of increased federal medical assistance percentage (FMAP) from July 2021 through December 2021. For the estimated impact of assuming an extension of the availability of increased FMAP from July 2021 through December 2021 on benefits expenditures, see the COVID-19 Increased FMAP Extension - DHCS policy change. For the estimated impact of increased FMAP from January 2020 through June 2021, see the COVID-19 Increased FMAP - DHCS and COVID-19 Increased FMAP – Other Admin policy changes.

**Authority:**

Families First Coronavirus Response Act (FFCRA)  
 Coronavirus Aid, Relief, and Economic Security (CARES) Act

**Interdependent Policy Changes:**

Not Applicable

**Background:**

On March 4, 2020, Governor Newsom declared a state of emergency in response to the developing pandemic of COVID-19. A statewide stay at home order was introduced on March 19, 2020. The federal government declared a national public health emergency on January 31, 2020, and a national emergency on March 13, 2020. The public health emergency was extended on October 23, 2020, and will be effective for 90 days unless extended. These actions triggered the availability of Medicaid and Children's Health Insurance Program flexibilities, including under Section 1135 of the Social Security Act. Additionally, the President signed major federal legislation—including the FFCRA and the CARES Act—that provides increased federal funding in Medicaid and creates new options for states to address the COVID-19 pandemic.

The effects of the COVID-19 pandemic are unprecedented in modern times from a public health emergency and economic perspective. This will have fiscal impacts across policy areas and beneficiary populations within the Medi-Cal program.

The increased FMAP is effective January 1, 2020, and extends through the last day of the calendar quarter of the Health and Human Services COVID-19 national public health emergency.

**Reason for Change:**

This is a new policy change.

## COVID-19 INCREASED FMAP EXTENSION - OTHER ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 86

**Methodology:**

1. A CHIP FMAP increase of 4.34% is applicable on CHIP expenditures, including CHIP Administration expenditures.
2. The COVID-19 Increased FMAP Extension policy change assumes a 6-month extension of the COVID-19 Increased FMAP policy change and is assumed to continue through December 31, 2021.
3. The following estimates are on a cash basis:

(Dollars in Thousands)

FY 2021-22	TF	GF	FF
FFCRA 4.34% Increased FFP	\$0	(\$1,558)	\$1,558
<b>Total</b>	<b>\$0</b>	<b>(\$1,558)</b>	<b>\$1,558</b>

**Funding:**

FFCRA 4.34% Increased FFP (4260-113-0890)  
 FFCRA 4.34% GF (4260-113-0001)  
 FFCRA 4.34% Increased FFP FI (4260-113-0890)  
 FFCRA 4.34% GF FI (4260-113-0001)

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*The Additional Information section provides supplemental information in support of the Medi-Cal Local Assistance Estimate.*

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**MEDI-CAL INFORMATION ONLY**  
**November 2020**  
**FISCAL YEARS 2020-21 & 2021-22**

**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:

$$\begin{aligned} \text{USERS} &= f(\text{TND}, \text{S.QV}, \text{O.QV}, \text{Eligibles}) \\ \text{CLAIMS/USER} &= f(\text{TND}, \text{S.QV}, \text{O.QV}) \\ \text{\$/CLAIM} &= f(\text{TND}, \text{S.QV}, \text{O.QV}) \end{aligned}$$

WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\\$/CLAIM	= Total monthly 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](http://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](http://www.dhcs.ca.gov)).

Nursing Facilities

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Long Term Care Nursing Facility</li><li>• Long Term Care Intermediate Care Facility (NF-A)</li><li>• Pediatric Subacute Care – Long Term Care</li><li>• These three provider types include Nursing Facility - Level A (NF-A), Nursing Facility – Level B (NF-B), Distinct Part Skilled Nursing</li></ul> | 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 Affordable Care Act (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 Affordable Care Act (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 Federal Financial Participation (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) Federal Medical Assistance Percentage provided to California by 23 percent, to 88 percent FFP, up from 65 percent. **This increase has now phased out and the state once again receives 65 percent FFP for CHIP, effective October 2020.**

In response to the federal ACA mandate and State legislative direction, the Department chose the Health and Human Services 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 older adults, 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

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## HOME AND COMMUNITY BASED SERVICES

### 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) was approved from October 1, 2011 through September 30, 2016. The Department initiated the 1915(i) renewal process by submitting a SPA renewal to the Centers for Medicare and Medicaid Services (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 the California Department of Developmental Services (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 include several different increase models including a 5% rate increase on services and survey based increases on wages.

The Department submitted a SPA to update the service specifications for respite care as required by CMS' companion letter to:

- Remove group-supported employment and specialized therapeutic services,
- Add housing access, family support, occupational therapy, physical therapy, and family/consumer training services, and
- Add Enhanced Behavioral Supports Home (EBSH) as a new setting for habilitation-community living arrangement services.

This amendment also established reimbursement methodologies for EBSH and incentive payments for individual supported employment providers, effective July 1, 2018.

The Department submitted a SPA to add the following:

- Community Crisis as a provider type under Behavioral Intervention Services,
- Categorically and medically needy limits, and
- The associated rate methodology.

The approved effective date was October 2, 2018.

The Department submitted a SPA to make changes to the reimbursement methodology to implement a one-year rate increase for certain services in high cost counties. CMS approved the SPA, effective May 1, 2019.

The Department ~~will submit~~ **submitted** a SPA to increase reimbursement rates for specified service providers for the period of January 1, 2020, to December 31, 2021, as authorized under W&I Code section 4691.12. The proposed effective date of the SPA is January 1, 2020.

## HOME AND COMMUNITY BASED SERVICES

**The Department submitted a SPA to add state-operated mobile crisis teams as a provider type under Behavioral Intervention Services and rate methodologies for state-operated services for the developmentally disabled. The proposed effective date of the SPA is May 1, 2020.**

**The Department will submit a SPA to add Intensive Transition Services and Speech-Language Pathology Assistants as a new provider type. The proposed effective date of the SPA is July 1, 2020.**

### 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), Home and Community Based Alternatives (HCBA), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with DD, and Self-Determination Program (SDP) Waiver for Persons with DD. A beneficiary may be enrolled in only one HCBS waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

#### Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, and community transition in 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 amended the ALW and authorized funding to add an additional 2,000 slots effective July 1, 2018, **bringing capacity up to 5,744.** CMS approved a renewal of the ALW on February 28, 2019 effective from March 1, 2019 to February 28, 2024.

The Department will be assessing the ALW for integration in the HCBA 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*

## HOME AND COMMUNITY BASED SERVICES

*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 **1115** 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. **The Department is proposing a one-year extension of this waiver to December 31, 2021.**

**Due to the COVID-19 pandemic, CBAS centers were not able to provide services in a congregate setting beginning the second half of March 2020. In response, the Department and the California Department of Aging (CDA) developed a new CBAS service delivery model, known as Temporary Alternative Services (TAS). Under this model, CBAS centers provide limited individual in-center activities, as well as telephonic, telehealth and in-home services to CBAS participants. This temporary model is effective through the duration of the public health emergency.**

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (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 the Budget Act of 2019, the Department shall develop **implemented** the structure and parameters for **of provider** supplemental payments for **qualified** CBAS in **services. The supplemental payments structure is subject to suspension on June 30, 2021. The Governor's Budget proposes to extend the supplemental payments until December 31, 2022.**

### Home and Community-Based Alternatives (HCBA) Waiver

The HCBA Waiver provides Medi-Cal members with long-term medical conditions, who meet the adult or pediatric acute hospital, subacute, or nursing facility (NF) Level of Care (LOC), with the option of returning to and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The Department contracts with Waiver Agencies for the purpose of performing waiver administration functions and providing the Comprehensive Care Management waiver service. The Waiver Agencies are responsible for functions including: participant enrollment, LOC evaluations, person-centered care/service plan review and approval, waiver service authorization, utilization management, provider enrollment/network development, quality assurance activities and reporting to the Department.

## HOME AND COMMUNITY BASED SERVICES

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 implemented the Waiver Agency model on July 1, 2018. The HCBA Waiver will serve up to 8,964 participants by the end of the 5-year waiver term. On October 1, 2019, the Department submitted an amendment to the HCBA Waiver to CMS for approval in order to modify waiver enrollment policy prioritizing all eligible individuals under the age of 21 for intake processing and increase the number of waiver slots allocated for reserved capacity enrollment in years four and five. Reserved capacity waiver slots may only be used by specific groups of individuals, as identified in the HCBA Waiver. CMS approved the amendment, effective January 1, 2020. Additionally, the Department will be assessing integration of the ALW into the HCBA Waiver during the next HCBA Waiver renewal.

### In-Home Operations (IHO) Waiver

~~The IHO waiver served 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 did not renew the IHO Waiver at the expiration of the current waiver term. At the point of annual reassessment for each participant, the Department offered the option of transitioning to the HCBA Waiver. All IHO Waiver participants were 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 for the period of January 1, 2017 to December 31, 2021.

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, minor home repair/maintenance and communication services.

~~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.~~

~~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 program provides services under a federal 1915(c) home and community-based services waiver.** The Department submitted a Waiver Renewal waiver renewal application on March 28, 2019. The~~

## HOME AND COMMUNITY BASED SERVICES

MSSP Waiver ended on June 30, 2019, and CMS approved a 90-day Temporary Extension in order to resolve CMS questions related to the ~~Renewal~~ **renewal** application. The Department responded to all requests for additional information, and CMS approved and renewed the MSSP Waiver on November 1, 2019 for an additional five-year term, effective July 1, 2019.

~~Under CMS approval to carve out MSSP from the CCI, the MSSP benefit will be removed effective January 1, 2021.~~

**The MSSP benefit was scheduled to be carved out from the CCI, subject to CMS approval, effective January 1, 2021. This proposed carve out has been delayed to January 1, 2022, as described in the CalAIM – MSSP Carve-Out of CCI policy change.**

In 2019, AB 74 (Chapter 23, Statutes of 2019) was approved, which provides a one-time-only supplemental funding for expenditure over a three-year period. The supplemental funding will fund waiver care management and care management support payments.

### Home and Community-Based Waiver for Persons with Developmental Disabilities

The SDP 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 developmentally disabled; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. As of February 1, 2016, BHT services for Waiver participants under the age of 21 is a state plan benefit 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, 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.

The Department submitted a Waiver Amendment to reflect a rate increase to Home Health Aide and Skilled Nursing Services to align them with increases to Medi-Cal, as authorized by the 2018 Budget Act. The appropriation in the 2018 Budget Act will be applied to increase the payment rates for certified Home Health Aides, Licensed Vocational Nurses, and Registered Nurses. This does not result in a change to the rate methodology. The Amendment was approved with an effective date of July 1, 2018.

The Department submitted a Waiver Amendment to provide time limited rate increases in specific geographic areas for providers of Community-Based Day Services, In-Home Respite Agencies, and providers of Community Living Arrangement Services under the Alternative Residential Model. This amendment also includes Community Crisis Homes as a new provider type under Behavioral Intervention Services, adds Community Based Adult Services as a new



## HOME AND COMMUNITY BASED SERVICES

waiver service, and adds Adult Day Health Care Center as a provider type under Community Based Adult Services. The approved effective date is May 1, 2019.

The Department submitted an additional Waiver Amendment as a result of SB 81 (Chapter 28, Statutes of 2019), which provides the CDDS with time-limited funding to provide supplemental rate increases for specified services, effective January 1, 2020 through December 31, 2021. The amendment was approved with an effective date of January 1, 2020.

The Department submitted a Waiver Amendment to add State-Operated Mobile Crisis Team as a provider type under Behavioral Intervention Services. The amendment also adds rate methodologies for specified provider types under Behavior Intervention Services and Community Living Arrangement Services. The proposed **amendment was approved with an effective date is February of April** 1, 2020.

**The Department submitted a Waiver Amendment to add Speech-Language Pathologist Assistant as a provider type for Speech, Hearing, and Language services. The amendment also adds services to transition consumers placed at Institutions for Mental Diseases into alternative community settings. The proposed effective date is October 1, 2020.**

### Home and Community-Based Self Determination Program Waiver for Persons with Developmental Disabilities (DD)

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. 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.

As of February 1, 2016, 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.

### **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

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## HOME AND COMMUNITY BASED SERVICES

placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place.

### 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, CMS 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 was extended by the Patient Protection and Affordable Care Act of 2010. On January 24, 2019, the Medicaid Extenders Act of 2019 was signed and authorized MFP state grantees to continue to transition eligibles through December 31, 2019, using available MFP funding. The Extenders Act provided CMS with the authority to allocate new funding to state grantees for calendar year 2019, to allow funding appropriated through the Extenders Act to be spent through 2023.

On August 6, 2019, the Sustaining Excellence in Medicaid Act of 2019 was signed and appropriated additional federal funds for allocation to MFP state grantees.

On December 20, 2019, the Further Consolidated Appropriations Act, 2020 amended the DRA of 2005 to extended the term of the MFP grant by five months, from January 1, 2020 to May 22, 2020.

**On March 18, 2020, the Families First Coronavirus Response Act (FFCRA) was enacted. Section 6008 of the FFCRA provides a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase to MFP services under Section 1905(b) of the Social Security Act. The increase is being applied retroactively beginning January 1, 2020, and extends through the last day of the calendar quarter in which the COVID-19 public health emergency period, including any extensions, terminates.**

**On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act extended the term of the MFP grant from May 22, 2020 to November 30, 2020. On December 27, 2020, the President signed the Consolidated Appropriations Act of 2021, which includes an extension of the MFP grant through FFY 2023 and appropriates \$450 million for FFY 2022.**

## HOME AND COMMUNITY BASED SERVICES

**and \$450 million for FFY 2023. Under the Act, the CCT Program will receive grant funding to continue to transition eligible beneficiaries through September 2023 and up to four years after, as long as grant funding remains available.**

**On September 23, 2020, the Centers for Medicare & Medicaid Services (CMS) notified state MFP grantees of a supplemental funding opportunity for states that operate MFP Demonstration programs, and that plan to continue participating in MFP after federal fiscal year (FFY) 2019-20. California is currently developing a proposal to submit to CMS to receive up to \$5 million in supplemental funding for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity. Proposals must be submitted to CMS no later than June 30, 2021.**

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 ~~April 1, 2020~~ **December 31, 2021**, 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. **Due to the COVID-19 pandemic impact on the state's health care delivery systems, the Department is requesting from CMS a one-year extension of the Medi-Cal 2020 waiver, to December 31, 2021.**

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 **2015**. 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. The PRIME program, as currently approved by the Centers for Medicare and Medicaid Services (CMS) ends June 30, 2020 (PY 5). On June 30, 2019, the Department requested federal approval to implement two new Managed Care Quality Incentive Directed Payment Programs for DPHs and DMPHs for the period of July 1, 2020 through December 31, 2020. The new programs will be separate and distinct from the existing PRIME program. The goal of the new programs is to enable hospitals to continue quality improvement efforts that have been underway at all 52 PRIME entities after PRIME expires on June 30, 2020. This transition will promote value-based purchasing and ties funding to quality outcomes. Additionally, the Department proposes to align PRIME entities' transition to the Quality Incentive Program with California's transition to the calendar year (CY) rating period for Medi-Cal managed care plans beginning in CY 2021.
- 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

## 1115 WAIVER-MH/UCD, BTR, & MEDI-CAL 2020

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 Safety Net Care Pool (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 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.

**On December 29, 2020, the state received notification from CMS, informing the state that CMS has approved a one-year extension of the Medi-Cal 2020 Section 1115 demonstration, through December 31, 2021. The approval authorizes what is predominantly an as-is extension of the demonstration’s Special Terms and Conditions (STCs) as a first step, with negotiations to continue with respect to certain demonstration programs extended under this approval. With regards to the state’s DSHP expenditure authority, DHCS is currently reviewing the language in the notification and consulting with CMS for further information regarding the implications for the state budget and the DTI.**

## MANAGED CARE

### Medi-Cal Managed Care Rates

Base rates are developed utilizing **primarily** plan reported costs and utilization data by category of services (i.e. Inpatient **Hospital**, Emergency Room, Pharmacy, **Physician** Primary Care Provider, Specialist, **Physician Specialty**, 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 **gain** 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~~ **for** the Child, Adult/Family, Seniors and Persons with Disabilities (SPD), and Affordable Care Act 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~~ **model** from UC San Diego. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Child, Adult/Family, SPD, and ACA OE ~~rate categories~~ **COAs** 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~~ **July 2019 through December 2020** rates, each plan's final rate is a blend consisting of ~~70%~~ **75%** of the county-specific rate and ~~30%~~ **25%** 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. **For example, The the** State has also implemented supplemental payments for the costs of providing Hepatitis C drug treatment and Behavioral Health Treatment for children.

The State implemented a one-time 18-month rating period for medical managed care for the period of July 1, 2019, through December 31, 2020, to aid in future prospective rate development as federally required. Beginning in CY 2021, rates will be developed annually on a calendar year basis thereafter.

**As part of the CalAIM initiative, beginning January 1, 2022, the Department proposes to transition the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model over the course of multiple years. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to the Centers for Medicare**

## MANAGED CARE

**and Medicaid Services (CMS) for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with a goal of allowing the Department to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is that it will allow cost averaging across multiple plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for averaging rather than just the experience of plans within a single county.**

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 This Managed Care Organization (MCO) Enrollment Tax is was effective July 1, 2016, through June 30, 2019. On April 3, 2020, CMS approved the Department's waiver of the broad-based and uniformity provisions of Sections 1903(w)(3)(B) and (C) of the Social Security Act for the modified MCO Enrollment Tax model. The effective date range from this approval is January 1, 2020, through December 31, 2022.**

**Prior to the enrollment-based MCO tax, SB 78 (Chapter 33, Statutes of 2013) introduced a 3.9375% revenue-based MCO tax. The Department is currently in the process of reconciling the MCO tax fund for the July 1, 2013, through June 30, 2016, time period in which the revenue-based tax was applicable. The reconciliation is expected to result in payments to plans, and may result in a net General Fund cost, if the calculated payments are greater than the reimbursement to the General Fund from the remaining fund balance. The Department is collecting the necessary data to provide a more precise estimate in the future. The final reconciliation is expected to be completed in FY 2021-22.**

### 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 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 the Department. If an MCP's MLR exceeds 95% of total net capitation payments, then the Department 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 and FY 2017-18 rates without the extension of the ACA OE MLR risk corridor through the FY 2016-17 and FY 2017-18 rating periods. The ACA OE MLR risk corridor for FY 2016-17 has been contractually established between the Department and MCPs. The Department is working on establishing the FY 2017-18 ACA OE MLR risk corridor contractual requirement and is working closely with CMS to determine whether future rating periods will require the extension of the ACA OE MLR risk corridor.

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## MANAGED CARE

### 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), into managed care. IHSS was removed from capitation rate payments effective January 1, 2018.

### Dental Managed Care (DMC) Medical Loss Ratio (MLR)

**The Department intends to exercise the authority in the DMC plan contracts to impose a minimum MLR of 85% for the FY 2019-20 and July 1, 2020, through December 31, 2020, rating periods. The Department will require DMC plans to remit necessary funds that do not meet the 85 percent threshold. The Department does not currently possess adequate data to provide an estimate at this time.**

### 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 **FFS** 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 **FFS** 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.

### Extended File Correction

**This assumption has been deleted as this is now a new policy change.**



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## PROVIDER RATES

### **Reimbursement Methodology and the Quality Assurance Fee for Freestanding Nursing Facility Level Bs & Freestanding Subacute Level B AB 1629 Facilities**

AB 1629 (Chapter 875, Statutes of 2004) requires **required** the Department to develop a cost-based, facility-specific reimbursement rate methodology for Freestanding Nursing Facility Level-Bs (FS/NF-Bs), including **and** 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 (QASP) Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment 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 skilled nursing facility 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 **for FS/NF-Bs and FSSA/NF-B facilities**, 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.

~~With the current AB 1629 program set to expire on July 31, 2020, the Budget proposes to extend and modify the current rate methodology. The proposal would continue to provide annual rate increases, but they would vary by year and the allocation of those increases will put a greater emphasis on value and quality of care over cost. The proposed methodology would extend the current QAF program and would provide the Department with additional authorities to collect delinquent QAF.~~

~~The proposal would also change the rate year from an August 1 start date to a January 1 start date beginning in January 2021 to align with the managed care rate year. Starting January 2022 would also replace the current QASP program with a new quality per diem add-on framework available to all facilities if they meet established quality metrics and benchmarks. Other features of the proposal include updating peer groups, increasing the percentile cap for direct labor from the 90<sup>th</sup> percentile to the 95<sup>th</sup> percentile, and exempting Freestanding Pediatric Subacute facilities from paying QAF.~~

**AB 81 (Chapter 13, Statutes of 2020) extends the facility-specific rate methodology for FS/NF-Bs and FSSA/NF-B facilities, QAF and QASP through December 31, 2022. The bill changes the rate year cycle from an August 1 start date to a January 1 and authorizes a five-month rate period, August 1, 2020 through December 31, 2020, to transition to a calendar year rate cycle. The bill establishes a weighted average rate increase of 3.62% for the August through December 2020 rate period, 3.5% for the CY 2021 rate period and 2.4% for CY 2022.**

**Additionally, AB 81 updates the peer groupings used for the rate methodology, increasing and reorganizing the peer groups from 7 to 11, and increases the percentile caps for direct labor and indirect labor from the 90<sup>th</sup> percentile to the 95<sup>th</sup> percentile. The bill also provides additional authorities to collect delinquent QAF, and exempts Freestanding Pediatric Subacute facilities from paying QAF.**

Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

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## PROVIDER RATES

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 by location. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. ~~Effective June 2014, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65<sup>th</sup> percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65<sup>th</sup> 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 during the 2008-09 rate year, increased by 3.7%.

## PROVIDER RATES

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. **SB 856 authorized the Department to extend the supplemental payments through FY 2018-19. AB 74 authorized the Department to extend supplemental payments for the period of August 1, 2019 through June 30, 2021. The Governor's Budget proposes to extend supplemental payments through December 31, 2022.**

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.

### **COVID-19 Impact on LTC Nursing Facilities**

**In response to the increased cost pressures incurred by the COVID-19 outbreak, the Department with CMS's approval has provided the following nursing facilities with rate increase equal to 10 percent of their regular 2019-20 total reimbursement amount:**

- **Freestanding Nursing Facilities Level-B**
- **Nursing Facilities Level-A**
- **Distinct Part Nursing Facilities Level-B**
- **Freestanding Adult Subacute Facilities**
- **Distinct Part Adult Subacute Facilities**
- **Distinct Part Pediatric Subacute Facilities**
- **Freestanding Pediatric Subacute Facilities (FS/PSA)**
- **ICF/DD (including ICF/DD-Habilitative, and ICF/DD-Nursing)**

**This increase does not apply to state-owned Skilled Nursing Facilities or ICFs, including Developmental Centers and Veterans Homes. The increased amounts are inclusive of add-ons, and the FS/PSA and the ICF/DD Proposition 56 supplemental payments.**

**The rate increases are effective March 1, 2020 and will continue until the expiration of the public health emergency or national emergency, whichever occurs first. Upon this, LTC reimbursements will revert back to their regular facility-specific levels.**

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## CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

CalAIM is a comprehensive set of proposals that collective are intended to: (1) identify and manage member risk and need through whole person care approaches and addressing the social determinants of health, (2) move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and (3) improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. See <https://www.dhcs.ca.gov/calaim> for more information.

Various components of the CalAIM are proposed to be implemented during 2021-22 and later years. Where fiscal impacts have been identified, policy changes have been included in the Medi-Cal Estimate to budget needed funding. Other components of the CalAIM proposal do not have estimated fiscal impacts in 2021-22 at this time, but are described hereafter:

### 1. Behavioral Health Payment Reform

The Department is planning to implement the first phase of behavioral health (BH) payment reform in FY 2022-23. The first phase of BH payment reform is expected to include a change in procedure codes used in claiming; and a transition from cost-based reimbursement using certified public expenditures (CPE) to an established fee schedule using intergovernmental transfers. The change to procedure codes will provide the Department with more specificity regarding both Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC) State Plan, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services provided to Medi-Cal beneficiaries. The transition from cost-based reimbursement to an established fee schedule will provide counties with more predictability in reimbursement. The Department expects these changes to be budget neutral.

### 2. BH Medical Necessity

The medical necessity criteria for SMHS, DMC State Plan, and DMC-ODS is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services, as well as result in disallowances of claims for specialty mental health and substance use disorder (SUD) services. The Department is proposing to modify the medical necessity criteria in order to align with state/federal requirements and more clearly delineate and standardize the benefit statewide. As part of this effort, the Department is also seeking to identify and implement screening and transition of care tool that may be used to determine the appropriate level of care for mental health services. It is anticipated that the new medical necessity criteria would be implemented no sooner than January 1, 2022.

### 3. BH Administrative Integration

Research indicates that approximately 50% of individuals who have a serious mental illness have a co-occurring substance use disorder and that those individuals benefit

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**CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)**

**from integrated treatment. The State provides Medi-Cal covered SUD and SMHS through two separate county-operated delivery systems, which makes it difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties participating in mental health and substance use disorder managed care are subject to two separate annual quality assessments, two separate post payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, counties providing integrated treatment to a Medi-Cal beneficiary must document the SUD service separately from the specialty mental health service. The purpose of this proposal is to make necessary state and county changes that would provide SUD and SMHS through one delivery system. Efforts to begin working on integration are targeted for January 1, 2022, aiming for a single county contract for SUD and mental health treatment starting January 1, 2027.**

**4. BH Regional Contracting**

**The Department recognizes that some counties have resource limitations often due simply to their size and the number of beneficiaries residing in their county. Therefore, the Department is encouraging counties to develop regional approaches to administer and deliver SMHS and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, the Department is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under SUD fee-for-service might also be provided through a regional approach. The Department is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.**

**5. DMC-ODS Program Renewal and Policy Improvements**

**The Department proposes to incorporate the Drug Medi-Cal Organized Delivery System into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. The Department also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewide. Finally, the Department is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, the**

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## CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Department proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

### 6. Enhancing CCS and CHDP Oversight and Monitoring

The California Children's Services program provides case management services, diagnostic and treatment services, and physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. In alignment with the State's responsibility to ensure that the same high quality standard of care is compliant with federal and State guidelines for all beneficiaries, as a part of its California Advancing and Innovating Medi-Cal (CalAIM) initiative, DHCS will implement new processes to provide enhanced monitoring and oversight of all 58 counties to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program that includes, but is not limited to, a review of all current standards and guidelines for both programs; the development of auditing tools to assess county operations and compliance; evaluating and analyzing the findings gathered during audits to identify gaps and vulnerabilities across counties within the programs; tracking trends; and, along with input from our county partners and other stakeholders, establishing goals, metrics, performance measures, and milestones to ensure counties are providing the necessary provider oversight and the medical and dental care for beneficiaries. DHCS will also enter into a Memorandum of Understanding with each County/City that will detail how the State will monitor county activities, policies and procedures, conduct audits, and implement corrective action plans.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue this robust strategic compliance oversight in order to preserve and improve the overall health and well-being of these vulnerable populations. This oversight project is budget neutral as no additional funds added to the county/city budgets.

### 7. Enhancing Eligibility Oversight & Monitoring

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**CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)**

**The Enhancing County Eligibility Oversight and Monitoring initiative within the CalAIM proposal was precipitated by recent audits performed by federal and state oversight agencies which found weaknesses in the Department's oversight practices, and suggest that both increased monitoring and the development and implementation of additional oversight activities are needed to reduce erroneous eligibility determinations and facilitate increased accuracy in the administration of the Medi-Cal and CHIP programs. Due to the continuous coverage requirement in the federal Families First Coronavirus Response Act (FFCRA) signed into law on March 18, 2020, and instruction to counties to halt all Medi-Cal renewal processes and negative actions through the duration of the Public Health Emergency (PHE), this CalAIM initiative will be delayed accordingly. The implementation dates selected will be based on resumption of normal county business processes as we continue to navigate the PHE, with a measure of time built in afterward for counties to process and clean-up the resulting backlog. By December 31, 2023, DHCS will have implemented enhanced county oversight and monitoring activities to include lifting the current hold-harmless policy and reinstating county performance standards, publishing a public facing county performance dashboard, and taking steps toward fiscal sanctions for counties which do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.**

**8. Regional Managed Care Capitation Rates**

**As part of the CalAIM initiative, beginning January 1, 2022, the Department proposes to transition the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model over the course of multiple years. The proposal to move to regional rates has two main benefits. The first benefit is a decreased number of distinct actuarial rating cells that are required and submitted to the Centers for Medicare and Medicaid Services (CMS) for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS with a goal of allowing the Department to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is that it will allow cost averaging across multiple plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for averaging rather than just the experience of plans within a single county.**



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**INFORMATION ONLY**
**REVENUES**1. Revenues

The State is expected to receive the following revenues from quality assurance fees and other collections (accrual basis):

FY 2020-21:	<del>\$27,110,000</del> <b><u>\$34,259,000</u></b>	ICF-DD Quality Assurance Fee
	<del>\$505,285,000</del> <b><u>\$453,686,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<del>\$9,612,000</del> <b><u>\$9,623,000</u></b>	ICF-DD Transportation/Day Care Quality Assurance Fee
	<del>\$1,224,000</del> <b><u>\$102,000</u></b>	Freestanding Pediatric Subacute Quality Assurance Fee
	\$2,317,734,000	MCO Enrollment Tax (Item 4260-601-3334)
	\$4,574,430,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	<del>\$5,011,000</del> <b><u>\$4,802,000</u></b>	Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)
	<del>\$80,177,000</del> <b><u>\$91,339,000</u></b>	Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)
	<del>\$1,474,013,000</del> <b><u>\$1,371,734,000</u></b>	Medi-Cal Drug Rebates Fund (Item 4260-601-3331)
	<del>\$8,994,596,000</del> <b><u>\$8,807,709,000</u></b>	Total
<b><u>FY 2021-22:</u></b>	<b><u>\$35,503,000</u></b>	<b><u>ICF-DD Quality Assurance Fee</u></b>
	<b><u>\$486,302,000</u></b>	<b><u>Skilled Nursing Facility Quality Assurance Fee (AB 1629)</u></b>
	<b><u>\$9,623,000</u></b>	<b><u>ICF-DD Transportation/Day Care Quality Assurance Fee</u></b>
	<b><u>\$2,584,032,000</u></b>	<b><u>MCO Enrollment Tax (Item 4260-601-3334)</u></b>
	<b><u>\$2,305,935,000</u></b>	<b><u>Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)</u></b>
	<b><u>\$2,039,000</u></b>	<b><u>Emergency Medical Air Transportation (EMATA) Fund (Item 4260-101-3168)</u></b>
	<b><u>\$83,129,000</u></b>	<b><u>Medi-Cal Emergency Medical Transport (MEMTF) (Item 4260-601-3323)</u></b>
	<b><u>\$1,542,198,000</u></b>	<b><u>Medi-Cal Drug Rebates Fund (Item 4260-601-3331)</u></b>
	<b><u>\$7,048,761,000</u></b>	<b><u>Total</u></b>

## **INFORMATION ONLY**

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance (QA) 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 Centers for Medicare and Medicaid Services 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 Quality Assurance Fee (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 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.

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**INFORMATION ONLY**

Proposition 52, approved by California voters on November 8, 2016, permanently extends the Hospital QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which resulted in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

AB 119 (Chapter 17, Statutes of 2015) extends the AB 1629 facility-specific rate methodology, QAF, and QASP program through July 31, 2020. Further, beginning rate year 2015-16, the annual weighted average rate increase is 3.62%, and the QASP will continue at FY 2014-15 levels, rather than setting aside a portion of the annual rate increase. Additionally, beginning FY 2015-16, the legislation requires the Department to incorporate direct care staff retention as a performance measure into the QASP Program.

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****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.

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**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.

**4. Senate Bill 260 (Chapter 845, Statutes of 2019) – Covered California Automatic Enrollment**

Senate Bill 260 (Chapter 845, Statutes of 2019) requires beginning no later than July 1, 2021, that Covered California automatically enroll individuals who transition from Medi-Cal and the State Children's Health Insurance Program into the lowest cost silver plan or their previous managed care plan before their current coverage ends. The Department is collaborating with Covered California to explore the timing of system implementation cost. The Department does not anticipate changes to the previous cost analysis.

**5. Confirm Inmate Eligibility to Federal Law**

The federal "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act" requires the Department to implement indefinite Medi-Cal suspension for eligible incarcerated juveniles. Current federal law requires eligible juvenile inmates to no longer have time-limited suspensions of Medi-Cal benefits; therefore, California's current state law limit of one year for Medi-Cal suspensions must be changed for this population to conform to federal law. Implementation of this new policy, including system modifications, is anticipated to occur after October 1, 2020.

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**INFORMATION ONLY****6. Minimum Essential Coverage – Increase in 1095-B Mailings**

Senate Bill 78 (Chapter 38, Statutes of 2019), Section (7), creates a Minimum Essential Coverage Individual Mandate which requires an individual who is a California resident to ensure that the individual, and any spouse or dependent of the individual, be enrolled in and maintain minimum essential coverage for each month beginning on and after January 1, 2020, except as specified. This bill requires the Department, which provides minimum essential coverage to individuals via Medi-Cal, to file specified returns to the Franchise Tax Board regarding that coverage, as prescribed by the Franchise Tax Board. The Department provided Form 1095-B mailings to beneficiaries, documenting minimum essential coverage, may increase with undocumented populations based on Franchise Tax Board's definition of minimum essential coverage.

**7. Medi-Cal Eligible Inmates COVID-19 Impacts**

**Due to the Coronavirus disease 2019 (COVID-19) pandemic, the Department has requested federal approval through the Section 1115 Waiver to cover expenditures on behalf of Medi-Cal eligible individuals who are inmates for services provided in public institutions, including jails and prisons. This coverage includes testing, diagnosis and treatment of COVID-19, or other State plan covered services where medically appropriate to ensure care is provided in a safe way without transporting individuals to acute care facilities. The program modifications are currently pending approval from the Centers for Medicare & Medicaid Services. This issue was reflected in the COVID-19 Additional Impacts policy change in the May 2020 Medi-Cal Estimate, but is not reflected in the November 2020 Medi-Cal Estimate due to uncertainty surrounding federal approval.**

**AFFORDABLE CARE ACT****1. Realignment**

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public/non-County Medical Services Program counties have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in Option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. Public hospital health systems will be paid at least cost for their new Medi-Cal population.

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**INFORMATION ONLY****BENEFITS****1. Pompe Disease and Mucopolysaccharidosis type I (MPSI) 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). MPS I (also known as Hurler syndrome) 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. **Universal screening** of all newborns for Pompe Disease and MPS I ~~beginning in August~~ **begin in September** 2018.

Children identified through the NBS Program as having, or at risk of having, Pompe Disease or MPS I 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) Child Health and Disability Prevention (CHDP)**

~~The Child Health and Disability Prevention (CHDP)~~ **CHDP** program administered by the state and counties provides ~~EPSDT~~ **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** preventive health screening examinations (i.e., well child health assessments) and immunizations to Medi-Cal eligible children under 21 years of age and to non-Medi-Cal eligible children under 19 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 19 years of age who were eligible for state-only 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)~~ **CHDP** policy change.

**3. Palliative Care Services Implementation**

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; and
- Provide access to curative care for beneficiaries eligible for palliative care.

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**INFORMATION ONLY**

Services are available concurrently with curative care and care is provided through a coordinated interdisciplinary team.

**4. Continuous Glucose Monitoring System Rebates**

**The Department is negotiating a rebate agreement for Continuous Glucose Monitors (CGM) for all eligible individuals under age 21, inclusive of both Medi-Cal and CCS. Currently, CGMs are available for individuals in Medi-Cal and CCS under age 21 through the Early and Periodic, Screening, Diagnostic, and Treatment benefit with a prior authorization. Execution of the rebate agreement is anticipated to be completed by early 2021. Medi-Cal and CCS providers will bill for the applicable CGM devices and accessories through the Medi-Cal fiscal intermediary. Actual rebate savings are estimated to begin in spring 2021. The Department will submit invoices to the CGM manufacturer on a quarterly basis. The Department will include actual and projected rebate savings in the May 2021 Medi-Cal Estimate.**

**The November 2020 Medi-Cal Estimate newly includes funding for Continuous Glucose Monitors for adults, as described in the Continuous Glucose Monitoring Systems Benefit policy change.**

**HOME & COMMUNITY BASED-SERVICES****BREAST AND CERVICAL CANCER TREATMENT****PHARMACY**

Medi-Cal Monthly 6 Rx Limit and Fee-For-Service Drug Prescription Copays  
**This assumption has been deleted as there is no fiscal impact**

**1. New High Cost Treatments for Specific Conditions**

There are additional treatments approved and ready to be phased into use.

Onasemnogene abeparvovec (Zolgensma) was approved by the Food and Drug Administration (FDA) on May 24, 2019, for children with spinal muscular atrophy aged less than two years with bi-allelic mutations in the survival motor neuron (SMN1) gene.

~~Tisagenlecleucel (Kymriah) is a one-time treatment for children and young adults up to 25 years of age with B-Cell acute lymphoblastic Leukemia that is refractory or twice elapsed after treatment. The therapy is administered in a single treatment and less expensive than some bone marrow transplants.~~

~~Pegvaliase pqpz (Palynziq) is a lifetime treatment, approved by the FDA on May 24, 2018 to treat Phenylketonuria adults who are unable to maintain phenylalanine levels (below 600 µmol/L) with current therapy.~~

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## INFORMATION ONLY

~~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 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.~~

**Golodirsen (Vyondys 53) is a lifetime treatment for treatment of patients with Duchenne Muscular Dystrophy who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. The drug was FDA approved on December 13, 2019.**

**Trikafta (elexacaftor/ivacaftor/tezacaftor) was approved by the FDA on October 21, 2019 for the treatment of patients with the most common cystic fibrosis mutation**

## 2. Non-Medi-Cal Rebates

The Governor’s Executive Order (EO) N-01-19 ordered the Department to consider additional options to maximize the State’s bargaining power, including the Medi-Cal program, to reduce state’s drug spending and more broadly promote access to affordable health care.

Currently the Medi-Cal program, under the federal Medicaid Drug Rebate Program, collects both federal and state supplemental drug rebates. Medi-Cal covers all drugs approved by the federal FDA, subject to medical necessity. The Department maintains the Medi-Cal Contract Drug List (CDL), which generally includes drugs for which there is a current state supplemental drug rebate agreement in place. To the extent there is no supplemental rebate agreement in place, the covered drug would be available subject to prior authorization establishing medical necessity.

Federal Centers for Medicare and Medicaid Services (CMS) policy guidance provides States an opportunity to seek Medicaid State Plan authorization to secure prescription drug benefits, rebates, or discounts for non-Medicaid populations by linking such benefits to a Medicaid prior authorization program. CMS guidance also indicates that states must demonstrate that inclusion of the targeted non-Medicaid populations further the goals and objectives of the Medicaid program, increases the efficiency and economy of the Medicaid program, and sufficiently benefits the Medicaid population as a whole.



## INFORMATION ONLY

The Department will seek CMS approval via a State Plan Amendment, or other applicable mechanism, leveraging the State's purchasing volume, to establish and administer a drug rebate program to collect rebate payments from drug manufacturers for drugs utilized by selected populations who are ineligible for full-scope Medi-Cal benefits.

### 3. Best Price

The Governor's EO N-01-19 ordered the Department to consider additional options to maximize the state's bargaining power, inclusive of the Medi-Cal program, to reduce State's drug spending and more broadly promote access to affordable health care.

California Welfare and Institutions Code, section 14105.31(b) defines "Best Price" as, "the negotiated price, or the manufacturer's lowest price available to any class of trade organization or entity, including, but not limited to, wholesalers, retailers, hospitals, repackagers, providers, or governmental entities within the United States, that contracts with a manufacturer for a specified price for drugs, inclusive of cash discounts, free goods, volume discounts, rebates, and on- or off-invoice discounts or credits, shall be based upon the manufacturer's commonly used retail package sizes for the drug sold by wholesalers to retail pharmacies." Federal law has a similar definition of Best Price (Social Security Act Section 1927(c)(i)(C)), that limits prices to those within the United States. These federal and state statutory authorities guarantee California's Medi-Cal program the lowest drug price that any manufacturer offers to any entity in the US. The Department is seeking to strike the limitation to prices within the United States, thus allowing the Department to negotiate Medi-Cal drug rebate contracts based on global drug prices.

### 4. Pharmacy Rebate Timeliness

**The CMS has a two-year limit on adjustments to rebates claimed. In instances where a dispute with a drug manufacturer results in a credit to the manufacturer for a time period more than two years prior, the recoupment of funds from CMS may not be allowed. CMS Accounting and the CMS Division of Pharmacy have conflicting guidelines related to timeliness. The Department has engaged CMS and is seeking guidance as to how it should proceed specific to rebate adjustments, and may seek a Good Cause Waiver with CMS to allow for adjustments beyond two years and other possible instances, if necessary.**

## DRUG MEDI-CAL

FQHCs and RHCs: DMC and SMHS

**This assumption has been deleted as this has been withdrawn.**

### 9. 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

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## INFORMATION ONLY

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.

### 10. Substance Use Disorder Managed Care Program Renewal and Policy Improvements

The Department proposes to incorporate the Drug Medi-Cal Organized Delivery System (also known as substance use disorder managed care) into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health managed care plans, and substance use disorder managed care plans. The expenditure authority for residential treatment provided in an Institution for Mental Disease will continue to be authorized through Section 1115 waiver authority. The Department also intends to provide counties with another opportunity to opt-in to participate in the substance use disorder managed care program in hopes of promoting statewide. Finally, the Department is exploring opportunities to improve the substance use disorder managed care program based on experience from the first several years of implementation. Accordingly, the Department proposes clarifying or changing policies to support the goal of improved beneficiary care and administrative efficiency.

## MENTAL HEALTH

Specialty Mental Health Services (SMHS) Claim Adjudication Errors  
This assumption has been deleted as this has been withdrawn.

FQHCs and RHCs: DMC and SMHS  
This assumption has been deleted as this has been withdrawn.

### 1. Short-Term Residential Therapeutic Program/Qualified Residential Treatment Programs

Congress enacted the Families First Prevention Services Act (FFPSA) on February 9, 2018. The intent of the FFPSA is to restrict the use of congregate care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specific congregate care setting meeting defined requirements. The FFPSA added Qualified Residential Treatment Programs (QRTP) as one of those congregated care settings that may be used when specific criteria are met. In California, STRTPs are similar to QRTPs and the California Department of Social Services (CDSS) is working to ensure STRTPs meet the requirements of a QRTP. The definition of a QRTP in Title IV-E overlaps with the definition of an Institution for Mental Disease (IMD) in Title XIX. Title XIX prohibits federal reimbursement for covered services provided to beneficiaries who are residents of an IMD. The Department wrote CMS and asked for STRTPs not to be considered as IMDs; CMS responded that it could not give this blanket approval, and would require the Department to individually assess each STRTP to determine if it is an IMD. The Department plans to complete these assessments by June 30, 2021.

### 2. Family Urgent Response System

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**INFORMATION ONLY**

**The Family Urgent Response System (FURS) requires the State to operate a hotline, available 24 hours a day, 7 days a week, to respond to urgent issues from families involved in child welfare, and then requires counties to deliver in-person mobile social services and specialty mental health services (SMHS) in response to hotline calls. The goal is to deescalate crises, provide urgent in-person mobile services, and prevent placement disruptions. State law requires the counties to have mobile services in place no later than six months after January 1, 2021, as long as an extension is requested and approved. Due to delays from the COVID-19 pandemic, the hotline launch is expected to be delayed until March 1, 2021. Counties would be expected to either launch their mobile response programs, or put interim response plans in place once the hotline is launched, until their mobile units are ready to serve clients. CMS has stated that 1915b waiver authority is required in order to mandate use of mobile SMHS for a specific Medi-Cal population (children in child welfare), and is working with the Department to provide that authority through our waiver extension process, to allow to be in place by March 1, 2021.**

**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 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 the Centers for Medicare and Medicaid Services (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

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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 FFY 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 STCs 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 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.

**The County Administration CMS Deferred Claims policy change will be deactivated until funds are available in the ADM-16 account to be reclaimed, of which \$8.21 million remains.**

### 2. Bridge to Reform (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

### 1. Ground Emergency Medical Transportation (GEMT) Public Provider Program

**Currently, the Department administers the GEMT Quality Assurance Fee (QAF) program under Welfare and Institutions Code § 14129 et seq., which is budgeted in the GEMT policy change. This policy change budgets payments to both public and private GEMT providers. AB 1705 (Chaptered 544, Statutes of 2019) requires the Department to implement a public provider GEMT Inter-Governmental Transfer (IGT) program no sooner than July 1, 2021. The public providers currently in the GEMT QAF**

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**program will transition into the new AB 1705 IGT program. These providers would no longer participate in the GEMT QAF program and funds associated with AB 1705 (public providers) are expected to shift into a new policy change when the final implementation date is known.**

**PROVIDER RATES****1. Aligning Rate Review with the Access Monitoring Review Plan**

To align rate reviews with the Access Monitoring Review Plan, the Department proposes to amend Section 14079 of the Welfare and Institutions Code. The amendment would require the Department to periodically review physician and dental services reimbursement levels at least every three years, rather than annually; would clarify that the review of rates pertain only to the Medi-Cal Fee-for-Service delivery system; require the Department to revise reimbursement rates to the extent the Director deems necessary to comply with federal Medicaid requirements; specify that the rate reviews would be conducted consistent with the Department's federally approved access monitoring plan; and remove obsolete and inaccessible requirements for the rate reviews.

**2. Prenatal Screening Program Fee Increase**

**CDPH administers California's Genetic Disease Screening Program (GDSP), which includes the Prenatal Screening (PNS) Program. This program screens for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.**

**The PNS program currently tests for both chromosomal abnormalities and neural tube defects (NTD). CDPH GDSP plans to modernize the PNS program by utilizing cell-free DNA screening (cfDNA). The new screening method is expected to be implemented in FY 2022-23.**

**SUPPLEMENTAL PAYMENTS****1. 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**

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

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**INFORMATION ONLY**

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. SPA 15-021 has not been approved by CMS; however, the Department expects the SPA to be approved prior to the end of FY 2019-20.

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.

SPA 19-0009: The Department submitted SPA 19-0009 in March 2019, with a proposed effective date of January 1, 2019. The proposed SPA seeks to improve the health of low-income children by increasing their access to needed vision services by providing comprehensive eye exams, corrective lenses, and frames at school sites. In addition, CMS has indicated that the Department has the option to restructure how school-based services are written into the State Plan, and remove any duplicative or unnecessary State Plan language. This new approach also includes removing references to all licensing, credentialing and supervision practitioner requirements for the LEA Program in SPA 19-0009.

**COVID-19****1. Managed Care Bridge Period (July 1, 2019 – December 31, 2020) Risk Corridor**

**To protect the managed care health plans, the State, and the Federal Government against excessive gains/losses due to unexpected cost/utilization changes as a result of the COVID-19 public health emergency, the Department will be implementing a two-sided risk corridor pursuant to AB 80 (Chapter 12, Statutes of 2020). The two-sided risk corridor will be symmetrical as it pertains to risk and profit. Calculations are anticipated to begin no sooner than January 1, 2022.**

**2. Managed Care Bridge Period (July 1, 2019 – December 31, 2020) 1.5% Rate Adjustment**

**The Department will be implementing a 1.5% reduction to the gross medical expense (GME) component of the managed care Bridge Period (July 1, 2019 – December 31, 2020) certified capitation rates. The 1.5% reduction was applied to the four largest categories of aid (COAs), which account for approximately 90% of the managed care population. The affected COAs include Child, Adult, Affordable Care Act Optional Expansion, and Seniors and Persons with Disabilities. The reduction was calculated as 1.5% of a lower bound GME rate, excluding the lower bound administration and underwriting gain loads.**

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**INFORMATION ONLY****OTHER: AUDITS AND LAWSUITS**1. 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 (20), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9<sup>th</sup> 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. The Department appealed the final judgment. Appellate briefing was completed in the fall of 2017. On June 19, 2018, the appellate court affirmed the final judgment in favor of plaintiffs. On October 17, 2018, the California Supreme Court denied the Department's request for de-publication of the appellate court's ruling. The Department issued instructions to petitioners/plaintiffs regarding the submission of claims related to this lawsuit in October 2018. On January 31, 2019, the court denied petitioners/plaintiffs writ to extend its prior ruling to non-party providers. On February 1, 2019, petitioners/plaintiffs motion for attorney's fees was denied. As of January 2020, the Department's fiscal intermediary continues to process eligible claims for payment submitted during the October 2018 period and the Department expects all related payments will be complete by the end of the 2019-20 fiscal year. This matter is now closed with associated payments displayed in the Payment for Reprocessed Claims for FQHC/RHC Policy Change, and will no longer be reported in these Informational Assumptions.~~

1. 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*

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

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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).

2. ~~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. The Appellate Court found that the judgement was not entered properly, 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. On January 28, 2019, the trial court signed the proposed judgment prepared by Plaintiffs. On July 9, 2019, the trial court partially granted Plaintiffs' motion for an attorneys' fee award of \$840,000 in fees and costs. Through subsequent negotiation, the parties agreed to the Department paying a final amount of \$775,000. This matter is now closed, and will be displayed in the Lawsuits/Claims policy change and will no longer be reported in these Informational Assumptions,~~

2. 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



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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 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 appellate court heard the appeal on June 11, 2019, and filed its ruling in favor of the Department on June 27, 2019, instructing the trial court to enter judgment denying the petition for writ of mandate. Petitioners filed a Petition for Review with the California Supreme Court, along with a Request for Depublication of the appellate court decision. -The Supreme Court granted review on October 9, 2019, and briefing remains ongoing.

3. 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 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

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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 April 12, 2018, the court sustained 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. On September 21, 2018, the court sustained the Department's demurrer to the first amended complaint but granted Plaintiffs leave to amend. Plaintiffs filed their second amended complaint on October 29, 2018, and the Department demurred on November 30, 2018. On January 31, 2019, the court again sustained the Department's demurrer with leave to amend. On June 21, 2019, the court overruled the Department's demurrer allowing the case to continue to discovery. The Department filed its answer to the third amended complaint on August 30, 2019. Discovery remains ongoing, and **the court has set a deadline of December 10, 2020 for the Plaintiff's class certification motion** case management conference was scheduled on January 22, 2020.

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On December 11, 2017, another lawsuit (*Deuschel*) was filed by an individual plaintiff against the Department, CHHS, and the Department of Social 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. Plaintiff filed an amended complaint on September 18, 2018. The Department filed its demurrer to the amended complaint on November 9, 2018. The court has since issued multiple continuances, and the entire case was stayed until April 22, 2020 January 21, 2020, with a demurrer and trial setting conference scheduled for the Department's demurrer now scheduled to be heard on July April 21, 2020.

4. Blue Cross of California v. DHCS, et. al.; California Physicians' Service DBA Blue Shield of California v. DHCS, et. al. ; Health Net of California, Inc. v. DHCS, et al.

Blue Cross of California Blue Shield of California, and Health Net of California (Plaintiffs) 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 that will be paid pursuant to SBx2 2 (Chapter 2, Statutes of 2016, 2nd Ex. Sess.) and AB 115 (Chapter 348, Statutes of 2019) in the event that Myers action results in the Plaintiffs being subject to the GPT and exempt from assessment of the MCO taxes. The Blue Cross and Blue Shield actions have both been formally stayed after being designated related cases to Myers and it is expected that the Health Net action will be stayed as well.

5. 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. On February 28, 2019, the parties executed a settlement which includes specified Department obligations regarding the delivery of in-home skilled nursing care and dismissal of the case. The court preliminarily approved the settlement on April 4, 2019 and also certified the plaintiff class. The Department mailed notice of the settlement to the plaintiff class on May 30, 2019. On September 30, 2019, the court gave final approval of the settlement, including an attorneys' fee award of \$435,000. DHCS is in process of implementing the settlement terms, including the release of multiple notices for public comment. This matter is now closed, and will be displayed in the Lawsuits/Claims policy change and will no longer be reported in these Informational Assumptions,~~

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**INFORMATION ONLY****6. 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 Demurrer was denied November 1, 2018, and its Answer was filed on November 12, 2018. Discovery and settlement discussions are ongoing. **Trial is scheduled for January 4, 2021.**

**7. California Pharmacists Association, et al. v. Kent, et al.**

The lawsuit was filed in U.S. District Court for the Northern District on June 5, 2019 against the Department and the federal Secretary of the U.S. Department of Health and Human Services. Plaintiff pharmacies seek injunctive and declaratory relief to prevent the Department from implementing reimbursement changes approved in State Plan Amendment no. 17-002 relating to covered outpatient drug benefits in Medi-Cal, including the Department's retroactive implementation of those reimbursement changes effective for dates of service on or after April 1, 2017. Plaintiffs allege that the Department's revised outpatient pharmacy reimbursement methodologies violate the Medicaid Act and other state and federal laws, and that the Federal defendants improperly approved such changes in the Medi-Cal State Plan. ~~A hearing on Plaintiff's motion for a preliminary injunction scheduled on August 30, 2019 was taken off calendar, and the court will make its decision based on the parties' briefing alone.~~ **On February 21, 2020, the court denied Plaintiffs' motion for a preliminary injunction, and requested additional briefing on the issue of retroactive implementation of the reimbursement changes. A briefing schedule for this remaining issue has not yet been set.**

**8. Independent Living Center of Southern California, et al. v. Kent, et al.**

In 2009, Plaintiffs sued the Department challenging legislatively-mandated Medi-Cal payment reductions (AB 5 and AB 1183) in the U.S. District Court for the Central District. On February 27, 2009, the district court issued a preliminary injunction against the payment reductions. On February 22, 2012, the U.S. Supreme Court issued a ruling vacating the Ninth Circuit decision affirming the district court's injunction. In May 2014, the parties in this case and three other federal lawsuits involving AB 5 and AB 1183 reductions executed a settlement in which the Department agreed not to recoup amounts from providers for certain time periods in exchange for Plaintiffs dismissing several state court lawsuits. On April 23, 2015, the district court issued an order dismissing with prejudice Plaintiffs' suit and retaining jurisdiction, until January 1, 2016, for purposes of attorney fees and settlement enforcement. On July 6, 2015, the Department agreed to pay \$180,000 to Plaintiffs' counsel Lynn Carman and the Medicaid Defense Fund to settle their claims for attorney fees. On that same date, the Court denied all other claims against the State for

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attorney fees, including those filed by attorney Stanley Friedman and the law firm Hooper, Lundy, and Bookman (HLB). On July 24, 2015, both attorney Friedman and HLB filed a notice of appeal of the order denying fees. On November 21, 2018, the Ninth Circuit reversed and ruled that attorney fees may in fact be available under State law since plaintiffs initially filed a State law claim. The case was remanded to the district court to determine whether plaintiffs are eligible for fees, and if so, to calculate the award amount. Discovery and briefing in the district court is ongoing. A hearing was held on June 24, 2019, and on August 7, 2019, the district court granted Plaintiffs' and intervenors' motions for attorneys' fees.—Following discovery and subsequent briefing, the district court on January 24, 2020 issued its decision awarding approximately \$7 million in aggregate fees, with approximately \$2.7 million awarded to attorney Friedman and approximately \$4.3 million awarded to intervenors HLB. On February 21, 2020, attorney Friedman filed a notice of appeal. The \$4.3 million payment to intervenors HLB ~~is~~ **was** displayed in the Lawsuits/Claims policy change **in the 2020 May Revise Local Assistance Medi-Cal Estimate.**

9. Hinkle, et al. v. Kent, et al.

Plaintiffs (individual Medi-Cal beneficiaries and other similarly situated individuals) and Plaintiff California Council of the Blind allege that the Defendants (including the Department, Alameda County, Contra Costa County, and San Diego County) have failed to provide effective communication to blind individuals, by neglecting to identify and track people who need alternative, accessible formats and neglecting to respond appropriately to requests for alternative, accessible formats. These failures allegedly denied Plaintiffs and other putative class members' critical information about their health benefits, discriminate against them on the basis of their disabilities, and violate their due process rights under the United States Constitution. Plaintiffs seeks certification of the class action, a declaration from the court that all Defendants are in violation of Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act, the California Unruh Civil Rights Act, and other California statutes and implementing regulations. Plaintiffs also seek injunctive relief ordering Defendants to comply with the law and to: 1) provide all information provided to Medi-Cal applicants and beneficiaries to Plaintiffs and similarly situated individuals in their requested alternative format; and 2) in consultation with Plaintiffs, develop a plan that includes any policy changes necessary for a durable remedy.

Plaintiffs filed their Complaint on October 22, 2018. Initial disclosures and an answer to the Complaint were filed on February 1, 2019. Settlement discussions are ongoing and mediation sessions were held on May 9, 2019, July 12, 2019, and January 17, 2020.

10. 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

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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. **On April 17, 2020, CMS provided the requisite federal approvals for the settlement terms. This matter is now closed, and will be displayed in the Lawsuits/Claims policy change and will no longer be reported in these Informational Assumptions.**

**10. Kent v. Phillip**

**The Department filed an estate recovery complaint to recover capitation payments made on behalf of a Medi-Cal beneficiary, consistent with state and federal policy. In response. The beneficiary's heirs filed a cross-complaint in San Luis Obispo Superior Court alleging the Department only has authority to recoup the costs of actual services rendered, and not the cost of capitation payments made on behalf of beneficiaries enrolled in Medi-Cal managed care. The cross-complaint was subsequently amended to include similarly situated individuals. On January 16, 2019, the court denied the Department's motion for judgement on the pleadings. No trial date has been set, and discovery is ongoing.**

**11. California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician Administered Drugs**

~~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.~~

**12. 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 completed audits of 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~~

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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 EHR incentive payments. The Department will request voluntary repayment from hospitals without pending payments, and initiate collection if necessary.

13. 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.

14. Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments for University of California, San Diego Medical Center, San Diego, California State Fiscal Year 1998 (A-09-01-00085)

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.

**According to the findings made by the OIG, The**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.

**The net overstatement of the UCSDMC limit by \$19,780,452 (\$3,855,284 and \$15,925,168) consisted of:**

- **\$5,012,475 overstatement for not calculating the limit using actual incurred expenses and payments;**
- **\$16,462,104 overstatement for not limiting total operating expenses to amounts that would be allowable under Medicare cost principles;**
- **\$3,559,577 overstatement for including bad debts as an additional operating expense;**

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- **\$11,976,911 overstatement for double counting charges for Medicaid managed care and county health plans and the Short Doyle program, and including charges for services provided to inmates;**
- **\$17,230,615 net understatement for reducing uninsured cash payments with allowances for insured patients and increasing uninsured cash payments by including payments for Clinical Teaching Support (CTS).**

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.

**OIG recommended the Department to refund the federal government \$3,776,100 representing federal share of the UCSDMC overpayment associated with the findings for Medicare cost principles, bad debts, Medicaid managed care and county health plans, Short Doyle program, and uninsured cash payments. The OIG report does not detail the \$3,776,100 or how the amount was calculated.**

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.

15. **Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments to Kern Medical Center, Bakersfield, California, State Fiscal Year 1998 (A-09-01-00098)**

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 **\$38,714,784** overstatement of the KMC limit consisted of the following items:

- **\$8,585,373 for not calculating the limit** ~~Using~~ **using** projected amounts instead of actual incurred expenses and payments;
- **\$26,533,060 for** ~~Not~~ **not** limiting total operating expenses to amounts that would be allowable under Medicare cost principles;
- **\$670,658 for** ~~including~~ **including** bad debts as an additional operating expense;
- **Double \$2,925,693 for** ~~Double~~ **double** counting charges for the Short Doyle program (**\$637,987**) and including charges for services provided to inmates (**\$1,927,240**) and Kern County employees (**\$360,466**).

**State law requires that if any DSH payment exceeded the limit as determined by an audit or a federal disallowance, the state should recoup the amount of the payment that exceeded the limit. The state plan also required recoupment of amounts that exceeded the limit.**



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OIG recommended the Department refund to the CMS \$14,165,950 **(or \$14,166,000, rounded to the nearest 100)** representing the federal share of the KMC overpayment **(\$28,202,171 x 50.23 percent)** associated with the findings for Medicare cost 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.

16. 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.~~

16. Audit of California's Medicaid Inpatient Disproportionate Share Hospital (DSH) Payments for State Fiscal Year 1998 (A-09-02-00054)

**The OIG reviewed the State of California's Medicaid Inpatient DSH program to verify the SFY 1998 payments made to individual hospitals did not exceed the hospital specific limits as imposed by Omnibus Budget Reconciliation Act (OBRA) 1993.**

**The Department made DSH payments to some hospitals that exceeded the SFY 1998 limits. The limits as determined by the state did not comply with the apparent purpose of OBRA 1993 and CMS' requirements and implementing guidance. Excess DSH payments totaling more than \$502 million (\$252 million federal share) were made to 27 hospitals that received SFY 1998 DSH payments in California. OIG also identified other issues pertaining to payments made to hospitals after closure,**

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**INFORMATION ONLY****duplication of Medicaid managed care data, and internal controls of the state's DSH operations.**

**OIG recommended the Department to refund the federal government \$33,318,976 (or \$33,319,000, rounded to the nearest 100) which consist of the following:**

- **\$31,645,462 representing the federal share of the DSH overpayments (\$63,001,119 x 50.23 percent) associated with the findings for Medicare cost principles and bad debts;**
- **\$1,673,514 representing the federal share of overpayments made to six hospitals due to the duplication of Medicaid managed care data in the SFY 1999 DSH calculations.**

**Except for bad debts, payments to closed hospitals, and duplication of Medicaid managed care data in SFY 1999, the Department disagreed with the findings based on its interpretation of OBRA 1993 and CMS' implementing guidance for OBRA 1993. The Department disagreed with this finding and the subsequent repayments. The Department submitted the required disallowance package to CMS, and is still waiting on final approvals. Should the package be denied, the Department will work with CMS on the appropriate next steps.**

**OTHER: REIMBURSEMENTS****1. Federal Upper Payment Limit**

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

**2. Accrual Costs Under Generally Accepted Accounting Principles**

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to an accrual basis.

**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

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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

### Strengthening Coordination of Benefits and Post Payment Recovery

**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. California's "CalABLE Savings Plan" opened to the public on December 18, 2018. 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. 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 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.

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**INFORMATION ONLY****OTHER: MISCELLANEOUS**1. Certified Vital Records

The Department has created 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. Medi-Cal Program Integrity Data Analytics

~~Assembly Bill 74 (Chapter 23, Budget Act of 2019) appropriated \$9 million in funding for the Department for Medi-Cal Program Integrity Data Analytics (MPIDA). An additional \$1 million is available 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 \$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.~~

2. Health Plan of San Mateo Dental Pilot Project

A dental integration pilot program in San Mateo County has been authorized. The **Health Plan of San Mateo Dental** pilot program **project** 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 scheduled for **January 2022**.

3. Electronic Visit Verification

~~Electronic Visit Verification (EVV) must be implemented for Medicaid-funded personal care services by January 2020, and 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,~~

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including education and training for all 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.

**Electronic Visit Verification (EVV) is a telephone and computer-based method that electronically verifies in home service visits. EVV systems must verify type of service performed; individual receiving the service; date of the service; location of service delivery; individual providing the services; and time the service begins and ends. Section 1903 of the SSA [42 U.S.C. 1396b(l)] requires all states to implement EVV for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) that require an in-home visit by a provider. In California, EVV impacts all PCS and HHCS provided under the Medi-Cal state plan and under several Medicaid waiver programs, including those Medicaid programs administered by the Department, the California Department of Social Services (CDSS), the California Department of Developmental Services (CDDS), the California Department of Aging (CDA), and the California Department of Public Health (CDPH).**

**States must require EVV use for all Medicaid-funded PCS by January 1, 2020, and HHCS by January 1, 2023. Otherwise, a state is subject to incremental Federal Medical Assistance Percentage (FMAP) reductions from 0.25% and up to 1%. The Centers for Medicare and Medicaid Services (CMS) approved California's request for a one-year good faith exemption for PCS on October 22, 2019. As a result of the exemption, California will not be subject to FMAP reductions in 2020 for PCS, however they will be subject to incremental FMAP reductions beginning with 0.5% starting January 1, 2021. Federal penalties for not complying with EVV requirements increase each calendar year by 0.25 percentage points to a maximum of one percent in 2023 for PCS. There is a similar penalty for HHCS if EVV for HHCS is not implemented by January 1, 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 **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. **The Department is**

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collaborating with CDSS, DDS, CDPH, and CDA to develop a cross-department EVV solution that meets federal requirements.

### FISCAL INTERMEDIARY: MEDICAL

Advance Payment Authority

This assumption has been deleted as this has been withdrawn.

### FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

### FISCAL INTERMEDIARY: DENTAL

1. Fiscal Intermediary (FI) and Administrative Services Organization (ASO) changes for Dental

~~Due to the significant changes in policy since the FI and ASO contract was negotiated, the Department is aware of the following proposed change to the contract with Delta.~~

- ~~• To meet the processing times in the contract and accommodate for increased TAR volumes, the Department is negotiating with the ASO for a rate to be applied for documents above the original range in the bid. The ASO has also requested additional staff to help adjudicate these claims.~~

2. State Controller's Office Interagency Agreement

The Department initiated an interagency agreement with the State Controller's Office (SCO) in FY 2016-17 to transition checkwrite services away from the Fiscal Intermediary (FI). Due to competing priorities, the Department put this project on hold. The Department initially planned to restart this work in FY 2017-18. However, due to lack of resources to fully support the project, a pending enterprise solution to the Federal Drawdown Reporting (FDR) system, as well as no legal mandate to transition the services at the time, the Department halted the project until the FDR could be properly implemented.

The Department does intend to work in the future with the SCO to alter the current check write function, which the FI is currently responsible for. The FI will continue to fulfill duties related to checkwrite until a new process has been implemented between the SCO and the Department. This complex effort will require multiple phases in order to alter the current system to allow for SCO takeover of the check write function. Costs to consider in the future pertain to analyzing business processes, system testing, updating the CD-MMIS and enabling the SCO systems the ability to perform the check write function.

**DISCONTINUED POLICY CHANGES**

**Fully Incorporated into Base Data/Ongoing**

**ELIGIBILITY**

**AFFORDABLE CARE ACT**

**BENEFITS**

PC 42 Youth Regional Treatment Centers

PC 50 Whole Child Model Implementation

**HOME & COMMUNITY-BASED SERVICES**

PC 189 Waiver Personal Care Services (Misc. Svcs.)

PC 198 Overtime for WPCS Providers

**BREAST AND CERVICAL CANCER**

**PHARMACY**

**DRUG MEDI-CAL**

**MENTAL HEALTH**

**1115 WAIVER—MH/UCD & BTR**

**MANAGED CARE**

**PROVIDER RATES**

**SUPPLEMENTAL PAYMENTS**

**COVID-19**

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**OTHER: MISCELLANEOUS**

PC 135 Dental Retroactive Rate Changes

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

## **DISCONTINUED POLICY CHANGES**

### **Time Limited/No Longer Available**

#### **ELIGIBILITY**

##### **AFFORDABLE CARE ACT**

PC 25 ACA MAGI Savings

##### **BENEFITS**

PC 47 Asthma Mitigation Project

##### **HOME & COMMUNITY-BASED SERVICES**

PC 43 Pediatric Palliative Care Waiver

##### **BREAST AND CERVICAL CANCER**

##### **PHARMACY**

##### **DRUG MEDI-CAL**

##### **MENTAL HEALTH**

##### **1115 WAIVER—MH/UCD & BTR**

PC 86 MH/UCD – Stabilization Funding

PC 90 MH/UCD – Health Care Coverage Initiative

PC 91 BTR – Low Income Health Program - HCCI

##### **MANAGED CARE**

PC 108 General Fund Reimbursements from DPHS

PC 101 MCO Enrollment Tax Mgd. Care Plans-Incr. Cap.Rates

PC 111 MCO Enrollment Tax Mgd. Care Plans-Funding Adj.

PC 112 MCO Enrollment Tax Managed Care Plans

PC 87 Whole Person Care Housing Services

##### **PROVIDER RATES**

PC 131 AB 97-Related Adjustment

##### **SUPPLEMENTAL PAYMENTS**

##### **COVID-19**

##### **OTHER: AUDITS AND LAWSUITS**

##### **OTHER: REIMBURSEMENTS**

##### **OTHER: RECOVERIES**



## **DISCONTINUED POLICY CHANGES**

### **Time Limited/No Longer Available**

#### **OTHER: MISCELLANEOUS**

CA 7 County Administration CMS Deferred Claims  
OA 103 Reconciliation  
PC 186 Payment for Reprocessed Claims to FQHC/RHC  
PC 44 Free Clinic of Simi Valley  
PC 265 Reconciliation  
PC 267 Additional Federal Funding to Other Dept.

#### **FISCAL INTERMEDIARY: MEDICAL**

OA 49 Medical FI Operations  
OA 54 Medical FI Hourly Reimbursement  
OA 55 Medical FI Cost Reimbursement  
OA 59 Medical FI Other Estimated Costs  
OA 61 Medical FI SRP Release 1 Hosting  
OA 62 Medical FI Optional Contractual Services  
OA 63 Medical FI Miscellaneous Expenses  
OA 65 Medical FI Change Orders

#### **FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

#### **FISCAL INTERMEDIARY: DENTAL**

PC 213 Pure Premium Fund Closeout  
OA 72 Dental FI Takeover 2016 Contract  
OA 73 Dental FI CD-MMIS Costs  
OA 74 Dental ASO Takeover 2016 Contract

**DISCONTINUED POLICY CHANGES**

**Withdrawn**

**ELIGIBILITY**

PC 266 Hearing Aid Coverage - Admin

**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**

**PROVIDER RATES**

PC 223 Nursing Facility Financing Reform

**SUPPLEMENTAL PAYMENTS**

**COVID-19**

PC 248 COVID-19 Emergency FMAP – Other Depts.

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**OTHER: MISCELLANEOUS**

OA 41 Medicare Beneficiary Identifier

OA 20 SURS and MARS System Replacement

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**